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VISIT TO THE UGANDA CDD PROGRAM

A Report Prepared By:
AGMA PRINS

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1. Introduction

I visited Uganda for 8 days in July, 1989 at the request of USAID/Uganda and UNICEF/Uganda. The initial request from USAID was for "assistance for the development of a long range plan for training of health inspectors and other extension staff... to increase training of concerned family members in the community to increase the number of children treated in the home... for dehydration and diarrhea (Kampala 01612, cable)." The terms of reference received from UNICEF upon arrival were considerably more extensive (see Annex 1) and asked for assistance going well beyond CDD to include PHC related activities. It became clear shortly after arrival that both scopes of work were beyond the possible given the short time available and the limited information extant in the areas of requested assistance. It was therefore agreed between the consultant and USAID and UNICEF representatives that the current visit would limit itself to the outline of steps necessary to achieve the overall terms of reference requested by UNICEF and a preliminary list of activities to which PRITECH could provide technical assistance, on condition that adequate funding could be made available to make this assistance possible. Because of the absence of the CDD program manager during the visit, the preliminary tasks were accomplished primarily with the assistance of the UNICEF CDD program manager, Mr. Steve Adkisson, the PATH consultant, Mr. Terry Eliot, who was relatively familiar with the program from previous visits and with some CDD national program staff. A one day field visit provided some extra insight into the program, completing information garnered from interviews and from program documents. However, the visit was too brief to allow for an in depth understanding of all aspects of the Uganda CDD program.

2. Background of CDD Uganda

The Uganda CDD program was initiated in 1984 with the goal of decreasing diarrhea related child deaths by 50%. Two phases were planned: Phase I (1984-1986) emphasizing case management improvements and Phase II (1987-1991) emphasizing epidemic investigation and control, environmental measures and integration with MCH. Program progress has been uneven and spotty due largely to the political and economic turmoil of the past decade. Despite increasing social stability since 1986, some parts of Uganda remain largely inaccessible due to continued violence. The severe continued economic crisis slows recovery nationwide.

Examples of CDD progress and problems include the following:

Recognition of the ORS packet by mothers has increased from 7% in 1984 to almost 90% in 1989 (UNEPI/CDD household level survey). However, only 21% of mothers know how to correctly administer ORT. In one recent study (Demographic and Health Survey 1988/89), only 8.9% of cases of diarrhoea of children under 5, in the two weeks preceding the study, had been treated with ORT.

Over 80% of District level managers and over 1,500 rural health workers have participated in mid-level managers' and operational level (OPL) training programs respectively. These programs are two-week courses, "integrating" numerous PHC topics. Follow-up and supervision have been weak. The quality of diarrhea care at the health center level is reportedly very uneven--despite the fact that most health care facilities have been equipped with an ORT "kit" containing all necessary supplies (spoons, cups, boilers, etc.). It should also be noted that less than 60% of the Ugandan population currently lives within 10 miles of a health unit.

Over 5.5 million packets have been imported over the past four years. But this number has not met the needs of the Ugandan population of over 16 million. Also, importation has been irregular. The use of ORS in treating diarrhea in health care facilities, however, has reportedly increased from 5% to 30% of cases. A current collaborative effort between UNICEF, PATH/USAID, the MOH and a private pharmaceutical company, Medipharm, is aimed at initiating local production of ORS before the end of calendar year 1989.

3. Facts and figures relevant to Uganda/CDD implementation.*

3.1. Population: 16 million

population growth rate: 2.8% or more

total fertility: 5.6 - 8.5 (according to region)

population under 5 years: 19.2%

population density: 64/km² (fifteenth most crowded in Africa)

rural population: 91% (eighth least urbanized country in the world)

average household size: 5-6 persons; 30% over 9 persons.

3.2. Organization

34 Districts divided in counties, sub-counties, parishes and villages.

Resistance Committees (RC) and councils (see Annex 2)

3.3. Health Budget

recurrent budget (MOH) 1988/89 = 16.9% of 1970/71 level

salaries: Ministers (of state) earn a maximum of 9000 U.Sh
(= 4% of UN LSSC estimate of monthly income needed to support a family of 5)

Ergo: All government employees supplement their income with other jobs. (for example: health inspectors probably work no more than 12 days/month at their official jobs -- even with UNICEF-paid incentives)

* These statistics have been drawn from the draft UNICEF "Situation Analysis" of 1989.

3.4. Child Health

Mortality: 0-11 mos: 106/1000
1-4 yrs: 50/1000

Principal causes of death: 0-11 mos: ARI, diarrhea, malaria
1-4 yrs: measles, malaria, diarrhea, ARI

Morbidity: principal causes of child hospital admissions in 1987: malaria and diarrhea.

No episodes of diarrhea/child/year: 4-5 episodes (<5 yrs)

Malnutrition: 5% incidence of acute malnutrition in children, nationwide

urban children are more likely to be malnourished

3.5. Health Care System

792 public sector health facilities (most in poor repair, poorly equipped)
145 non-government health facilities

350 private physicians
6000 traditional healers

27% of population is within 5 km of a health facility
57% of population is within 10 km of a health facility

3.6. Mass Media

radio listenership (listen regularly): 30%
radio ownership: 26%
television: 5-6 hrs daily transmission
audience 50,000 in Kampala and environs

3.7. Education

primary school attendance: 70%
secondary school attendance: 8.9%

4. The Health Inspectorate

In an attempt to reach mothers more directly and more easily than is possible either through the health services or through mass media, the CDD program in Uganda has turned to the Health Inspectorate. This service, the traditional hygiene and sanitation personnel of the Ministry of Health, has been for all practical purposes, largely defunct until quite recently. During the long years of war, its 1,000 or so extension agents, including health inspectors (HI), more junior health assistants and on-the-job trained health orderlies, gravitated toward their homes to practice agriculture or other survival occupations. As a result, the

current distribution of this personnel diverges significantly from the theoretical organigram in Figure 1. Deprived of office space, equipment, supervision or skills training, many of these personnel neglected or significantly reduced the practice of their profession. Skills levels declined. Motivation was low. Corruption helped provide for extra earnings.

Since 1988, CDD has attempted to give the Health Inspectorate new direction. Thirty HI personnel from each district were to be trained in three day workshops to teach mothers about ORT. HI personnel were to spend 12 days each month identifying "families-at-risk" (see Annex 3 for definition) to visit in order to teach them about diarrhea prevention and treatment; contacting Resistance Committees (RCs) to explain the CDD program and providing CDD education to school children and other community groups. Participating HI personnel (health inspectors and health assistants only) were to receive small daily allowances to encourage their participation (allowances paid by UNICEF). So far, this strategy has been implemented in 15 districts with mixed results.

Figure 1

Theoretical Health Inspectorate
Organigram

|
District
(Health Inspector)

|
County
(Health Inspector)

|
Sub-County
(Health Assistant)

|
Parish
(Health Orderly)

|
Village

Other PHC programs, recognizing the potential of the Health Inspectorate, have become interested in using these personnel also. There is some feeling that the HI should become a sort of PHC extension service, combining more traditional hygiene and sanitation responsibilities with those of PHC workers. While this idea certainly has merit, there is a danger of demanding or expecting too much too quickly without sufficient attention being given to careful in-service training to re-establish old skills and introduce the necessary new ones.

5. Traditional Healers, Women and Private Practitioners

The CDD national team spends an average of 12 to 15 days in each district to complete current training activities for CDD collaborators. This includes 3 days of training for 30 health inspectors, 1 day of training for groups of up to 40 traditional healers for each county, 1 day for up to 30 women leaders (from RCs) per district, 1 day for up to 30 private practitioners (MDs, midwives and pharmacists) and 1 day per county for groups of up to 20 rural health unit workers. The one day training sessions focus on diarrhea case management, discussion of (false) traditional beliefs and practices and discussion of the role of the participants in spreading the CDD message through the community. Consistent follow-up is done only for the Health Inspectorate personnel. There are indications that the other groups either do not actively promote CDD after their training or make many errors in their teaching and use of ORT (for the most part)

Even though the amount of training provided is clearly insufficient, at the current rate of one district per month, it would take 2 1/2 years of training activities for these groups alone to cover all 34 districts. At present this training has been stopped after a coverage of about 15 districts in order to review and consolidate what has so far been achieved.

6. Some Observations and Suggestions Regarding the Health Inspectorate Work and Training

6.1 Current Training Program (CDD)

These suggestions and observations are based on discussions with CDD staff, with a few Health Inspectorate personnel in the field and with two families at risk as well as on review of existing training materials. They are not based on actual observation of training activities and, thus, are probably incomplete and possibly inaccurate. However, they are offered as discussion and reflection topics for those responsible for further training activities.

- The preliminary three day training for Health Inspectorate personnel appears too brief for the content covered. Evening sessions appear very ambitious in content and scope. Perhaps

because of the brevity of the training, there appears to be heavy emphasis on lecture, reading and discussion with little emphasis on practice (simulation or field work) feed back and correction. For example, it would be useful to do a simulation exercise regarding discussion of traditional beliefs with mothers, the use of the pamphlet to teach mothers about ORT, counseling, or working with an RC. These simulation exercises should be as real as possible. Criteria should be established for evaluating the effectiveness of the interaction. Observers should offer exact, precise, actionable feedback. An opportunity should be offered for a second try to improve performance. Even better would be practice sessions with actual communities.

- There is no room in the current training plan for presentation (to the participants) of the objectives of the training, discussion of the expectations of the participants, agreement seeking on the schedule, mutual introductions and other introductory activities which set the tone for participatory rather than top down, directive training approaches. There also do not appear to be any evaluative activities in the current schedule. Such "process" activities during training are vital to assure active engagement of the participants in the training as well as to allow the trainers to judge the effectiveness of their training.
- It would be useful to include a session on how to follow-up and work effectively with the women healers, traditional healers and private practitioners which have been trained. For example, can the women leaders be taken along to visit families at risk? Is it possible, in some cases (having prepared for it in advance), to take children with diarrhea and their parents to a convinced traditional healer? These future interactions between Health Inspectorate personnel and the other members of the local "CDD team" (including health center personnel) need to be carefully defined. Time needs to be allotted in the work schedules to assure that these follow-up contacts and activities really happen.
- It would be useful to have a session on what mistakes mothers frequently make when giving ORT to their children so that Health Inspectorate personnel will emphasize these messages during their education sessions. For example, superficial investigation suggests that, although the vast majority of mothers recognize ORS, less than half know how to mix it correctly (what are the most common mixing errors?) and only around 20% know how to administer it correctly - often giving too little liquid.
- Another area which appears weak is the necessary emphasis on sufficient (frequent, in small quantities) feeding during

diarrhea and "catch-up" (one extra meal per day for one week) after diarrhea.

- A session on targets and standards and criteria for success would appear very useful. Just what activities should a health assistant seek to accomplish in a month (talking to RC's, schools, families at risk, visiting traditional healers, private practitioners etc.) How many times should each activity be accomplished; e.g. how many families at risk should be visited per month? How much time should each activity take - maximum and minimum. e.g. how much time should he spend with a family during a first or second visit? What are the minimum criteria for the successful accomplishment of any given activity; e.g. - how do you evaluate whether you work accomplished anything? Examples of social accomplishments might be stated as follows: "At the end of the first home visit the mother should be able to recite the two essential components of good diarrhea care: food and liquids" or "At the end of the RC meeting at least two members should agree to accompany the H.A. on a home visit."

6.2 Current Activities

- It appears that, in some instances, the health assistants and health inspectors do not actively seek to initiate or continue active working relationships with the other people in their communities who have received CDD training: the women leaders, the traditional healers, the private practitioners and even the health center staffs. This is unfortunate as the training these other people received is likely to go to waste unless they too receive active follow-up and are provided opportunities to actively use their new knowledge (as well as to refine and strengthen that knowledge)
- While the "family-at-risk" concept is an important and useful one, it is probably not sufficient as a public sector education strategy for ORT. Many questions arise:
 - Is it really true that as currently defined (see definition in Annex 3), "families at risk" are more in need of ORT education than others?
 - Is it really true that these most disadvantaged families serve as "satellite homes", eg. models for others to copy in regards to diarrhea treatment?
 - How many "families-at-risk" should a health assistant seek to identify in any one community (the records examined by this writer suggest that sometimes up to 20 families are identified in a village (average village size 2,000-4,000 people??)

- If a health assistant at a sub-county level really covers between 40-60 villages, how many "families-at-risk" can realistically be visited on a work schedule which allots a maximum of 12 days/month to all CDD activities? How long is each visit? How many follow-up visits should be made and can realistically be expected.

For the sake of example, suppose that a health assistant (HA) covers a population of 30,000 people in his sub-county. With an average family size of 8 (1980 census), this would be 3,750 families. If 5% of these families were considered "at risk", the health assistant would have 186 families to visit. These families would be dispersed over a large area, often accessible only over very poor roads, which the HA must cover by bicycle. Assume the HA spends at least 45 minutes during each visit with each family and that a minimum of 2 visits are necessary to assure adequate teaching of the CDD messages. Assume that average travel time between households is 45 minutes. Assume, also, that the HA spends six days working with RCs, schools, etc. Assume the HA works a 6-8 hour day.

Under these assumptions the HA would need over one year to adequately cover the families at risk in his area (5% of the population) [$((186 \text{ families} \times 3 \text{ hours/family}) \div 7 \text{ hrs/workday}) \div 6 \text{ days/mo}$].

It would seem useful to assess and refine the "family-at-risk" strategy on the basis of this type of calculation (based on figures which represent real field conditions of the HAs). It is probable that, given the limits of bicycle travel, many "families-at-risk" will never be reached by the current approach no matter how carefully these visits are planned. Clearly complementary public education approaches will be needed to assure adequate comprehension of ORT by mothers (recognition, mixing, use, storage, nutrition, etc.)

Given the low ORT usage figures (averaging less than 10% nationwide) discovered during the recent Demographic and Health Survey in Uganda, a broader educational strategy seems advisable. Reinforcement of the roles of RC women leaders and of traditional practitioners is one option. Increased use of radio (to reach the 20% of the population who do have regular access to radio) should also be considered. Health education provided at health centers should be assessed to see if it can be improved to reach more people more effectively. Perhaps the lowest rung of the Health Inspectorate, the health orderlies, should be trained to conduct home visits in their areas where these do not overlap with areas already covered by health assistants

- The policy concerning the provision of ORS to traditional healers should be reviewed. Currently traditional healers are trained to use ORS (although many mixing errors are reported)

but are not provided with packets. One reason for this apparently is that some traditional healers were found selling their packets in the market. It seems unlikely that healers will incorporate the use of ORS into their practice if they are not provided with packets. It does not seem realistic to expect them to eventually purchase private sector packets at a pharmacy (nor to send their patients to do so). Perhaps a limited monthly stock could be provided (or sold at minimum cost) to healers who during a follow-up visit could demonstrate correct mixing and explain correct usage of ORS. Even sale of ORS packages by traditional healers in the market does not seem like a negative phenomenon -- it only serves to further spread ORS usage -- as long as the seller knows how to mix it correctly.

- During the brief field visit conducted during this writer's visit to Uganda, it became evident that some health assistants were not teaching ORT in households of families-at-risk, preferring to conduct group demonstrations at RC meetings. Also, the mothers' leaflets were not always used as educational tools but were sometimes simply handed to mothers with no explanation (after ORS demonstration) or were reserved for literate mothers only. Use of these leaflets as educational tools needs to be reinforced. The need to verify and reinforce mothers' knowledge during home visits, even after group education sessions needs to be emphasized.

7. Other Comments and Suggestions

- According to a team in the field and to Grace Akudu at UNICEF, the integrated OPL training package is to address Health Inspectorate personnel as well as other health personnel. The idea is to create a "health team" of various local health professionals working together to implement primary health care and public health. The team would include, at the county and sub-county levels; the health assistant, the community health worker, the health educator and the medical assistant (or other health unit staff). Besides their health specialty tasks, all members of this team should share basic community health tasks such as health education, preventive activities (including home visits), health planning and the like. All health personnel are to participate in the OPL course to reinforce or learn the skills necessary to these joint PHC tasks. The two week program, as it currently stands, covers the following topics:

- PHC concepts and objectives
- IEC for behavior change
- Breastfeeding and nutrition
- Growth monitoring and promotion
- Diagnosis, medical history taking
- Counseling

- Home visiting
- Family planning
- Cultural beliefs and practices about common diseases
- Fever, malaria and typhoid fever
- Worm infestations
- Anaemia
- Ear and skin conditions
- Diarrhoea and dehydration
- Common accidents
- Respiratory tract infections
- AIDS
- Sterilisation
- Immunization
- Management of essential drugs
- Health information system
- Environs mental health
- Continuing education

Clearly such a diverse curriculum in a two week period can serve as no more than a review of already existing knowledge. Since many of the Health Inspectorate personnel have been in the field with no in-service refresher training and very little active exercise of their profession for many years, it is unrealistic to believe that such a course could prepare them adequately to take on the diverse duties which are now being suggested for them (as a sort of community level primary health care worker in addition to their more traditional tasks of food inspection and water and sanitation activities). Additional, in depth, training will be required for them to effectively operationalize their basic knowledge.

At the same time, any training strategy for Health Inspectorate personnel will have to take into account the intended OPC training strategy and content.

8. Activity Descriptions: possible PRITECH assisted activities

8.1 Training of National and District Level Trainers

Rationale: CDD/Uganda has conducted and planned for substantial training activities for various kinds of health-workers and community leaders. Some of this training is supported by intense supervisory activity. While the CDD national and district level staff have learned a great deal about training simply by having participated in the design and implementation of many CDD training activities, none of the current staff has been specifically and solidly prepared to develop, execute and evaluate training activities. Under the circumstances, CDD has done a commendable job in past training efforts. However, existing training designs reflect the lack of solid training expertise, for example, in the directive emphasis of the activities and the overly ambitious content. More practical, participatory and thorough training designs would lead to more effective application of the learned

skills by participants. Improvement of the training skills of regional (and, perhaps, district) supervisors would also strengthen supervision.

Proposed Activities: The proposed strengthening of training skills would occur in two, possibly three steps. An initial 3-week workshop would seek specifically to strengthen the participants' skills in the use of participatory, experiential, practical training methods, techniques and materials. Participants would leave the workshop with a personal plan for using their new skills and with personal self-improvement objectives. Immediately after the workshop, a core group of participants would work with their trainers to revise existing training designs to reflect their new perceptions about effective training.

Six to nine months later, the same participants and, hopefully, the same trainers would meet for another two week workshop which should place more emphasis on how to design training in addition to honing the participants training skills. Depending on need, a third workshop up to a year later could be envisioned. Each of these workshops would be preceded by a three week planning period which would include meetings between trainers and future participants to more precisely define learning needs according to existing skills levels and performance expectations.

Human Resource Needs

The training team should be composed of two trainers with considerable experience in training of trainers in participatory training methods. Two less experienced trainers could serve as co-trainers. One person needs to be responsible for the logistics of the program. At least one of the expert trainers should have previous experience in the development of national training teams for health related activities.

8.2 Development of a detailed task/job description for Health Inspectorate personnel.

Rationale

Although there appears to be a general description of what Health Inspectorate personnel are supposed to do (encourage people to build latrines, give technical advice on improving water sources, inspect restaurants, markets, building plans), no specific detailed task descriptions have been developed which could serve as guidelines to preparing work plans, to setting standards of performance, to developing skills-based training, to detailing supervisory checklists. There is the intention that the role of the Health Inspectorate be refined and adapted so as to place more emphasis on public health education, community organization and home visiting. The more clearly these new tasks can be delineated,

the easier it will be to develop and monitor the skills and performance of Health Inspectorate personnel at all levels.

Proposed Activities

Establish a working group to develop specific task descriptions for Health Inspectorate Personnel according to their level of responsibility. Task descriptions should address:

- a. What is to be accomplished during home visits (step-by-step) to families at risk (see example in Annex 4)?
- b. What is to be accomplished at a village or community level (see sample list in Annex 5).?
- c. What other tasks are to be accomplished (e.g. building inspections, etc.)?.
- d. What should be accomplished during supervisory visits?
- e. The expected frequency and duration of tasks and other criteria or standards of success.
- f. The relationships of Health Inspectorate personnel with other health workers and extension personnel from other services.

Human Resource Needs

A committee of not more than 12 people, preferably less - made up of key representatives of the Health Inspectorate, the Health Inspectorate Training School, CDD and other appropriate MOH departments-should be established. A facilitator, knowledgeable about hygiene sanitation, water and primary health care activities, but not directly implicated in the decision-making should organize and facilitate the discussions and seek to bring the group to consensus.

8.3 Development of a Long-Term, In-Service Training Strategy for the Health Inspectorate

Rationale:

Due to the difficult conditions in Uganda of the past 15 or more years, the personnel of the Health Inspectorate have long been underutilized or even largely inactive. Although the exact number of personnel in the field is not known, there are believed to be more than one thousand nation-wide, all the way to the village level. The Health Inspectorate consists of three levels of personnel: Health Inspectors (three years of post secondary school training) largely responsible for supervision at the District and County level; Health Assistants (two years of post-secondary school training) largely responsible for activities at the sub-county

level, and Health Orderlies (on the job training only) largely responsible for community activities at the parish and village levels. Because of lack of appropriate housing and other necessities, however, the divisions of responsibility are, in actuality, not so neat and distribution of personnel throughout the country is very uneven. The National School of Hygiene (?), located over an eight-hour drive from Kampala, graduates between 20 and 30 Health Inspectors and Health Assistants a year at present.

Recently, the CDD program has started working with the Health Inspectorate, training Health Inspectors and Health Assistants to conduct home visits and community level health education activities for CDD. These activities have served as a motivational spur to reactivate the Health Inspectorate in the field. Other health programs (e.g. EPI) have begun to realize the potential of Health Inspectorate personnel as PHC field workers - because of their wide reach within communities. There is thus, apparently, growing interest in the retraining of these personnel to enable them to carry-out broader community level PHC functions in addition to their more traditional water, sanitation and inspection functions.

Although the initial level of technical training and scientific knowledge of the Health Inspectorate personnel is said by many to be quite strong, experience during CDD training programs has shown that many of these personnel have not actively used their training and skills in many years and are therefore quite rusty. Also, the highly technical pre-service professional training apparently emphasizes scientific knowledge over such practical skills as community organization, communication and counseling skills, health education, planning, management and organization of activities. In addition, if indeed the tasks of the Health Inspectorate are to be broadened to include other PHC activities, special training will need to be developed to prepare them for these activities.

This training cannot all be accomplished at once. Although the proposed PHC/OPL course might provide a base for further training, it will be insufficient as overall practical preparation. Experience during CDD training has shown that many Health Inspectorate personnel must work hard to gain or regain basic skills. Therefore a phased approach to inservice training is proposed with a brief one week specialized course every six to nine months, each course specifically geared to new work activities to be introduced during the period after the course. Each course should start with a review of the successes and problems encountered during the past six to nine months and end with the preparation of a work plan for the succeeding months.

The basis of the training activities should be detailed task/job descriptions developed by the working committee (activity #2 above)

Proposed Activities

After the establishment of detailed task and job descriptions the following planning steps should be accomplished:

1) Evaluate the degree to which existing Health Inspectorate personnel are currently carrying out these tasks and assess additional in-service training needs to enable existing personnel to carry out tasks defined by the working group. Also identify obstacles, not specifically related to training needs, which may inhibit Health Inspectorate personnel from carrying out defined tasks.

This evaluation should take the form of a one to two week field study based on in-depth interviews with existing Health Inspectorate personnel.

2) Establish a list of training content areas and work with appropriate MOH personnel to prioritize these according to the level of Health Inspectorate personnel.

3) Taking into account the schedule, content and coverage (in terms of level and numbers of personnel) of the proposed PHC/OPL course, develop a training strategy and schedule (eg. who participates, how frequently, who will organize, conduct, follow-up and evaluate training etc.). Detail which activities will be added to the Health Inspectorate task description after each training. Detail how the impact of training will be monitored and evaluated.

4) Detail the content methods and process to be used for each training activity, as possible. (See Annex 6 for a preliminary list of ideas)

Personnel Resource Needs

A training specialist with considerable experience designing and carrying out participatory, practical in-service training for this type of para-professional health personnel should work with a small group of appropriate MOH counterparts - including Health Inspectorate, PHC and CDD representatives among others. Collaboration with Health Education and the Health Manpower Development Center should be considered.

8.4 Develop Long-Term Health Inspectorate Man-Power Development Strategy.

Rationale

See #3 above

Proposed Activities

To the extent possible the strategy will include the following:

- Description and analysis of the current Health Inspectorate manpower situation:
 - numbers and levels of personnel
 - their location and job responsibilities
 - their age (eg. in relation to retirement) and official employment status
 - their experience and training
 - current standards and criteria of employment, promotion etc.
 - current office and other resource availability
 - salary and benefit structures
 - obstacles to full-employment etc.
- Analysis of future employment needs and conditions
- Training targets for the school and for new recruitment into the Health Inspectorate service.
- Analysis of current school curriculum in relation to newly developed job descriptions and recommendation for revision of the curriculum.
- Analysis of school personnel and material resources in terms of proposed curriculum revisions.
- Analysis and proposals of the relationship between proposed pre-service (professional) and in-service (on-going) training.

Human Resource Needs

A manpower development specialist and a training expert experienced in the professional development of similar PHC/Hygiene and sanitation personnel in Africa should work with representatives of the MOH, the Health Inspectorate school and the Health Inspectorate service.

8.5 Development of a Program for the Organization and Training of Traditional Healers

Rationale

There are probably more than 5000 traditional healers in Uganda. The deterioration of the modern health services network during the long years of social unrest led many Ugandans to rely more heavily on other, traditional sources of health care. One study showed that as many as 35% of Ugandans obtained medicine from sources other than the formal health sector during their most recent episode of illness. Perhaps as much as 42% of the caseload of

traditional healers is for diarrhoeal disease. With this in mind, CDD/Uganda has included traditional healers in District level CDD training activities. A one day training program has been designed for them. As the groups of participants are often large (up to 40 or 60) the training tends to be didactic, although an effort is made to engage the healers in discussions. Emphasis is on the definition of diarrhoea, its causes (according to western medicine), cultural beliefs associated with diarrhoea, dehydration and malnutrition as consequences of diarrhoea and ORT. Anecdotal evidence suggests that many healers who have attended these brief courses make serious errors in the preparation and administration of ORS.

The Healers were contacted through the Resistance Committees at the District level, with help from the local Ministry of Culture representatives. Healers are, in principal, organized in associations registered with the Ministry of Culture. The largest of these is Uganda Meddacala Lyu Yo. There are no national lists of members, these reportedly being kept at the district level.

Given the importance of the traditional healers in Uganda a closer collaboration with them is sought, especially in the area of primary health care.

Proposed Activities

Working with the ministry of culture the existing organizational networks of the traditional healers should be identified and analyzed. Healers who have participated in CDD training (and whose names are, thus, available) should be interviewed to find out their organizational memberships, if any, as well as their expectations from and attitudes toward belonging to professional organizations. County and district level personnel of existing organizations should be contacted to discover the membership and activities of various traditional healers' organizations.

At the same time, a random sample of healers who have participated in CDD training should be interviewed to determine what effect the training has had on their practices vis-a-vis diarrhoea treatment, what they found useful and not useful about that training and what they would like to learn more about in future training activities.

Ministry of Health, Ministry of Culture and Traditional Healers' representatives should meet to discuss possible roles and activities of traditional healers for primary health care and draw up a list of activities to be promoted for traditional healers (e.g. what they should/could do in relation to PHC). The intended interaction between traditional healers and the MOH health care team should be defined.

Based on these findings a training strategy and training content would be defined including who should be responsible for conducting

the training activities. The CDD training team should assist in the development of appropriate materials, perhaps after their 2nd TOT workshop.

Personnel Resource Needs

One trainer with some knowledge and or experience working with traditional practitioners, possibly assisted by an appropriately trained and experienced medical anthropologist should work with two to four Ministry of Health and Ministry of Culture personnel to develop and define these activities as well as to carry them out.

8.6 Operations Research about the "Family-at-Risk" Approach

Rationale

Currently a large chunk of the public sector CDD education strategy is based on targeted home visits to "families-at-risk", who are essentially socially and economically handicapped families (as defined by a set of criteria - see Annex). The belief is that these families are the most in need for special education concerning ORT because their children are especially vulnerable to ill health, while their adults have least access to other channels of health related information (Health Centers, women's groups etc.). In addition, some CDD staff believe that these families could serve as "satellite homes" for CDD messages, serving as examples to other families. As mentioned in another section of this report ("Some observations and suggestions..."), there are many potential pitfalls with this approach. The criteria for the selection of these families as target families were not carefully researched. Also, it is not clear how effectively or fully these families can be reached by existing Health Inspectorate personnel, nor how effective the duration being provided is.

Activities

Key issues and questions regarding "at risk families" should be formulated by concerned CDD and HI staff working with an experienced social science researcher. A study protocol should be designed and implemented. The study should last no more than three months, and the study results should be analyzed as quickly as possible.

Interpretation of the results and the development of an action strategy to apply the findings, in a practical way, to improving the CDD education activities, should be carried out jointly by the researcher and CDD and HI colleagues.

8.7. Development of Supervisory Protocols and Checklists and Revision of the CDD reporting system.

Rational:

CDD Uganda is to be commended on the attention devoted to follow-up and supervision of the trained Health Inspectorate personnel. Regional coordinators visit each district in their region every month for three days, distributing per diems, verifying monthly worksheets, collecting district level monthly reports, choosing at random one or more county and sub-county personnel to visit, and even visiting some families-at-risk. This intense supervision is providing an opportunity to strengthen skills acquired in training and to correct errors.

This supervisory effort could be rendered more effective by the development of supervisory protocols and checklists. Such tools would lessen the tendency to emphasize logistical matters (transportation failures, reporting lacks, work plans) over quality of work accomplished (what was taught at a school, what messages were emphasized - or not - to families at risk, what collaborative efforts were carried out with women leaders and traditional healers, etc.)

Also, a simpler and more standardized reporting format would permit supervisors and national staff to spot more easily weak areas and potential pitfalls. The reports should provide a number of standard tables and charts to record facts and figures regarding monthly activities. A section on problems and successes and a last section on activities planned for the following month would be useful additions. The reporting system should include mechanisms for specific and concrete feedback to all levels of concerned personnel.

Proposed Activities

The existing system should be studied. A detailed list of information needs at various levels of the system should be drawn up by CDD HI personnel with the assistance of a health information specialist. This analysis of information needs should be based, in part, on the task description for the Health Inspectorate personnel (activity 2) and should reflect agreed to performance standards and criteria. Reporting formats and supervisory tools should be designed to reflect the information needs and performance objectives defined.

Personnel Resource Needs

A health information specialist should collaborate with a team of appropriate CDD and Health Inspectorate personnel.

8.8 Development of a Reinforced Public Sector Communications Strategy

Rationale

Current recognition of ORS in Uganda is over 80%. Knowledge of correct mixing, however, is less than 50%. Knowledge of correct usage is under 20% and actual usage during the last episode of diarrhoea is under 10%. Current public sector communications activities (primarily home visits to families-at-risk, counseling in health facilities and "social mobilization" of Resistance Committees) should be strengthened and refined to address key weaknesses in knowledge and practices: eg. correct administration of ORS, "catch-up" feeding after diarrhea, etc.

Proposed Activities

Available information should be analyzed to identify needs for message refinement and additional channels of communication. Additional educational materials should be developed as necessary.

Human Resource Needs

An IEC specialist should work with appropriate CDD personnel.

8.9 Development of a Long-Term CDD operational plan including appropriate policy and strategy clarifications.

Rationale

CDD/Uganda has developed quite good yearly CDD action plans. However, at present, no long-term integrated plan exists. Official CDD policies (eg. concerning ORS use and distribution, treatment policy, position of anti-diarrhoeas etc.) have not been written down nor officially endorsed by the MOH. The clarification of long term plans strategies and policies would help give the CDD program more cohesion and integration than currently appears to be the case. It would also help clarify long-term human and material resource needs and recurrent costs, helping to clarify thinking about sustainability.

Proposed Activities

A CDD planning specialist would work with CDD staff members to prepare a draft plan and strategy.

8.10 Strengthening case management in health care facilities

Rationale

Treatment practices in health care facilities in Uganda are reportedly uneven. This is due partly to the lack of policy

definition treatment protocols and expectations (eg. what is expected of a health worker at a health center when faced with a case of acute diarrhoea). Part of the problem may also be lack of adequate training and supervision of some curative health personnel.

Proposed Activities

A health facility survey (WHO protocol) should be conducted to pinpoint case management problems. Simultaneously written policies should be elaborated regarding case management standards in health care facilities. Subsequent to both these activities, a strategy should be elaborated to improve case management in health facilities. One possible tactic would be to visit health facilities in the course of supervisory visits (by HI coordinators) to the districts. A series of 2-3 hour "mini-modules" could be developed to improve specific skills as part of each supervisory visit (eg. organize a brief training activity in the morning or afternoon during regular supervisory visits). This approach would require strengthening of the training skills of the Regional supervisors and perhaps of the district level supervisors as well.

Human Resource Needs

A skilled researcher, experienced with CDD case management, is necessary to conduct the Health Facility Survey. A physician/trainer could both conduct the survey and develop a strategy for improving case management. This individual should be assisted by appropriate CDD and health personnel (team of 2-5 people?)

9. Possible PRITECH Assisted Activities

ACTIVITY	PERSONNEL NEEDS	OTHER RESOURCE NEEDS	DURATION	TECHNICAL ASSISTANCE COSTS	COMMENTS
1) • Training of national and district Level CDD staff in training techniques and methods (20-25 participants)	<ul style="list-style-type: none"> • 1 outside trainer expert in experiential/participatory training methods • 1 other trainer with similar expertise. • 2 less experienced co-trainers • 1 logistics organizer 	<ul style="list-style-type: none"> • training supplies (flip charts, markers, tape, paper office supplies, etc.) • participant & local trainer per diems • lodging for all • secretarial support • reproduction facilities/supplies 	<ul style="list-style-type: none"> 3 weeks planning 3 weeks training 1 week revision of existing training activities 1 week report writing 	<ul style="list-style-type: none"> 8 person weeks \$20,000 	<ul style="list-style-type: none"> WASH has developed national training teams of mixed health and water and sanitation staffs in Zaire, Rwanda and other places. Results have been outstanding
• Follow-up of above 6-9 months later	IDEM	IDEM	<ul style="list-style-type: none"> 3 weeks prep. 2 weeks training 1 week report writing 	<ul style="list-style-type: none"> 6 person-weeks \$13,500 	

ACTIVITY	PERSONNEL NEEDS	OTHER RESOURCE NEEDS	DURATION	TECHNICAL ASSISTANCE COSTS	COMMENTS
2) Development of a detailed task description for Health Inspectorate personnel	<ul style="list-style-type: none"> • Committee of local H.I., CDD and MOH personnel as appropriate • 1 Facilitator/trainer with experience in water and sanitation, CDD and health manpower development 	<ul style="list-style-type: none"> • meeting rooms • secretarial support • office supplies 	3 weeks: <ul style="list-style-type: none"> • 1 week prep. • 1 week committee meeting • 1 week finalization 	3 person-weeks \$7,000	<ul style="list-style-type: none"> - This could come from either WASH or PRITECH - It may be a PRITECH "System's Support" activity - Should be scheduled simultaneously with or prior to activity 1
3) Development of a long-term <u>in-service</u> training strategy for the Health Inspectorate	<ul style="list-style-type: none"> • 1 trainer/planner as for activity 2 • - appropriate MOH personnel 	<ul style="list-style-type: none"> • Transportation for field visits • Secretarial support 	6 weeks	6 person weeks \$13,500	<ul style="list-style-type: none"> - possibly combine with activity 2 - consider a joint PRITECH/WASH team - either together or overlapping

ACTIVITY	PERSONNEL NEEDS	OTHER RESOURCE NEEDS	DURATION	TECHNICAL ASSISTANCE COSTS	COMMENTS
4) Development of a long-term Health Inspectorate manpower development strategy (eg. Personnel needs, professional training, promotion, supervision etc.)	<ul style="list-style-type: none"> • 1 manpower development specialist (with experience in para-professional health manpower) • 1 professional training expert • representatives of Health Inspectorate from MOH and from HI school 	<ul style="list-style-type: none"> • trans- portation for field visits 	1 month	8 person-weeks \$20,000	<ul style="list-style-type: none"> - possibly should overlap with in-service training specialist (activity 3) - again, this is possibly a joint WASH and PRITECH activity
5) Development of a program for the organization and training of traditional healers for ORT and other activities	<ul style="list-style-type: none"> • 1 trainer with experience working with traditional healers • 1 medical anthropologist • appropriate Ministry of Culture and MOH personnel 	Transportation for up-country travel	series of three week periods over the course of one year	16 person-weeks \$40,000	

ACTIVITY	PERSONNEL NEEDS	OTHER RESOURCE NEEDS	DURATION	TECHNICAL ASSISTANCE COSTS	COMMENTS
6) Operations research about the "family-at-risk" approach	<ul style="list-style-type: none"> • 1 O.R. specialist • 1 or more local researchers (from the University?) • appropriate field staff 	<ul style="list-style-type: none"> • printing of questionnaires • transportation • per diems for local researchers 3 weeks design 	<p>3 weeks implementation</p> <p>3 weeks for analysis and operational recommendations</p> <p>(study itself may last up to 3 months)</p>	<p>9 person-weeks \$20,000</p>	possibly in two phases (eg. design and start research process, then come back for analysis and interpretation)
7) Development of supervisory protocols and check lists and revision of the reporting system	<ul style="list-style-type: none"> • 1 health information specialist with experience with PHC programs in Africa • appropriate CDD staff 		3 weeks	3 person-weeks \$7,000	- both MSH and PRITECH have a good deal of experience in this area
8) Development of a reinforced public sector communications strategy, including radio and a stronger role for women leaders and other local people	<ul style="list-style-type: none"> • 1 IEC specialist 		1 month	4-5 person weeks \$10,000	

ACTIVITY	PERSONNEL NEEDS	OTHER RESOURCE NEEDS	DURATION	TECHNICAL ASSISTANCE COSTS	COMMENTS
9) development of a long term CDD operational plan and policy/strategy statement (FEB, 1990?)	<ul style="list-style-type: none"> • 1 CDD planner • CDD National team members (as appropriate) 		3 weeks	three person-weeks	this is a PRITECH specialty which would greatly enhance the overall integrity and cohesion of the CDD effort
10) strengthening case management	1 Physician/trainer/researcher 2-5 local CDD staff and/or health personnel	<ul style="list-style-type: none"> • Transportation • Paper • Secretarial-support 	7 weeks 4 wks survey 2 wks strategy development 1 wk wrap-up	\$17,000 (7 person-weeks)	Follow-up support might be needed to develop appropriate training/supervision materials
11) establishment of a DTU at Makerere University Teaching Hospital	1 physician with extensive CDD/ORT experience	<ul style="list-style-type: none"> • appropriate space and equipment for DTU 	3 weeks	three person weeks \$7,000	

\$165,000

Nota Bene:

This table has only outlined ad-hoc technical assistance costs, assuming that local costs and technical supervision and direction would be provided by UNICEF. If a more sustained role for PRITECH was to be considered, the budget would make provisions for an additional 8 weeks annual support by the Senior Program Manager. Consideration should be given to hiring a local ex-patriate to work with CDD staff on a long-term basis as "PRITECH representative" This person would serve as a liaison with PRITECH, facilitate PRITECH inputs and assist the CDD coordinator and UNICEF with program implementation, as appropriate. The cost of such assistance would add \$75,000 - 100,000 annually to the budget (PRITECH provides its overseas staff salary, benefits, COLA and differential, but no housing)

Terms of Reference
Ms. Agma Prins - Pritech

You have been invited to conduct an initial review of the CDD training programme for the revitalization of the National Health Inspectorate and to assess the possibility of Pritech's involvement in the development of a 5 year training plan that will result in the development of the Health Inspectorate into a cadre of active health workers with the skills to work with the public to influence health practices.

Future Pritech cooperation could include the development of training programmes and materials design.

Health Inspectorate

1. Review existing CDD training programme to identify areas for improvement.
2. Assess existing Health Inspectorate manpower, facilities, and training programmes.
3. Develop outline of 1990-1995 training and manpower development programme to serve as basis for assessment of future cooperation with Pritech, with indicative budget and possible funding options.

Traditional Healers

1. Contact existing Traditional Healer Associations and interview CDD staff as background for the development of a long term programme to develop district based Traditional Healer associations and the establishment of an organized framework for Traditional Healers which can be used by the CDD programme to contact and train Traditional Healers in ORT.
2. Develop an outline of a programme for the organization and training of Traditional Healers for ORT, with phased introduction of additional health topics, such as diarrhoeal diseases prevention, again with indicative budget and possible funding options.

Operational level training

1. Review and assess draft OPL training package and offer suggestions on further development with Pritech assistance including production of timetable and budget.

Annex 2

Local Administration/Resistance Committees

The Independence Constitution provided for elected councils at district level and for Kampala city and other major municipalities and towns. After the overthrow of the first Obote government, however, these councils ceased to be elected assemblies.

Popular representation of officials by election has returned to Uganda through the Resistance Committee system.

The system is based on universal participation of all citizens over age 18 who are de facto members of village resistance councils. The councils are empowered to "identify local problems and find solutions ... (and) formulate and review development plans." To implement the decision of the councils the members elect Village Executive Committees from among themselves.

The Committees form the day-to-day administrative structure of the system and the Chairman is considered the village leader. The Committee members stand and are elected for specific responsibilities by serving as secretaries for:

Youth
Women
Information
Mass Mobilisation and Education
Security
Finance

The Resistance Committees are specifically charged to:

- Assist the police and chiefs in the maintenance of law and order.
- Maintain security.
- Encourage support and participate in self-help projects and mobilize people, material and technical assistance.
- Vet and recommend persons in the area who should be recruited into the Armed Forces, Police Force and Prisons Service at village and parish levels.
- Serve as the communication channel between the Government and the people.
- Oversee the implementation of Government policy.
- Where necessary, elect ad hoc and other sub-committees to assist the Resistance Committee in its functions (GOU, Resistance Councils and Committees Statute, 1987).

Resistance Committees and Councils at higher administrative levels are elected from members of the Committees directly reporting to it. The Committees form electoral colleges for each successive level in the hierarchy and in this pyramid fashion village level councils are responsible for the election of representatives within the district system and to the National Resistance Council.

Each Committee at every level is mandated to have at least one woman member who is responsible for women's affairs. Some committees have more than one woman member, and one RCI in Kampala was composed entirely of women in 1988. This is a major step in the recognition of the equality of women and the need to assist them to fulfill their potential in national affairs.

The first General Elections for the Resistance Council system were held on succeeding weekends in February 1989, beginning with Resistance Committee 1 and ending with the National Resistance Council. The expanded National Resistance Council now has 278 members, the majority of whom have been elected through the RC system, including one Women's Representative from each district.

The Resistance Committee system is the cornerstone of present government policy and represents a real opportunity for community based development. However, there are significant bottlenecks to the full realization of the potential for this system. The Resistance Committees have many responsibilities but few real powers as the executive arm of central government is controlled by parent ministries and the local government executives are responsible to the Ministry of Local Government.

The future effectiveness of the RC system will depend on the continued responsiveness of the government executive and political apparatus to their representations.

ANNEX 3

DEFINITION OF FAMILY AT RISK

- Mother raising children in the absence of the father
- Family with more than two children under five
- Family with little or no land of their own
- Family is recently arrived in the village
- Family caring for orphaned or disabled children
- Family with problems of alcoholism or other parental problems

It is postulated that these families are least likely to seek treatment for sick children and are least likely to participate in community education activities. Therefore they most need extra information on ORT. Also, it is suggested, by the CDD coordinator, that these families serve as "satellite homes" stimulating others to use ORT.

ANNEX 4

Example: Outline of protocol for 1st visit to "family at risk"

1. Greet family, introduce yourself.
2. Explain purpose of you visit
Specify: _____.
3. Ask to meet children under five.
4. Ask mother about the most common health problems the children have had recently.
5. Ask specifically about:
 - 1) Diarrhoea
 - 2) Fever
 - 3) Cough.
6. Ask what mother did about each of these problems.
7. Be supportive and give appropriate additional advice.
8. Teach mother about ORT (liquids & feeding) and demonstrate preparation of ORS.
9. Ask verifying and checking questions to ensure good comprehension (use leaflet).
10. Measure upper arm circumference to check nutritional status of under-five children.
11. Ask about current feeding practices.
12. Give appropriate advice.
13. Check immune status of each child give appropriate advice.
14. Review key points of discussion with mother/parents.
15. Give calendar with vaccination days, well-baby clinic and other appropriate activities at nearest health facility.
16. Conduct tour of house and environs with mother
Note specifically: drinking water storage
availability of soap
source of drinking water
hygiene in kitchen area
etc.

17. Give appropriate advice.
18. Review key points of all discussions with mother/parents.
19. Ask mother to commit herself to specific actions (accord these on "action agreement form.")
20. Thank family for visit.

After visiting all "at risk families" in a community make appropriate report to RC woman leader and health center personnel.

Nota bene: The activities listed here could also be subdivided into two or more visits.

ANNEX 5

Sample list of duties of a health inspector/assistant in a community

1. Meet with local authorities/leaders and seek agreement on program of activities/steps-develop preliminary organizational format.
2. Do a community diagnosis:
 - identify key health problems
 - identify key water and sanitation related health problems
 - identify key community health leaders
 - identify community resources (eg. skilled workers, materials, source of finance)
 - identify "families-at-risk."
 - study and analyze community knowledge attitudes and practices related to health and illness
 - identify water and sanitation resources and how they are used.
3. Develop an action plan with community leaders.
4. Conduct appropriate training with community leaders.
5. Visit "families-at-risk"
6. Agree on monitoring system for "families-at-risk" by appropriate community leaders.
7. Help organize other appropriate community level activities.
8. Seek out and educate/train/follow-up key health leaders (eg. pharmacist, TBA, trade practitioners, private clinician etc.)
9. Conduct market inspection once every three months.

ANNEX 6

Suggested training content areas for Health Inspectorate personnel (in-service training/refresher courses).

I. Community Mobilization/Participation

- methods of community diagnosis
- problem identification and analysis
- how to help community members to take responsibility, to participate in problem solving
- how to help a community plan and carry-out activities
- how to identify "families at risk"
- how to identify key influential people in the community

II. Health Education

- techniques for teaching groups of people
- how to increase participation/commitment
- how to reinforce learning
- how to verify learning
- how to plan educational sessions
- how to decide on the content of educational sessions
- how to choose and use audio-visual learning aids (stories, songs, pictures, theater etc.)
- how to teach an individual
- how to put people at ease
- how to give useful feedback
- counseling skills
- how to design educational programs (eg. more than 1 lesson)
- how to find out about local cultural beliefs and use them in health education.

III. Administration Organizational Skills

- developing a work plan
- how to prioritize activities
- how to develop lists of resource needs
- how to develop a budget
- locating and mobilizing existing resources
- how to participate in supervision (either as a supervisor or as the person being supervised)
- how to keep records
- how to decide what kind of information is useful, how to gather and store it, how to analyze and use it.
- how to write useful reports
- how to evaluate your own work
- how to manage stocks of supplies
- how to establish objectives and targets for your activities

IV. Health Technical Skills

- how to recognize specific kinds of diarrhoea and what to do about them.
- recognizing child nutritional status and what advice to give to mothers about child feeding
- how to determine major child health problems in a community
- advice to mothers regarding:
 - fever
 - cough
 - skin diseases
 - measles
 - family planning
 - aids
 - simple wounds
- review of latrine construction and water source improvement techniques

The Handbook for Health Assistants

The current "Handbook for Health Assistants - CDD in the Community" is meant as a reference booklet for Health Inspectorate personnel to use after they have completed their initial three day training. This booklet is in its third revision. Currently it contains a mixture of topics related to diarrhoea prevention and treatment, water-related diseases, community organization, work planning and CDD managerial procedures.

By dividing this booklet into a series of shorter and more precisely defined "booklet-modules" as outlined in Annex 7a, greater clarity as well as flexibility could be achieved. Appropriate modules could be incorporated into materials for a wide range of community extension personnel. Additional, topic specific, modules could be added as the need arose. Clarification would be further enhanced by starting and or ending each chapter by a brief listing of key points surrounded by a box. A suggestion for a reorganization of diarrhoea related content is contained in Annex 7b. Annex 7c offers more detailed recommendations regarding the technical content of the existing booklet.

Revision of this booklet and development of mini-modules ("booklet-modules") is an integral step in the elaboration of an overall manpower development and in-service training strategy for the Health Inspectorate and should therefore wait until this strategy has been outlined and agreed to. The revision of the diarrhoea module could occur sooner however.

Each module should, eventually, be accompanied by a training guide, for use by those in charge of training the health assistants in the activities described in the module.

ANNEX 7a PROPOSED SERIES OF BOOKLET-MODULES
TO REPLACE CURRENT "HANDBOOK FOR HEALTH ASSISTANTS"

BOOKLET I: The Role and Tasks of a Health Assistant

1. Job description (tasks) of a health assistant
2. Getting to know your area
3. Doing a community diagnosis
4. Identifying and approaching community leaders
5. Community level problem identification, analysis and planning
6. Working with community groups
7. Using local resources
8. Identifying individuals needing special attention
 - secondary audiences/ intermediaries
 - families at risk
9. Tasks at the household level
10. Planning a monthly work schedule
11. Reporting on your activities
12. Evaluating your activities
13. Managing your resources (office materials, teaching materials, you transportation, etc.)
14. Management procedures (allowances etc.)

Booklet II: Working with People

1. Getting to know the people in your community
2. The importance of cultural beliefs, practices and attitudes
3. Starting from people's needs and perceptions
4. Essential steps in communication/education
5. Working effectively with a community
6. Working effectively with groups
7. working effectively with individuals
8. planning and education session and program
9. counseling, listening, helping
10. giving feedback
11. some educational methods and techniques
12. working with a supervisor
13. working as a supervisor

Booklet III: Treating and Preventing Diarrhoea

1. What is diarrhoea
2. Consequences of diarrhoea
3. Treating diarrhoea
4. Preventing diarrhoea
5. Cultural beliefs about diarrhoea

Booklet IV: Assuring Good Child Feeding

1. Measuring child nutritional status
2. Consequences of poor nutrition
3. Importance of breastfeeding
4. Weaning
5. Feeding a healthy child
6. Feeding a sick child
7. Cultural beliefs about child feeding

Booklet V: How to Identify and Prevent Water-related Diseases

Booklet VI: Treating and Preventing Malaria

Booklet VII: Preventing and Treating ARI

Booklet VIII: Preventing and Treating Immunizable Diseases

Booklet IV: Dealing with AIDS

ANNEX 7b: CONTENT SUGGESTIONS FOR REVISED BOOKLET ON DIARRHOEA

Booklet: Treating And Preventing Diarrhoea (key content areas)

Chapter I: What is diarrhoea?

- Diarrhoea is any change in the normal frequency, consistency, odor, appearance of stools.
- There are many different types of diarrhoea and diarrhoea can be caused by many different things.
- Regardless of cause or type, there are three things to remember:
 - almost all diarrhoeas will go away by themselves in less than one week even with no treatment
 - most medicine to stop the diarrhoea is not only useless, but also dangerous for young children
 - all diarrhoeas, however, have potentially serious consequences and so proper treatment should be given to prevent those consequences.

Chapter II Consequences of Diarrhoea

- The most serious consequences of diarrhoea are:
 - weakness
 - dryness/dehydration
 - loss of weight/malnutrition
 - death.
- The treatment of diarrhoea is not to stop the diarrhoea, but to keep the child strong so that these serious consequences do not occur.

Chapter III: Treating Diarrhoea

- To treat diarrhoea the best thing to do is:
 - give a lot to drink
 - continue to feed (including breastfeeding)
 - give extra food after diarrhoea is over

This is called ORT

- Preparation of ORS and/or home fluids
- How to give ORS (time, quantity, storage)
- How to feed
- What to do if child vomits, refuses, wants to sleep etc.

- What danger signs to watch out for
- When to take a child to the health center
- What to do when your child gets better (eg. "catch-up" feeding)

Chapter IV Preventing Diarrhoea

- Emphasis on six main points:
 - exclusive breastfeeding to age four months
 - vaccination (esp. measles)
 - special care with child stools
 - handwashing with soap
 - personal and domestic hygiene with plenty of water
 - proper weaning
- Causes of diarrhoea
 - water and food contamination
 - other illnesses
 - dirt on hands, objects, utensils
 - feeding extra liquids to breast-fed child under four months
 - baby bottles
 - sudden weaning or improper weaning

Chapter V: Diarrhoea Myths

- 1) Why knowing cultural beliefs is important in teaching people about diarrhoea (you can use existing beliefs to convince people to use ORT, for example)
- 2) How to find out about existing cultural beliefs and practices
- 3) How to talk to parents about existing beliefs
- 4) Examples of existing beliefs which are not true and may be harmful.

ANNEX 7c NOTES AND SUGGESTIONS RE. CDD CONTENT

OF CURRENT "HANDBOOK FOR HEALTH ASSISTANTS"

Pg 1 "Diarrhoea has three levels of danger." This should be changed to: "There are three major types of diarrhoea"

"Chronic" should be changed to "persistent" diarrhoea which is defined as diarrhoea lasting for more than two weeks

"Acute diarrhoea" is any diarrhoea of sudden onset in which the stools are different from normal (eg. it is not necessary to specify "watery stools" nor number of stools per day). It is not recommended to specify a three week limit since even a diarrhoea lasting as little as 24 hours can under certain circumstances be very dangerous.

"Dysentery" - Should be changed to "bloody diarrhoea" The emphasis is on blood in the stools. Neither mucus nor fever are specific indicators for shigella dysentery, the most common and dangerous sort in young children.

After the Definition of Diarrhoea, suggest a section on the "Consequences of Diarrhoea." (see pg. 3). Emphasis should be on weakness, dehydration and malnutrition, and eventually death. I am unaware of any studies clearly and consistently linking dehydration to low intelligence. This is a strong motivator for encouraging mothers to take diarrhoea seriously - but we should be careful not to sensationalize. I think we should place equal emphasis on the nutritional and dehydration consequences. By putting such a strong emphasis on dehydration and recognition of the signs of dehydration, we risk that mothers will wait until the child is dehydrated to take action.

It would be useful, right up front, to emphasize that the vast majority of diarrhoeas should not be treated with drugs to stop the diarrhoea. These drugs are not very effective and are often dangerous for small children.

Pg 2 "Teach mothers that although diarrhoea is painful and uncomfortable, the real danger is the dehydration."

I suggest that health workers be encouraged to find out what mothers think to be the dangers of diarrhoea (eg. weakness, dryness, listlessness or whatever) and emphasize these as signs of the danger of diarrhoea - which can be prevented with proper feeding and liquids during diarrhoea and extra feeding after diarrhoea.

CHAPTER 2 Suggest this chapter be moved to later section of the book.
(see specific comments below)

CHAPTER 3 This chapter "treating diarrhoea" should come immediately after a description of consequences.

Emphasize again that all cases of diarrhoea need to be treated to prevent the worst consequence: weakness, dryness etc. Some cases may need additional treatment, but these are very rare and will be dealt with later.

Emphasize and highlight: The best treatment for diarrhoea is:

drinking a lot of liquids eating good food

This is called ORT (oral rehydration therapy)

Pg 9 I believe this section on dehydration should come later - under "danger signs"

Pg 10 "to keep the child from drying up, becoming weak, loosing weight the mother should

- 1) Give your child more to drink
(you can give household drinks like water, juice, water pap, infusions or the special ORS)
- 2) Breast Feed
- 3) Continue Feeding
Give you child many small meals every day of food he particularly likes to eat.
- 4) After diarrhoea has stopped, give your child one extra meal each day for one week.

The two messages: "child needs ORS.... Help" and "3. take your child to a health center" at the bottom of page 10 are contradictory. Also mother should not necessarily wait for signs of dehydration to seek help.

Another approach would be: some children do not improve even if the mother gives good diarrhoea care (ORT). If your child has these danger signs:

- the diarrhoea lasts for more than 3 days
- there is blood in the stool
- there is a high fever
- the child will not eat or drink
- there are signs of dehydration.

Take your child to a health center for additional care.

Pg. 11 Suggest caption to picture six read: "give the drink to the person with diarrhoea many times each day.

Suggest also that ORS be promoted as a drink to keep child strong and to prevent dehydration.

Pg. 12 Suggest that recommendation pictures 9 & 10 be: "keep giving food that your child likes to eat" - don't limit food types to give during diarrhoea. Add section on "catch-up," feeding after diarrhoea emphasizing "good foods" like in picture 10.

Pg. 13 Is there a standard teaspoon size in Uganda? Otherwise there may be many measurement errors in SSS solutions using the proposed recipe.

There should be a section on problems: eg. if child vomits or refuses to drink - what to do.

After Chapter re. treatment, I suggest you place chapter re. prevention. First highlight, how to prevent children from setting frequent diarrhoea:

- 1) Breast-feed exclusively until four months.
- 2) Wash your hands with soap before eating and preparing food and after using the toilet.
- 3) Take special care in covering child stools.
- 4) Vaccinate your children
- 5) Wash yourself, your children, your household utensils, your clothes as often as you can with plenty of clean water
- 6) Wean your child gradually at the proper age.

I suggest the section on prevention be simplified - perhaps details could go in Annexes. PP. 24-28 do not belong in the section on diarrhoea and should be eliminated from this booklet (though they could possibly go in another booklet)

A final chapter on cultural beliefs is not a bad idea, but care should be taken to discuss how existing beliefs can be incorporated in a positive way in educational activities to convince mothers of the utility of ORS. Not all existing beliefs are negative, even when they are not strictly verifiable by western scientific standards.