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**FAMILY PLANNING TRAINING AND SUPERVISION:
REVIEW OF THE DEVELOPMENT OF A
GUIDE FOR THE PRIMARY HEALTH CARE PROJECT
IN PERU**

**A Report Prepared By:
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Traditional Midwives With AID Participation

PREFACE

I want to thank Helene Kaufman, of the Health and Population Office, AID/Peru, and Genny Martinez, a program specialist, also from AID/Peru, for asking me to work again in Peru. To all the field people who spent hours and hours in discussions to produce something that would help to improve the health structure, I also express my thanks. For me, this experience was greatly enriching.

Once again, I have to thank Esme de Bonat for interpreting my spanglish and for typing my manuscript.

It has been a pleasure to work for the American Public Health Association, because of the trust in and freedom given to me during my assignment.

I. INTRODUCTION

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The assignment was divided into two parts. The first week was devoted to a follow-up of the previous assignment on training resources. During the next two weeks, the consultant assisted the Ministry of Health in developing a supervision guide for the primary health care program.

To meet the needs of the Peru mission, some changes were made in the assignment. The follow-up to the previous training assessment was done the last week, and the specific objective to be accomplished was related to one of the recommendations made in the consultant's first report, "Training Activities and Persons trained in FP in Peru and Future Prospects." The change was made so that family planning (FP) could be introduced in the primary health care project by reviewing the curriculum for training community health workers. The other task remained the same; the specific objective was to develop a supervision guide.

To accomplish the first objective, the consultant worked directly with the personnel involved in the project, helping them to develop their own materials. It is considered to be better to allow the people themselves to develop their materials, because they can learn how to design and prepare information, they feel that their products are their own, and they will have the experience of their own reality. It can be said that the result of this task was a team effort, the consultant playing only the role of coordinator and providing technical assistance.

To accomplish the first objective of introducing family planning in the curriculum of the promoter and the traditional midwife, a meeting was called with three regions (see Chapter II). A team from only one region was involved in the development of the guide, but the work was discussed in a meeting with personnel from the other regions. No MOH center-level staff were involved in the work (see next section), although, for reasons of strategy, operational-level MOH staff were consulted.

Ministry of Health Structure

The Ministry of Health (MOH) health structure in Peru is a central level operation that has a normative function. Eighteen regions operate under the norms specified by the central level. The regions manage their own budgets and adapt the norms. One of the government's intentions is to delegate power to the regions. The regions have other operational levels: areas, health centers, posts, and the community. Fifty-eight hospital areas are responsible for 107 hospitals and 540 health centers. The health centers are responsible for 1,200 health posts. Each level offers different health services; these services range from the handling of simple pathology

at the community level to the use of the most complex medicine at the regional hospital level. Each level refers the most complicated cases to the higher level.

In recent years, because the MOH has suffered considerably because of economic impoverishment, it has been short of personnel, who are not attracted by the low salaries. There has been no supervision, and very little has been done in the areas of health education and preventive medicine. Even the Mother and Child Program has not been implemented as such. The objective is to meet spontaneous demand, and not to prevent maternal and child illnesses. The bureaucracy also poses a problem. Few decisions are made, and those that are made are not enforced. The central level designs norms that are not practical, and it does not consider the opinions of operative-level personnel, who are concerned about the "legal dispositions" but not practical action. The regions want to be independent but they are afraid to make decisions and move on their own.

Health Situation

At this time, it is difficult to determine exactly health conditions in Peru. Information is poor and the indicator varies. It is generally accepted that the deterioration of Peruvians' health is attributable to the economic situation. Contagious diseases are increasing. General mortality is 13/1,000, infant mortality is 101/1,000 or 120/1,000. Maternal mortality is 4/1,000, higher than the mortality rate in other Latin American countries. Life expectation is 57 years.

The high mortality rate is attributed to controllable contagious diseases, which act on a population weakened by variable degrees of malnutrition. The fundamental or concomitant cause of death of 57 percent of the children is insufficiency of breath or nutritional deficiency at birth. Feeding is qualitatively and quantitatively deficient in 44.5 percent of the children under 5 and in 33.3 percent of pregnant mothers.

Primary Health Care Program

In 1978, the government specified that the objective of the primary health care project was to extend health services to the rural communities.

The primary health care project is based on the idea that the simple attention-techniques can be applied by trained personnel of the community, and that these techniques can be used to solve many of the health problems resulting from simple pathology, such as dehydration, diarrhea, bronchial diseases, and maternal mortality. The health workers are one promoter and

one empirical midwife. They are elected by the community. After a short training period, they serve as volunteers to the community. They dispense some drugs and are supervised by the health post, which is run by an auxiliary nurse and sometimes by the doctor or nurse of the health center. No family planning is included in the activities of the community.

The MOH appointed a group at the central level to design the norms for the project; the promoter's and traditional midwife's functions; the training, supervision, and information, systems; etc. In 1979 the training of community personnel in each region began, but because of the economic situation, these personnel have not been supervised. The information system does not operate. There are not enough personnel in the regions to implement the project. One can conclude that the project was incomplete and weak from the start.

At the end of 1979, AID gave the MOH a three-year, \$7 million loan/grant for the expansion of the primary health programs. Each region, with assistance from AID, is to develop its own project. In October, five regions had received AID money. Four were to receive funds at the end of 1980. The money is channeled through the Ministry but goes directly to the regions. Supplies and equipment are furnished the same way. The items included in the AID budget were for supervision, training, equipment, medicines, and technical assistance.

Although the money has been received from AID and the number of staff has increased, the regions continue to train personnel in accordance with MOH norms, which delegate to the promoter 100 activities. No supervision is being provided. If it is given at all, it is not of the quality expected. There is no information on the activities developed by the promoter and traditional midwife. The regions, although they do not think that the norms of the central level are practical, do not dare to change them.

Conscious of these problems, AID/Peru has designed a strategy to provide directly technical assistance to the regions. In this plan, the regions which are operative and responsible for the project, may, in collaboration with an expert, develop their own systems in areas that have been identified as weak (e.g., supervision, information system, training, supplies, etc.).

II. OBSERVATIONS

II. OBSERVATIONS

This chapter is divided into two sections. The first section covers the introduction of FP in the curriculum for training promoters and traditional midwives. The second section covers the development of a guide on supervision.

Introduction of FP in Curriculum of the Promoter and Traditional Midwife

To accomplish the first objective, and in accordance with the methodology of working directly with the persons responsible for the project at the regional level, a workshop was held on October 21-24, in Trujillo. The workshop was organized with the assistance of two persons in charge of training in other regions. Personnel from the regions of Huaraz, Huanuco, and Piura did not attend the workshop for reasons unknown.

The meeting was coordinated by Maria de Tanco and Ann Terborgh, from Development Associates, Inc.

An informal meeting, the intention was to introduce FP into the curriculum and to share the experiences of the operational-level staff with personnel from the different regions.

On the first day, each region presented a summary on the training of promoters and traditional midwives, the selection process, the place and length of training, the contents of the course, evaluation, and educational techniques.

A. Selection

The criterion for selection is that personnel be chosen by the community. The promoter in particular must be literate. The health personnel motivate the community. In Trujillo, this job was done by the auxiliary nurse of the health post; in other regions, the personnel from the health center or the area provided motivation. It was recommended that the person responsible for the selection not be the auxiliary nurse, because in many instances he is committed to the communities and to his friends and can influence the community in the selection of personnel.

B. Place

Some regions trained promoters and midwives in a health center; others offered training in a hospital of the area or the regional hospital.

It was recommended that training be conducted in the health center nearest to the promoter's or midwife's place of work. In this way, those in the region can be involved directly with the new trained personnel from the community.

C. Duration

The regions have followed the MOH norm: 45 days of training for the promoter and 18 days for the traditional midwife.

D. Technical Education

The technical education was practical and included demonstrations, all at an elementary level. The teachers were previously trained and are qualified to teach at the level of these personnel.

E. Curriculum

A question was raised about the promoter's ability to assimilate such a dense content and to develop at the end of the course 100 activities other than family planning. Furthermore, when the need to revise the curriculum was mentioned, it was necessary to ask about the activities that were to be carried out by the promoter. It was observed that operative personnel had been concentrating on applying a curriculum and had not taken the trouble to identify the activities that would be conducted by the promoter. For this reason, much of the meeting was devoted to a review of the activities of the promoter to determine whether the number of activities could be reduced, the curriculum could be reduced, and FP could be introduced. Some changes were made in the activities. The final list is attached Appendix C. Some problems were observed when changes were being made.

1. The central-level norms have established all the promoter's activities, and the central level is not willing to change these norms too much.
2. Activities were not given priorities. According to the present Minister, the MOH has three priorities: to reduce morbimortality of the population, to reduce fertility, and to protect the population with a Mother and Child Program.

3. To date, no one knows what the promoters have been doing.
4. The MOH has not decided how to provide the FP service, and nobody from the group knew whether the promoter would give information and education, and services, too, or only supplies.

The curriculum was not revised because of a lack of time, but the FP Unit was designed. The promoter can now give information and education to the population on FP and contraceptive methods and refer members of the community to the health post and health center for services. The unit offers 12 hours of practice and demonstrations (see Appendix B). FP units are to train new personnel and retrain other previously trained staff.

The activities of the traditional midwife were reviewed; this was a simple task because midwives have more specific functions. They conduct FP activities in information and education, refer patients, and resolve doubts of acceptors about the side effects. It was decided that the curriculum for midwives would be the same as the curriculum for the promoters.

The last day of the meeting was devoted to supervision (see next section).

At the end of the meeting, some recommendations were made; they are included in this report.

Development of Supervision Guide

The specific objective was to develop a supervision guide for operational-level staff. The methodology was to work with the Ordenor Centro Health Region, using a team of four persons. The effort was to last three and a half days. Unfortunately, a strike was foreseen for October 16, and work was interrupted. Furthermore, it was difficult to get the people to concentrate. The guide was not discussed with the rest of the personnel. It has not been approved before the consultant's departure.

To date, supervision within the health structure is made by levels: the national level supervises the regional level, the regional level supervises the area; the area supervises the health center; the health center supervises the health post; and the health post supervises the promoter and the traditional midwife. The frequency of supervision varies from level to level and from region to region, as does the duration of supervision. At the national level, the auxiliary is required to supervise the promoter and the traditional midwife once a month, and at least two days per community.

This is the only such required supervision. The person responsible for the supervision varies also, according to the level and existing resources. Generally, there is a supervisory team and, in some cases, only one person must supervise all aspects of work.

Various points were made:

1. There is no simple, practical guide on supervision.
2. Supervision to date has been a form of control and inspection, and little technical assistance has been provided. Even less motivation and support for the supervisee have been provided. It is important to discuss the importance of motivation and of positive encouragement. In Latin America, government planners have been concerned about issuing projects for norms, programs, etc., but they do not seem to realize that such projects will be operated by human beings, who should be motivated. Though this fact seems obvious enough, it is frequently forgotten.
3. Although the direct supervisor for the community is the auxiliary nurse, it was not possible to design a guide only for auxiliary nurses, because the new concepts of supervision should specify who will supervise the auxiliary nurse.
4. It was not possible to develop a guide for primary health care only because of the decision of the MOH that primary health will not constitute a separate program but will be integrated. There is no way to provide supervision only for primary health.
5. When the community is supervised, direct attention should be paid to the community and to supplies.

The guide (see Appendix E) is a simple, easy-to-read document, didactic. It is intended for the entire system. At the end is a check list that includes many, if not all, of the aspects that should be observed. The list is not so complicated that the supervisor will have to spend all his time completing it.

The definition of supervision, procedures, and objectives are included in the guide.

The last day of the meeting in Trujillo was devoted to supervision. Unfortunately, the guide could not be discussed, because the people from Huaraz did not accept it (it was not approved by the region). The concept

of supervision and what supervision is now were discussed. The group agreed that supervision was control and inspection, but not technical assistance or motivation. The group also agreed on the need to train personnel to appreciate this new concept of supervision.

A curriculum was designed (see Appendix E). The objective was that personnel would be able to observe, give technical assistance, and motivate other personnel during the supervision. The techniques would be mostly sociodramas and group work.

III. CONCLUSIONS

III. CONCLUSIONS

In general, it can be concluded that there is a great need among the regional people for technical assistance to accomplish goals and improve performance.

It is important to involve executive-level staff in a process for analyzing norms and materials. These personnel complain that they are not considered when projects are being designed. Nor are they asked to help design projects although they have the experience. Furthermore, it is important to permit the sharing of experience. The training meeting was useful to all the people responsible for training. They learned what has to be done in the other regions and how.

Working directly with regional-level staff is a problem, as these personnel do not feel they can change the norms designed by the central level which, within the law, corresponds to the rule-making level. They admit that the norms are not practical, given their own circumstances, and they want to be autonomous, but they are not willing to take risks.

The promoter's activities and responsibilities are not known. It is desired that he conduct all the activities of the health sector. It is difficult to establish priorities, and this problem in turn makes it difficult to change the curriculum (shorten it or divide it). These problems were not satisfactorily resolved at this meeting.

As regards FP, it was resolved that the promoter and the traditional midwife must inform and educate the community, refer patients, and clarify the doubts of acceptors about the side effects of the methods. The question of who would provide services or even resupply equipment and supplies was not resolved. This question must be answered by the central level. The curriculum was designed and will be included in all the programs of study, although the MOH central level has not officially given the order (stated it in writing). This is important to the personnel involved.

The consultant found that little supervision was provided and that the quality of the supervision that was given was deficient. The principal objective is to control and inspect. No adequate guide is available.

A supervision guide was designed. An effort was made to design something simple, practical and elementary. The main objectives were to make uniform the supervision concept; introduce a broader concept about observing and detecting problems; provide immediate and direct technical assistance during supervision and motivation; encourage personnel in their own activities; establish the procedures to be carried out before, after, and during the supervision; specify the qualifications that each supervisor must have to be a good supervisor; and develop a checklist that is divided in the areas or elements that form a health organization: physical plant, material

and equipment, organization, final activities, health education, supervision, supplies, information and evaluation, training, budget, and community. For each area there is a series of simple items that indicate how each area operates. A space is provided for recommendations and comments.

The guide has not been approved by the region, and it has not been tested in the field. Thus, some time must elapse before the guide is introduced at the national level.

It is important to mention that, during the supervision of the community, direct attention will be paid to the community; educational work will be done; and supplies will be taken.

IV. RECOMMENDATIONS

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1. Technical assistance to the regions should be continued, but an effort should be made to find support at the central level of the MOH.
2. Meetings of exchange between the personnel of the different regions should be supported. Specifically, at this time two meetings should be held: one for supervision (it could be held in February) and one to follow up the training meeting.
3. The limitation and establishment of priorities of the activities of the promoter should be encouraged. The curriculum should be revised.
4. A work group of personnel from two or three regions should be relocated to design the promoter's manual.
5. After the supervision guide has been approved by the Region of Huaraz, it should be distributed to the regions of Huanuco and Trujillo so that it can be tested. Its applicability should be discussed at the February meeting.
6. Training in supervision should be supported, using educational techniques, sociodrama, and group dynamics. Training should not be limited to lectures.
7. The central level should be asked to define the Family Planning Program norms.
8. The recommendations from the training meeting (see Appendix G) should be supported and followed up.

APPENDICES

Appendix A
PERSONS CONTACTED

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PERSONS CONTACTED

USAID

Helene Kaufman, Population and Health Officer

Genny Martinez, Program Specialist

Personnel from Region de Salud, Ordenor Centro

Dr. Leoncio Susuki, Director

Mercedes de Susuki, Chief Nurse

Georgina Valverde, Coordinator, Primary Care

Nelida Chavez de Calderon, Coordinator, Mother and Child Program

Rene Trinidad Muñoz, Midwife

Hilda Olivera de Lopez, Chief Nurse, Huaraz Hospital Area

Salomom Juarez Pim, Coordinator, Primary Care, Huaraz Hospital Area

Walter Moscol, Chief Physician, Recuay Health Center

Personnel from Other Health Regions

Marina Lopez Caro, Technical Office of Nursing, Regional Direction, Centro Oriental, Huanuco

Consuelo Gutierrez R., Chief Nurse, Health Region Nor Medio

Imelda Castillo P., Pharmacist

René Montero, Chief Nurse, Hospital Area No. 1, CHEPEN

Carmen de Mestanza, Nurse, Primary Care Program, Hospital Area No. 2, TRUJILLO

Esperanza Mateo, Midwife, Program of Support to Primary Care, Hospital Area No. 2, TRUJILLO

Development Associates

Ann Terborgh

Appendix B

OBJECTIVES OF FAMILY PLANNING UNIT

**VI. UNIT: ACTION OF THE TRADITIONAL MIDWIFE AND PROMOTOR
TRAINED IN RESPONSIBLE PARENTHOOD AND FERTILITY REGULATION**

OBJECTIVES OF THE UNIT: When the present Unit ends, the participants will be capable of:

- Orienting the Community on Fertility Regulation and Responsible Parenthood;
- Orienting on the services provided by the State in this Program, and deriving the persons who are interested;
- Following up acceptors in their communities.

<u>Health Condition</u>	<u>Educational Objectives</u>	<u>Experience of Learning Suggestions and Resources</u>	<u>Time in Hours</u>
Multiparity High Rate of Abortion Unwanted Children Abandoned Mothers	<ol style="list-style-type: none"> 1. Explain the concept of responsible parenthood in terms of family welfare. 2. Make known the program of the Ministry of Health. 3. Describe each one of the methods. 4. Use and contraindications of each method. 5. Make known the side effects of the methods. 6. Refer complications with the use of methods to the Health Centers. 	<ol style="list-style-type: none"> 1.1. Comments with participants on the size of the family. 1.2. Detect and analyze positive and negative attitudes in relation to the program. II. Exposition dialogue on Program of Fertility Regulation in the Region. III. Practical demonstrations of methods IV. Exposition dialogue on use and contraindications. V. Sociodrama of each one effect. VI. Practice of transfer records. 	12

Appendix C

PROFILE OF ACTIVITIES OF THE HEALTH PROMOTER

Appendix C

PROFILE OF ACTIVITIES OF THE HEALTH PROMOTER

I. PARTICIPATION IN COMMUNITY DEVELOPMENT

- A. Integrate the Committee of Community Development as health representative of its community.
- B. Register the number of families in her community identifying the UFAR.
- C. Orient the families on the birth and death registrations.
- D. Organize the community first aid supplies and maintain the stock in coordination with the Committee of Community Development.
- E. Coordinate actions with members of other sectors.

II. ENVIRONMENTAL HEALTH

A. Water Supply

1. Identify in the community the system of water supply.
2. Coordinate with the person in charge of environmental health in order to achieve the measure of protection of wells, springs, and rivers, etc.
3. Educate the community on the supply, preservation, and consumption of water.

B. Sanitary Disposal of Excretions and Garbage

1. Identify the sanitary condition of the area as regards excretion and garbage.
2. Coordinate with the health representative and promote the participation of the community for the installation of water-closets.
3. Educate the community in the use and preservation of water-closets and the disposal of garbage.

4. Collaborate on the installation of water-closets.

III. IMPROVEMENT OF LIVING QUARTERS

- A. Educate the family in the improvement and cleanliness of housing.

IV. CONTROL OF CONTAGIOUS DISEASES

A. Vaccination

1. Identification of people who are amenable to being vaccinated by staff of the Health Post (in order to collaborate in this action).
2. Educate the people in the importance, need, and benefits of vaccination so that they will participate in the program.

B. Tuberculosis

1. Identify and refer to the Health Establishment the chronic coughers.
2. Follow up cases to control the administration of the treatment indicated.
3. Locate the contacts and refer them to the Health Service.
4. Provide education in:
 - a. Characteristics of the disease.
 - b. Preventive measures.
 - c. Importance of periodic control and treatment.

C. Eradication of Malaria

1. Identify and refer to the Health Establishment all cases of fever with suspicion of malaria.

2. Educate the family in:
 - a. General characteristics of the disease.
 - b. Control measures.
3. Follow up the cases to control the administration of the treatment indicated.
4. Provide health education in:
 - a. Characteristics of the disease.
 - b. Preventive measures.
 - c. Importance of the treatment.
 - d. Collaboration with the personnel in charge of the malaria program.

D. Control of Rabies

1. Collaborate on all program activities.

E. Other Contagious Diseases in the Region

- a. In accordance with the epidemiological characteristics of the region, carry out action destined to the control of each one of the diseases.
- b. Identify and give notice promptly to the Health Service about the suspicious cases of contagious diseases, as well as epidemics.

V. MATERNAL-CHILD CARE AND FERTILITY REGULATION

A. Health of the Mother

1. Attract the pregnant woman before the fifth month of pregnancy and refer her to the midwife.

2. Educate the mothers about the need of being attended by the midwife or health staff.
3. Establish coordination with the traditional midwife.
4. Give attention to normal childbirth in emergencies.

B. Child Health

1. Healthy Child

- a. Precociously contact the newborn, infants, and preschool children and control them.
 1. Inspection of R.N. to detect abnormalities and refer them to the Health Establishment.
 2. Weight control.
 3. Feeding, hygiene, and vaccines.
- b. Give the child periodical appointments for control.
- c. Coordinate with the Health Service to obtain feeding support.

2. Sick Child

- a. Provide immediate and prompt attention to the sick child.
- b. Educate the mother about the preventive measures that should be taken to prevent complications.
- c. Refer the child to the nearest Health Center in case of complications.

C. RESPONSIBLE PARENTHOOD AND FERTILITY REGULATION

1. Inform and educate the community on responsible parenthood and fertility regulation.

2. Methods.
3. Indications and contraindications.
4. Detect and orient acceptors to the collateral effects of the methods.
5. Transfer the required cases.

VI. SYMPTOMATIC TREATMENT OF THE MOST COMMON DISEASES
THAT AFFECT ALL GROUPS: FIRST AID IN EMERGENCIES

- A. Provide prompt care in cases of cough, diarrheas, vomiting, fever, colics, parasitosis, boils, constipation, dehydration, or frequent problems.
- B. Educate the family and refer the most complicated cases.
- C. Give first aid in the event of fainting, shock, wounds, poisoning, foreign bodies, suffocation, drowning, bites, and stings from poisonous animals.

VII. ADMINISTRATIVE ASPECTS

- A. Responsible for custody and maintenance of equipment, materials, and medicine allocated to community.
- B. Register completed activities to be identified and reported by the health auxiliary.
- C. Resupply and control medicines through the community organizations.

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Appendix D

PROFILE OF ACTIVITIES OF THE TRADITIONAL MIDWIFE

Appendix D

PROFILE OF ACTIVITIES OF THE TRADITIONAL MIDWIFE

A. Social Role of the Trained Traditional Midwife

1. Identify the organizations representative of the community and the communal authorities and leaders to coordinate actions.
2. Integrate the organizational structure of the community, which includes the Health Committee.
3. Participate in the communal meetings, where the problems and needs of the community for health are identified.
4. Identify location in the Health Service system.
5. Coordinate activities with the promoter of health and with the Health Post.
6. Find out what maternal-child care activities are developed by the Health Post, Health Center, and Hospital.
7. Support the health promoter in actions related to the Program of Applied Nutrition, to the Program of Feeding Assistance, and others which reach the community.
8. Participate in the continuous training programs developed by the Hospital Area.
9. Report monthly on the activities carried out by the Health Post.

B. Maternal-Child Attention

1. Pre-Natal Period

- a. Attract pregnant women.
- b. Coordinate with the promoter on cases referred by him.
- c. Determine signs and symptoms of pregnancy.
- d. Give attention to the pregnant women.

e. Detect pregnant women at risk for reference. For example:

- precocious primipara;
- old primipara;
- old multiparous;
- previous cesarea;
- multiple pregnancy; and
- large multiparous for prompt reference.

f. Calculate the probable date of childbirth.

g. Inform the pregnant woman on hygiene, feeding, preparation of layette for the baby, and fertility regulation.

h. Make a monthly report on control of normal pregnancies to detect signs and symptoms of alarm (e.g., fever; loss of blood; loss of liquid; headache; dizziness; persistent vomiting; edemas; lack of fetal movements; and weight loss) for prompt attention to Health Services.

Refer the pregnant woman for antitetanus vaccine.

2. Intranatal Period

a. Prepare and make a simple examination of the parturient in order to determine her stage of child labor.

b. Conduct activities preparatory to the attention of a normal childbirth.

1. Prepare conveniently for the attention to be given to normal childbirth.

2. Prepare the environment.

3. Obtain the necessary material and equipment to attend a normal childbirth. The supplies include:

- a. Bag (contents and preservation);
 - b. Disinfecting and boiling the material.
 - c. Midwife Guide (system of transfer and monthly report).
4. Personal appearance of the traditional midwife.
- a. Use of cap and apron.
5. Cut nails, wash and brush hands.
6. Prepare the parturient.
- a. General and vulbar hygiene.
 - b. Emotional support.

To request help from the health auxiliary, detect alarming signs and symptoms, such as:

- fever;
- swelling;
- hemorrhage;
- escape of limbs and cord;
- loss of meconial liquid; and
- lengthy period of labor.

d. Mechanisms of the childbirth.

1. Identify the signs that indicate the expulsion of the fetus.
 - a. Contractions
 - b. Straining

2. Wash and brush hands.
 3. Attend normal childbirth in accordance with the techniques and procedures taught.
- e. Give prompt attention to the newborn.
1. Observe characteristics of baby's cries.
 2. Aspiration of secretions.
 3. Tie and cut umbilical cord, apply antiseptic, and cover umbilical stump.
 4. Care of the eyes: apply antiseptic.
 5. Simple inspection of the newborn to discover congenital malformations.
 6. Keep baby warm.
- f. Identify the signs and symptoms of the separation of the placenta.
1. Blood flow.
 2. Uterine contractions.
- g. Receive the placenta.
1. Examine both sides of the placenta and see that it is complete.
 2. Elimination of the placenta.
- h. Identify the signs of alarm to request prompt assistance from the health auxiliary.
1. Retention of placenta.
 2. Hemorrhage.

i. Immediate care of the mother.

1. Observe signs and symptoms of alarm for opportune reference to the Health Service.

a. Headache.

b. Shivering.

c. Hemorrhage.

d. Convulsions.

e. Rents of perine.

2. Clean vulbar section of patient and place bandages in accordance with usual practices.

j. Subsequent care of the newborn.

1. Clean the baby.

2. Weigh the baby.

3. Dress the baby.

k. Identify sign and symptoms of alarm in the newborn for prompt reference to the Health Service.

1. Low weight.

2. Malformations.

3. Pathological jaundice.

4. Cyanosis.

5. Paleness.

3. Post-Natal Period

a. Visit the puerpera:

1. Orient her to personal hygiene.
2. Food.
3. Care that must be taken by the mother with the newborn.

- a. Maternal lactation.
- b. Care of the umbilical cord.
- c. Fertility regulation.

b. Identify signs and symptoms of alarm for prompt reference to the Health Services; for example:

- fever;
- abdominal pains;
- hemorrhage;
- urinary retention; and
- fetid Lochia.

c. Coordinate with the Health Service to bring her under the Maternal-Child Feeding Program (PAMI).

d. Derive the mother and newborn to the Health Post in coordination with the Promoter.

1. Examine the mother.
2. Examine the newborn.
3. Inscription of the newborn in the Civil Register.
4. Vaccination of the newborn.

5. Periodical control of the child.
6. Provide information on the services where fertility regulation and responsible parenthood control are provided.
7. Follow up the cases referred.
8. Orientation of the family as regards responsible parenthood and fertility regulation.

C. Provision of First Aid in Emergencies

1. Provide first aid in cases of wounds, burns, stings, bites, and other emergencies.
2. Other activities
 - a. Provide education to the families in:
 1. Orientation of family on responsible parenthood and fertility regulation.
 2. Cleaning of house and way in which it can be protected to keep out animals and insects.
 3. Importance of boiling and preserving drinking water.
 4. Elimination of domestic refuse.

D. Responsible Parenthood and Fertility Regulation

1. Information on responsible parenthood.
2. Fertility regulation.
3. Methods.
4. Indications and contraindications.
5. Detection and orientation of acceptors on the collateral effects of the methods.

6. Transfer of the cases referred.

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Appendix E
SUPERVISION GUIDE

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SUPERVISION GUIDE

I. INTRODUCTION

The Regional Direction of Health, conscious that a good system of supervision helps to improve the quality of the attention of the individual, family and community, has prepared the present supervision guide. The object of this guide is to provide some orientations and a working instrument for the activities of supervision that will be carried out at each level of the Health Service System, as well as in the community, and to systematize the function of supervision in order to have a uniform criterion, giving more consistency to the supervision process.

II. SUPERVISION GENERALITIES

It is a dynamic, democratic, creative process and it is learned simultaneously by both the supervisor and supervisees, where the individual efforts are harmonically coordinated, in order to achieve the objectives proposed.

Supervision plays an important role, since its function is not only evaluative; it orients and corrects and, if circumstances call for it, it is executive.

Supervision must basically have a motivating action and provide the necessary support to the supervisee so that he can develop his own capabilities and resolve his problems in accordance with the existing resource

1. PURPOSES

- a. To contribute to the improvement of the quality of care to the community.
- b. To help to use the resources allocated to the different levels of the Health Service System in accordance with the guidelines.

2. OBJECTIVES

- a. To appreciate and evaluate the development of the activities of the health programs.

- b. To detect the problems that limit the fulfilment of goals and to provide technical assistance to the personnel who are supervised.
- c. To motivate and provide the support required to the person supervised so that he can develop his own capabilities and resolve his problems.

The specific objectives are designed in accordance with the plan of each supervision.

3. REQUIREMENTS OF THE SUPERVISION

- a. It must be properly planned.
- b. All the decisions taken in the supervision must be backed by the immediate upper level.
- c. Supervision must be developed in an atmosphere of work, trust and sincerity, so that all activities are carried out in this way.

4. REQUIREMENTS AND QUALIFICATIONS OF THE SUPERVISOR

- a. Know the plans, programs, policies, and strategies of the Health Regional Direction, as well as those of the supervised establishment.
- b. Know the methods, techniques, procedures, norms, and functions of the program to be supervised.
- c. Have the capacity to observe, analyze, verify, and listen to the supervisees.
- d. Have the capacity to make decisions and influence and recommend solutions that are consistent, creative, and adaptable to realities.
- e. Be objective and act impartially, not giving way to subjectivity.
- f. Have the capacity to teach and relay clearly and precisely a message; know how to work in groups.
- g. Be motivated in the work to be carried out to transmit it to the personnel to be supervised; encouraging them in their success and backing them in their difficulties, as all human beings are eager to receive recognition to feel sure about their work.

III. PROCEDURE

A. BEFORE SUPERVISION

1. Establish the chronogram for supervision, including the establishments to be supervised and the time that will be spent in each one.
2. Determine the specific objective of the supervisory visits to be made.
3. Know and analyze the reports and recommendations of the previous supervisions.
4. Identify the supervising team and determine the functions of each member.
5. Establish the itinerary of supervision and hour of initiation.
6. Follow all administrative proceedings and fulfill the existing provisions of the region for supervisory visits (per diem, permits, transportation).
7. Establish adequate systems of coordination with the different services, departments, and functions in order to maintain a good system of supply.
8. Notify the services to be supervised well in advance so as not to interfere in local plans; request the necessary support (transportation, premises, etc.).

B. DURING SUPERVISION

1. Upon arrival at the establishment, interview the person who is responsible, and his team, in order to explain the object of the visit and to obtain his opinion on priority needs.
2. Observe, revise statistical information, interview personnel, supervise, and, if necessary, meet with the patients and community to identify the activities that are being carried out and to evaluate the development of the administrative aspects included in the checking list.
3. Verify on-site the fulfilment of the recommendations left after the last supervision.

4. Establish priorities of needs and problems in order to provide support and technical assistance, which are necessary and opportune, to provide an immediate solution.
5. Give direct attention to the community in accordance with the situation.
6. In so far as possible, bibliographic material should be provided to personnel in order to keep them up-to-date on the health aspects.
7. Take advantage of the supervision trip to replenish the peripheral establishments with equipment and material, fulfilling the administrative provisions for such purposes.
8. Leave congratulations, suggestions, and recommendations in writing, determining reasonable periods for their fulfillment.
9. Hold a meeting with all personnel of the health establishment to let them know what problems have been found and what recommendations and suggestions have been made.

C. AFTER SUPERVISION

1. Write up a supervision report in accordance with the corresponding guide, and present it to the immediately superior chief.
2. Resolve problems when possible, or when the person has the competence to solve them, and do whatever is possible so that problems will be solved when they are not beyond the person's level of competence.

IV. SUPERVISION CHECKLIST

The checklist of the supervisor is designed to help the supervisor in the stage of observation of the development of the activities of the health programs.

The list includes a series of areas that correspond to the different elements or aspects of the Health organization:

- Physical Plant
- Equipment and Furnishings

- Final Activities
- Training
- Supervision
- Supplies
- Statistics
- Budget
- Community

A list that can be used at all the levels of supervision was prepared. It is quite possible that in some areas or for some items, the list does not apply at all levels. This does not matter. Inapplicable items can be crossed out.

Completing this checklist is only one part of the supervision, and it must be used within the framework given in the guide.

Name of the Supervisor: _____

Place, Name of Supervisee: Hospital Area _____

Local Center/Hospital _____

Health Post _____

Promoter _____

Date of Supervision: _____

A. Physical Plant

- | | Yes | No |
|-----------------------------|-----|-----|
| 1. Premises are appropriate | ___ | ___ |
| 2. Good hygiene on premises | ___ | ___ |
| 3. Maintenance of premises | ___ | ___ |

Installations

- | | | |
|----------------------------------|-----|-----|
| 1. Water | ___ | ___ |
| 2. Sewage | ___ | ___ |
| 3. Adequate illumination | ___ | ___ |
| 4. Electric light | ___ | ___ |
| 5. Installations worked properly | ___ | ___ |

Yes No

Own Property

Observations and Recommendations: _____

B. Equipment and Furniture

1. Equipment

- a. Is there an updated inventory? _____
- b. Does the inventory correspond to what is in stock? _____
- c. Is the equipment in good condition? _____
- d. Are there minimum essential requirements? _____
- e. Is there a refrigerator? _____
- f. Does it work properly? _____

2. Furniture

- a. Is there an updated inventory _____
- b. Does the inventory correspond to what is in stock? _____
- c. Is the furniture in good condition? _____
- d. Are there minimum essential requirements _____

Observations and Recommendations: _____

C. Organization

1. Dependency _____

	Yes	No
2. Is there an organogram?	___	___
3. Personnel: Number _____ Physician _____ Midwife or Nurse _____ Auxiliary Nurse _____ Accountant _____ Statistical or other Personnel _____		
4. Are there manuals, guides, and defined functions?	___	___
5. Does the staff know them?	___	___
6. Are the staff identified and are they motivated to the work?	___	___
7. Is the coordination between the hierarchy and executive level adequate?	___	___
8. Are staff meetings held?	___	___
9. How frequently? _____		
10. Is there knowledge of the programs that are developed? Are these programs integrated?	___	___
11. Is there a work plan?	___	___
12. Is it fulfilled?	___	___
13. Is there any incentive in the institution for the workers?	___	___
Observations and Recommendations: _____ _____		

D. Activities

1. Are the goals for the different activities known?	___	___
--	-----	-----

2. Are the following activities fulfilled?

<u>ACTIVITIES</u>	<u>Yes</u>	<u>No</u>	<u>Are the guidelines followed?</u>
a. Vaccination			
b. Tuberculosis Control			
1. Sample-taking			
2. Control of sick people			
3. Administration of medicine			
c. Maternal Health			
1. Control of pregnant women			
2. Control of puerperas			
3. Attraction of pregnant women			
4. Derivation of puerperas			
5. Follow-up			
6. IUD insertions			
7. Prescription of O.C.			
d. Child Health			
1. Control of newborn			
2. Control of infants			
3. Control of preschool child			
4. Follow-up			
5. Attention of morbidity.			

Yes No Are the guidelines followed?

e. Food Support

1. Pregnant woman
2. Infant's mother
3. Child
4. Follow-up

f.

1. First Aid
2. Derivation of patients

g. Are the patients who are referred well attended?

h. Health Education

1. Frequency: Daily () Monthly () Weekly ()

2. Subjects most frequently covered: _____

3. What techniques are most frequently used? Number: _____

4. What audiovisual aids are used?

5. To whom is health education directed? _____

Environmental Sanitation

1. Improvement of housing
2. Protection of springs
3. Construction of WCs
4. Others:

E. Training

1. Health Personnel

a. Is there a program for training personnel? No Yes

Is it fulfilled? No Yes

b. Who has been trained since the last supervision? _____

c. Are personnel trained for the work they are doing?

Physician _____ Midwife _____ Nurse _____

Health Auxiliary _____ Others _____

d. What are the future training requirements? _____

F. Community Resources

1. Are leaders of the community trained? No Yes Which?

Community Leaders _____ Traditional Midwives _____

Promoters _____ Teachers _____

(To observe a course).

a. Are scheduled courses held? Yes No

b. Is there a curriculum for the course? Yes No

c. Is the curriculum followed? Yes No

d. Do the instructors know the subject? Yes No

e. Do the instructors use an adequate language? Yes No

f. Is an appropriate evaluation of knowledge made? Yes ___ No ___

Comments and Recommendations: _____

G. Supervision

1. Received

a. Person who made the last supervision: _____

b. Date of last supervision received: _____

c. Were the recommendations from the previous visit fulfilled?

Yes ___ No ___

d. Opinion of person supervised of supervision received: _____

2. Made

a. Is the supervision planned? Yes ___ No ___

b. Is there a chronogram? Yes ___ No ___ Is it fulfilled? Yes ___
No ___

c. Is a report made of the supervision? Yes ___ No ___

d. Is the guide used during the supervision? Yes ___ No ___

e. Is technical assistance provided? Yes ___ No ___

f. Is direct attention given to the patients of the community?
Yes ___ No ___

g. Are meetings held with the community? Yes ___ No ___

Comments and Recommendations: _____

H. Records and Statistics

1. Are the following records kept?

a. Attention: Daily? Yes ___ No ___ Correctly? Yes ___ No ___

b. Attention: Monthly? Yes ___ No ___ Correctly? Yes ___ No ___

c. Information analyzed? Yes ___ No ___

I. Supplies

1. Are supply orders filled out? Yes ___ No ___

2. Are they well done? Yes ___ No ___

3. Are the orders duly sent? Yes ___ No ___

4. Is advantage taken of the supervision to take the supplies?

Yes ___ No ___

5. Are the orders received when requested? Yes ___ No ___

When the latter happens, what action is taken? _____

6. When the supplies are received, are they checked? Yes ___ No ___

Recorded? Yes ___ No ___

7. Is the warehousing of the supplies adequate? Yes ___ No ___

8. Is the stock of medicines adequate? Yes ___ No ___

Is there a sufficient quantity of medicines? Yes ___ No ___

Comments and Recommendations: _____

J. Budget

1. Does the person supervised participate in the elaboration of the budget? Yes ___ No ___
2. Does he know what the budget for his establishment is? Yes ___ No ___
3. Does he know what the expenditure is to date? Yes ___ No ___
4. Is it appropriate? Yes ___ No ___
5. Are the accounts up-to-date? Yes ___ No ___
6. Does the promoter use the money to replenish medicine? Yes ___ No ___
7. Does the community control the money for the medicine? Yes ___ No ___
8. Does money correspond to sales? Yes ___ No ___

K. Community

1. Does the communal organization know and participate in the health activities? Yes ___ No ___
2. Is there a Health Committee? Yes ___ No ___
3. Does it have active participation? Yes ___ No ___
4. Are the promoter and traditional midwife selected by the community?
Yes ___ No ___
5. Did the health team motivate the community? Yes ___ No ___
6. Does the community know if the promoter is a volunteer? Yes ___ No ___
7. Does the community recognize the work of the promoter? Yes ___ No ___

In what way? _____

Comments and Recommendations _____

Appendix F

OBJECTIVES OF SUPERVISION UNIT

CONTINUOUS EDUCATION IN SUPERVISION

End Objective: That, at the end of the training, the personnel will be capable of observing, motivating, and providing technical assistance to the supervisees.

Problems

Supervision is an important means to fulfill the objectives of the health sector, and it is not being carried out in accordance with all the supervision procedures.

Educational Objectives

1. The participants must know the concept and the objectives of the supervision.
2. The participants must know the technique of supervision.
3. The participants must know the requirements of the supervisor.
4. The participants must know the procedure of the supervision.
5. The participants must be in a position to interpret and use the Supervision Guide.

Experiences and Learning Suggested and Resources

Exposition and discussion on the objective of the supervision.

Exposition and discussion on observation, motivation, technical assistance, and "sociodrama."

Questioning of participants' opinion. Elaboration of a list of opinions or replies.

Exposition and discussion of activities to be developed in each stage of supervision.

Practice in the handling of the Guide.

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Appendix G

**SUMMARY OF RECOMMENDATIONS FROM
FAMILY PLANNING TECHNICAL MEETING ON
TRAINING OF PROMOTERS AND MIDWIVES WITH AID PARTICIPATION**

MINISTRY OF HEALTH
Regional Director of North-Central Health

FAMILY PLANNING TECHNICAL MEETING
ON TRAINING OF PROMOTERS AND MIDWIVES
WITH AID PARTICIPATION

Participants

Mrs. Maria de Tanco, Consultant, AID

Miss Anne Terborgh, Senior Division Officer, Development Associates, Inc.

Mercedes Laredo de Susuki, Chief Nurse, Health Direction, Ordenor Centro, Huaraz

Reno Trinidad Munoz, Chief Midwife, Health Direction, Ordenor Centro, Huaraz

Marina Lopez Caro, Technical Office of Nursing of the Regional Direction, Health Region, Centro Oriental, HUANUCO

Consuelo Gutierrez R., Chief Nurse, Health Region Nor Medio

Imelda Castillo P., Pharmacist, Health Region Nor Medio

Rene Montro, Chief Nurse, Hospital Area No. 1, Chepen

Carmen de MESTANZA, Nurse, Primary Care Program, Hospital Area No. 2, Trujillo,

Esperanza Mateo, Midwife, Program of Support to Primary Care, Hospital Area No. 2, Trujillo

This meeting was promoted by AID with the purpose of exchanging experiences and analyzing the educational contents of the training courses for health promoters and traditional midwives, held on October 21-24, 1980, in the Regional Hospital of Trujillo. The object of this meeting was specifically to introduce family planning.

RECOMMENDATIONS

1. In the stage of motivation to the communities and in the selection of promoters and midwives, the multidisciplinary team of the Plan for the Support of Primary Health Care should participate in the Area of Level.

2. The Committee of Support of Primary Health Care should include the following professionals: social worker, nutritionist, dentist, accountant, and health educator.
3. The activities of the Primary Care Program should be rescheduled to determine the percentage of the supervision budget to be allotted to the phase of motivation and attraction of promoters and midwives.
4. In the phase of attraction, two persons should be considered as candidates for the training courses of midwives and promoters in order not to lose the quota in the event of the absence of the person proposed with first priority.
5. The Health Establishments which are nearest to the localities from which the participants come should be the places where the courses are held.
6. The modifications proposed in this meeting on the activities to be carried out by the promoter and the midwife should be considered, and the educational contents should be examined in order to include or modify the curriculum.
7. The midwife should be responsible for attracting the traditional midwives.
8. The unit related to Responsible Parenthood and Fertility Regulation should be considered in the curriculum for the training of traditional midwives and health promoters.
9. The Regional Health Directors should determine and make official the policy and strategy to be followed for the establishment and performance of the Fertility Regulation Program.
10. Information on the activities of the promoters and midwives should be collected, using uniform criteria, in order to have actual information that can be analyzed at the next meeting in April 1981 in the city of Huanuco.
11. A work team should be formed, with the participation of the different health regions, to elaborate a Uniform Manual of Health Promoters and Traditional Midwives, and to prepare the Supervision Guide.
12. In accordance with the Guide, educational courses on supervision should be rescheduled and held continuously for the personnel who are responsible for the supervision at the different levels.

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