

PA-ABD-040
5-8-85

Report of the Sixth Annual Workshop in
"FAMILY PLANNING, NUTRITION, AND PRIMARY HEALTH CARE FOR AFRICA:
PROGRAM DESIGN, MANAGEMENT, AND EVALUATION"

June 3-28, 1985



The Center for Population and Family Health
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New York, N.Y.

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This workshop was supported under USAID Cooperative Agreement
AFR-0662-A00-2068-00.

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EXECUTIVE SUMMARY OF THE REPORT OF THE SIXTH ANNUAL WORKSHOP
IN "FAMILY PLANNING, NUTRITION, AND PRIMARY HEALTH CARE FOR
AFRICA: PROGRAM DESIGN, MANAGEMENT, AND EVALUATION"

INTRODUCTION

While this was the sixth annual workshop conducted by the Center for Population and Family Health (CPFH), it was the third workshop:

- o focused primarily on Africa
- o simultaneously translated (English-French)
- o funded under cooperative agreement
AFR 0662-A-00-2068-00

TRAINEES

Thirty-eight participants from 13 sub-Saharan African countries

Anglophone		Francophone	
Kenya	5	Burkina Faso	3
Nigeria	3	Guinea Bissau	2
Sierra Leone	2	Madagascar	1
Sudan	4	Niger	6
Tanzania	3	Senegal	1
Uganda	2	Togo	2
		Zaire	4
	<hr/> 19		<hr/> 19

Six participants from other regions

Haiti	3
M.P.H. students	3

CURRICULUM

- o Community needs and resources assessment
- o Program design strategies
- o Specific problems and interventions
- o Management, training, supervision, evaluation, and research

NEW EMPHASES ADDED IN 1985:

- o Qualitative methods in planning and evaluation
- o Hands-on experience with micro-computers
- o Structured sequences of small group assignments and final group exercise by country teams
- o Human rights and maternal and child health
- o Community financing and self-sufficiency
- o Expanded training module
- o Greater use of participants as presenters and facilitators

EXTRA-CURRICULAR ACTIVITIES

- o Films
- o Computer center site visits
- o Library tours
- o Field visits to service delivery sites
- o Social activities
- o Women in development study group
- o Study groups on development topics

EVALUATION

Strongly positive results were obtained from the five different approaches used, including:

- o Pre- and post- testing of participants' self-appraised competence level with respect to 20 curriculum areas. This approach also included questions about general concepts and specific skills gained during the workshop.
- o Pre- and post- testing using a 50-item questionnaire covering management, training, supervision, primary health care interventions, community participation, and law and policy.
- o Analysis of preliminary and final exercises in program design.
- o Rapid feedback analysis of participant response to specific sessions.
- o Participant responses to open-ended questions and qualitative impressions reported by participants and staff.

A. INTRODUCTION

This report describes the sixth annual intensive workshop in "Family Planning, Nutrition, and Primary Health Care," conducted in New York City, June 3 through June 28, 1985. The workshop was designed to teach managers, evaluators, trainers, and researchers the underlying principles, practical techniques, and tools for designing, implementing, managing, and evaluating integrated service delivery programs. Special attention was given to increasing the level of epidemiologic, demographic, and management skills required for programs whose goals are the provision of family planning, nutrition, and primary health care services for lower income groups living in rural and urban slum areas in Africa.

While this was the sixth annual workshop conducted by the Center for Population and Family Health (CPFH), it was the third workshop focused exclusively on Africa.

- o Total enrollment in the workshop was 44, as follows:
 - . 38 sponsored participants from 13 sub-Saharan African countries;
 - . 3 sponsored participants from Haiti
 - . 3 others including 2 MPH students (1 U.S. and 2 Haitians)
- o Twenty-two participants were from countries in which in-country follow-up workshops have been conducted or contemplated.
- o For the third time, the workshop was conducted in both French and English using simultaneous translation for all presentations. This permitted representation and full participation of twenty-two trainees from eight Francophone countries. Guinea Bissau and Madagascar were represented for the first time in the 1985 workshop.

The curriculum and format of this workshop series have evolved since the workshop was first offered in 1980. In 1985, several new emphases were added, as follows:

1. Qualitative and quantitative methods for needs and resources assessment and evaluation were stressed throughout the workshop. The focussed group discussion and the mini-survey were given prominent attention through presentations and demonstrations.
2. All participants were given the opportunity to have a "hands on" experience with micro-computers. The rapid feedback evaluation component of the workshop was the vehicle for achieving this. As rapid feedback forms

were collected at the conclusion of a morning session, a group of 5-7 participants entered the data and produced the analyses during the lunch break, and presented the results to the entire group at the start of the afternoon session.

3. A structured sequence of workgroup assignments was again used to enable participants to apply new concepts and skills in the management, supervision, and training component of the workshop.
4. A final group exercise presented by country teams and subjected to a peer review process enabled participants to apply principles learned during the workshop and to obtain feedback from their peers on the extent to which the principles were appropriately applied.
5. A new unit was devoted to a presentation and group exercise in human rights and maternal and child health.
6. A new unit was developed to cover the topic "community financing and self-sufficiency".
7. Greater use was made of participants from previous in-country workshops as presenters and facilitators in the program.
8. An expanded module on training was developed to cover training policy-makers and top managers, training of trainers, and training village workers using competency based training approaches.

The following sections of this report cover the rationale, objectives, curriculum, participants, faculty, facilities, and evaluation of the 1985 workshop.

B. RATIONALE

In many developing countries, health care systems have followed western models of specialized, urban, technology-intensive medical care. While such physician-oriented systems may provide good to excellent care for an affluent minority in a number of countries, the majority are denied even the most basic family planning, maternal and child, and primary health care services.

The CPFH has assisted in the development of projects that make these basic family planning and related health services more accessible. These community-oriented programs in rural villages and urban slum areas rely primarily on trained allied health and lay personnel, using hospitals, clinics, and physicians only for referral and supervision. These personnel have proven to be effective in delivering a wide range of family planning and simple health services in their own communities. These services include the provision of oral contraceptives, condoms, and foam (and, in some instances, injectables) together with simple approaches to the recognition and treatment of diarrheal diseases, parasite infestation, respiratory infections, malaria, malnutrition, and injuries.

Within this broad framework, CPFH technical assistance has focused primarily on areas such as management information systems based on simplified data collection and record keeping; evaluation; supervision; logistics and supply; innovative analytic approaches; training of lay and allied health personnel, including methods to identify these workers, as volunteer or paid agents; and general public health, epidemiologic and demographic research approaches. A major focus of CPFH activities during the years ahead is to utilize this expertise and experience in assisting additional groups and countries interested in developing, expanding, and/or improving family planning and basic health and nutrition programs.

This training program has strengthened our ability to expand these efforts more rapidly by enabling us to work more intensively with a selected group of individuals to complement our program-specific technical assistance activities. The experience gained in several country programs in which we are involved has been translated into guidelines for the development of the basic curriculum units for this training program and for the in-country training programs included under this cooperative agreement.

C. GOALS AND OBJECTIVES

The overall goal of the training program is to develop and strengthen the in-country capability of African program managers, evaluators, researchers, and trainers to design, implement, manage, and evaluate integrated family planning and primary health care programs. Specific objectives are to:

1. Refine and adapt to African needs a developed curriculum emphasizing the demographic and managerial components of integrated service delivery programs.
2. Train African participants to conduct a community needs and resources assessment.
3. Teach African participants to select and develop appropriate program design strategies.
4. Present a range of specific family planning, health, and nutrition problems together along with specific interventions so that African participants can implement improved service delivery programs.
5. Prepare African trainees to use modern management, evaluation and research techniques to improve and strengthen their programs.
6. Conduct a 4-week training program for approximately 25 African participants in June 1983, June 1984, and June 1985.
7. Provide technical assistance to enable participants to serve as trainers in adapting the curriculum of this program to programs in their own countries and to assist with the design and implementation of eight such efforts. At least 20 participants will be trained in each country program.
8. Evaluate the immediate and medium-term results of the training program.

The evaluation of the degrees of achievement of objectives 1-6 is discussed in the section in "Evaluation." Separate reports are available for the 7 in-country workshops already completed (objective 7), and an independent evaluation (which will include objective 8) is currently being finalized.

D. CURRICULUM

Four major areas of curriculum have been developed, all of which draw on basic epidemiologic, demographic, and management disciplines. These areas include: community needs and resources assessment; program design strategies; specific problems and interventions; management, research, training, supervision, evaluation, and policy issues.

The following sections present a general outline of the areas included in the curriculum. The detailed syllabus, schedule, and workgroup exercises are attached as Appendix 1.

1. Community Needs and Resources Assessment

Objective: To train participants to conduct community needs and resources assessments. Training included:

- o Identification of major fertility, health and nutrition problems with particular emphasis on the use of existing data sources and the use of appropriate qualitative and quantitative approaches.
- o Identification of existing family planning, health and nutrition resources including physicians, nurses, midwives, auxiliaries, hospitals, clinics, health posts, and health training institutions.
- o Identification of gaps in services and constraints in the delivery of services.
- o Identification of cultural factors relevant to the delivery of health services, e.g., traditional sex roles tradition of voluntarism in a society; tradition of community participation; and cultural health, nutrition and fertility related behavior.
- o Identification of community resources which may be mobilized for family planning, health and nutrition programs with special reference to political and social structure, religious organizations and traditional and indigenous workers not included in the formal health structure.
- o Identification of the decision-making structure and process in the formal health sector in order to develop an understanding of the approaches and actions needed to gain acceptance for community oriented integrated service delivery programs.
- o Use of both qualitative and quantitative approaches in conducting needs and resources assessments.

2. Program Design Strategies

Objective: To teach participants to select and develop appropriate program design strategies.

Topics covered included: community participation, single-purpose programs, multi-purpose programs, mix of preventive and curative services, commercial sector opportunities, social marketing approaches, door to door canvassing and service delivery, local community depots, and relationships with existing health structures (referral, backstop, linkages).

An important related area of curriculum development concerned the relationships and linkages between the health sector and other development sectors. For example, activities in the agricultural sector often have a direct bearing on nutrition; educational programs (especially those addressing adult literacy) may be expanded to include family planning, health and nutrition content.

3. Specific Problems and Interventions

Objective: To present selected problems and interventions to enable participants to improve service delivery programs.

For these priority problems, the curriculum covered the epidemiology of the problem; pertinent demographic and ecological considerations; specific interventions available; their modes of action; and, the important issues of safety, indications, contraindications, and cost.

The priority problems and interventions covered included:

- o family planning
- o pregnancy and delivery
- o nutritional deficiencies (emphasizing children and pregnant and lactating women)
- o major parasitic and infectious diseases (with special emphasis on infant diarrhea and oral rehydration programs, immunization, malaria, and respiratory diseases)

The presentations and discussions of problems and interventions focused on community-based service delivery.

4. Management, Evaluation and Research

Objective: Prepare trainees to use modern management, evaluation, and research techniques to improve and strengthen their programs.

Topics covered included: presentation and use of a systems model for use in program design, management, and evaluation; setting objectives, and specifying evaluation criteria; selection of strategies to be incorporated into overall program design; development of information systems for administrative monitoring, supervision, and evaluation.

The management component also included training and supervision and throughout stressed the logistics, implementation planning, and financial aspects of the programs.

5. Workgroups

In addition to the class lectures, discussions, and seminars, the use of small workgroups was an important component of the curriculum. The purpose of these workgroups was to engage participants in problem-solving activities to allow them an immediate opportunity to begin applying the concepts, skills and approaches presented during the course.

During the first week of the course, participants and faculty advisors were formed into 10 workgroups.

Each workgroup met 8 to 10 times to complete a series of exercises related to the sequence of topics covered in the curriculum. At least one group was asked to present the results of each exercise ensuring that all groups were called upon at sometime during the workshop.

During the last week of the course, workgroups undertook a final exercise which involved preparation of a plan for a specific program (see Appendix 1). Each group presented the results of its work in a context of peer review and open discussion. Examples of these final exercises are included in Appendix 2. See the section on Evaluation for a full discussion of the Final Exercise.

6. Other Activities

In addition to the official workshop syllabus (Appendix 1), a number of professional and social activities were made available to the participants.

a. Computer demonstrations and visit

In response to participant demand during the session on information systems, demonstrations of mini-computers, video display terminals, and word processing equipment were arranged. In addition, all participants had the opportunity to enter data on microcomputers as part of the "rapid feedback" component of workshop evaluation.

In addition, several participants visited the Playing to Win Computer Center to further acquaint themselves with computerized information systems.

b. Visits to the CPMC Pediatric Care Center

A majority of participants expressed interest in viewing a Pediatric ICU in operation, thus several small group visits were organized. Although somewhat inconsistent with the philosophy of PHC, these field trips satisfied many of the the group members who were interested in learning about high technology facilities available at CPMC.

c. Visits to the Young Adult Clinic (YAC) and the Margaret Sanger Center Clinic

Visits to these facilities were arranged for small groups of participants where they observed education, counseling, and clinical service provision.

d. Evening session focused on Women in Development (WID)

This activity was an informal get-together whose aim was to facilitate "networking" between participants, NYC-based WID organizations, CPFH staff and local women planning to attend the UN End of the Decade for Women Conference in Nairobi.

e. "Round table discussion groups" on general development issues

Several participants attended free-flowing group discussion offered by the International House. These "round table discussions" provided a forum for exchange on a variety of topics ranging from nuclear arms to grassroots development projects.

f. Film sessions included the following presentations:

Health by the People. Health and development in rural Mexico. (English, 60 minutes)

Community based family planning in Zaire (English and French), 50 minutes.

g. Library Tours

Participants visited the CPFH library for orientation to services available. A Popline search was prepared in advance for each participant, several participants requested literature searches during the month, and search request forms were distributed for future searches.

h. Social Activities

A variety of social activities were offered during the month of the workshop. These included an opening reception, a picnic in upstate New York, boatribe around Manhattan, a closing party hosted by participants, and numerous small group evening activities hosted or organized by CPFH staff. By the end of June, all participants had been invited at least once to dinner at a CPFH staff member's home.

i. Certificate and group photographs

At the closing ceremony of the workshop, certificates of participation and group photographs were distributed to all participants (Appendix 5).

E. PARTICIPANTS

Participants were drawn from two primary sources: African government and private sector organizations involved in the delivery of family planning, health and nutrition services. Nomination of candidates for the Workshops were obtained either through CPFH's own in-country program contacts, or in response to an extensive mailing to AID missions, international agencies regional and country offices, and selected African country programs and agencies. Particular attention was given to recruiting candidates for the workshop from programs in AID priority countries in which the CPFH is currently involved and in which in-country follow-up training activities are planned. Referrals from participants in the previous workshops since 1980 were another important source of nominations.

For the 1985 Workshop, more than 250 applications were received, of which 41 were selected as sponsored participants to attend the workshop. Appendix 3 contains a complete participant list. In addition, three students (both French and English speakers) enrolled in the MPH program at the School of Public Health were given special permission to take the course for academic credit towards their degree because of their demonstrated interest in and commitment to developing world health problems.

The following table describes the composition of the 1985 Workshop. While our intention was to select teams of participants from countries, we did have two countries in 1985 represented by single participants. We originally had selected four participants from Senegal, however, a physician's strike in that country prevented three of them from attending. A single participant from Madagascar was accepted as a last minute substitution from our waiting list.

**1985 PARTICIPANTS BY COUNTRY, SEX, LANGUAGE,
PROFESSION AND SPONSOR**

Country	NO. # of Participants	SEX		LANGUAGE		PROFESSION					SPONSOR								
		Male	Female	Francophone	Anglophone	Physicians	Nurse-Midwives	Administrators	Nutritionists	Health Evaluators	CPFH Africa Training	CPFH Operations Research	USAID Mission	USAID Worldwide	Assoc. for Volun- tary Sterilization	U.N. Fund for Pop- ulation Activities	CPFH/USAID Mission Joint Sponsorship	CPFH/UNFPA Training Grant	African Medical Research Found.
Burkina Faso	3	1	2	3	0	1	1	1											
Guinea Bissau	2	2	0	2	0	1	1	1	1										
Haiti	3	2	1	3	0	1	1	1	1										
Kerya	5	3	2	0	5	1	2	1	1										
Madagascar	1	0	1	1	0	1	0	2	1										
Niger	6	1	5	6	0	2	2	2	1										
Nigeria	3	0	3	0	3	1	3	1	1										
Senegal	1	1	0	1	0	1	1	1	1										
Sierra Leone	2	1	1	0	2	1	1	1	1										
Sudan	4	3	1	0	4	1	1	1	3										
Tarzanian	3	0	2	0	3	1	1	3	1										
Togo	2	2	0	2	0	1	1	1	1										
Uganda	2	2	0	0	0	1	1	1	1										
Zaire	4	3	1	4	0	1	1	1	1										
TOTAL	41	20	21	22	19	7	10	19	2	3	10	1	18	2	3	1	2	3	1

F. FACULTY

The faculty for this program was drawn from the interdisciplinary faculty of the Center for Population and Family Health, and other School of Public Health and Medical School faculty from Departments of Pediatrics, Epidemiology, and Tropical Medicine, and selected outside consultants.

A most important faculty resource again proved to be the field staff assigned to ongoing overseas projects in which the Center is involved. Their participation enriched the course by making available the views of professionals who are involved in the day to day operations of actual programs. In addition, since field staff were housed together with participants, they provided important "after hours" companionship and assistance in taking advantage of New York attractions. In addition to the faculty, a program coordinator, secretary, and messenger were assigned to provide support for the program.

External consultants and their areas of expertise included:

Mr. Bill Bower, Hesperian Foundation, Villager Run Programs, Training.

Dr. Mary Lou Clements, University of Maryland - Oral Rehydration Therapy, Respiratory Diseases.

Dr. Abdul Rahman El Tom, Department of Community Medicine, University of Khartoum, Nutrition.

Dr. David Morley, Institute of Tropical Child Health - Pediatrics, Training.

Dr. Maryse Pierre Louis, Center for Family Health, Haiti - Family Planning, Training.

Dr. Aly Biely, Consultant, USAID, Khartoum, Community-based Programs.

Ms. Sally Craig Huber, Community Financing

- Dr. Gilberte Vansintejan, Training

Dr. Rosalyn King, Drew Post-Graduate Medical Center, Logistics

Public Health and Medical School faculty included:

Dr. Nicholas Cunningham, Pediatrics
Dr. Phillip D'Allesandro, Tropical Medicine
Dr. Sten Vermund, Epidemiology
Dr. Sam Toussi, Epidemiology, Refugee Health

In 1985, a special effort was made to involve participants in the presentation and discussion of workshop topics. Chief among these efforts were the following:

- o Presentation of the conceptual framework for the workshop - Mr. Ezekiel Kalaule, CAFS, Kenya
- o Supervision role play - Mr. Ezekial Kalaule and Ms. Sellah Nakisha, Kenya; Mr. Peter Opio, Uganda; Mr. Cle Sitayo, Tanzania; Drs. Maude Frederick, Yves Lionel Mettellus, and Jean Marie Baptiste, Haiti.
- o Training - All participants were involved in demonstration of techniques for training village health workers.
- o Nutrition - Ms. Sylvetta Scott, Sierra Leone, and Dr. Aboubakry Thiam, Senegal
- o Family Planning - Dr. Mohamed H. Mohamed, Kenya
- o Community Participation - Drs. ElKarib and Mekki, Sudan; Dr. Victor Cole, Sierra Leone, Dr. Moha, Niger, Ms. Mubiru, Tanzania
- o Human Rights - Mr. Kalaule, Kenya; Dr. Attia ElAbdeen, Sudan; Dr. Thiam, Senegal; Ms. Mubiru, Tanzania; Mr. Drame, Guinea Bissau; and Citoyen Bafwanga, Zaire.
- o Mrs. Akintunde of Nigeria, presented a special lunch-hour seminar on the work of the Women and Development Organization of Ibadan, Nigeria.
- o Several participants with special expertise in training and program management served as resource people within their workgroups.

G. FACILITIES AND RESOURCES

Existing facilities and physical resources of the Faculty of Medicine and the CPFH were used for this program including classrooms available in a variety of locations and the well-equipped Audio Visual Center of the main Health Sciences Library. The Center's specialized library with over 10,000 documents, 3,000 books and monographs, and 135 journal and newsletter subscriptions was also utilized. A large number of publications were made available to the participants and the Library provided free literature searches to participants on their country programs and instructed them on how to make use of the POPLINE search service in the future.

All participants received a comprehensive package of published and unpublished materials for their use on return to their countries. A list of materials distributed to all participants is contained in Appendix 4.

Housing arrangements for participants were made at the International House -- a short bus ride from the CPFH and its classroom locations. International House is a private, non-profit residential program center near the main campus of Columbia University, which houses over 500 students and trainees from 75 different countries. Among its services and facilities are: a dining hall, gymnasium, health services, library and meeting rooms, and an extensive program of intellectual, social, cultural and recreational activities.

Simultaneous translation of the Workshop was arranged through Rennert Bilingual Institute of New York. To preserve the participatory dynamic of the Workshop and to avoid the stilted formal format often associated with simultaneous translation, an innovative system was employed. This system used infra-red transmitters and lightweight headsets thereby eliminating extensive wiring and permitting easy physical movement and rearrangement of the room configuration for different training purposes. Overall, the system worked well. Participant assessment of the simultaneous translation of the Workshop is covered in the section on Evaluation.

H. EVALUATION

1. Design

Evaluation methods used in the 1984 workshop included:

- o Pre- and post-testing of participants' self-appraised competence level with respect to 20 curriculum areas. This approach also included questions about general concepts and specific skills gained during the workshop.
- o Pre- and post-testing using a 50 item questionnaire covering management, training, supervision, primary health care interventions, community participation, and law and policy.
- o Analysis of preliminary and final exercises in program design.
- o Rapid feedback analysis of participant responses to specific sessions.
- o Participant responses to open-ended questions and qualitative appraisals reported by participants and staff.

2. Competence Levels and Concepts and Skills Gained

Pre and Post testing of participants self appraised competence level in 20 curriculum areas was carried out using the instruments developed for earlier workshops. In addition to assessment of competence levels, the post test asked whether general concepts and specific skills were gained in each of the 20 areas.

In some cases, a curriculum area corresponds to a single session in the unit evaluations (e.g. malaria and other parasitic diseases). In other cases, several unit sessions comprise a curriculum area, (e.g. needs assessment), and in the final category, the curriculum area constitutes a major theme, dealt with specifically in certain sessions, but also addressed throughout the course, (e.g. program design, management, evaluation and nutrition).

The following table presents the results of this evaluation.

- o Columns 1-4 present pre and post-Workshop comparisons of participants' self-assessed level of competence in each of the 20 curriculum areas. Column 1 is the percentage of participants rating themselves "high" and "very high" on the pre-test. Column 2 is the same percentage obtained on the post-test. Columns 3 and 4 present the absolute (col. 3) and percentage (col. 4) changes from the pre-test to the post-test.

o Columns 5-6 present post-Workshop findings on the extent to which participants reported gaining general concepts (col. 5) and specific skills (col. 6) in each of the 20 curriculum units.

Overall, the 1985 results are highly positive. Participants showed post test gains in excess of 100% improvement in their self-assessed levels of competence in 15 of the 20 curriculum units.

Gains in general concepts and skills were among the highest levels in 6 years of workshop experience.

**PRE AND POST SELF ASSESSED LEVEL OF COMPETENCE IN
TWENTY ONE CURRICULUM AREAS AND CONCEPTS AND
SKILLS GAINED UPON COMPLETION OF WORKSHOP**

Curriculum Unit	Percent Rating Themselves "High" and "Very High"				% Who Gained	
	Pre Test (1)	Post Test (2)	Absolute Change (3)	% Change (4)	General Concepts (5)	Specific Skills (6)
Primary Health Care	37.5	78.0	+ 40.5	108	88	86
Community-based Maternity Care	34.2	72.5	+ 38.3	112	91	88
Community-based Family Planning	31.0	75.6	+ 44.6	144	98	86
Community-based Nutrition	37.5	65.0	+ 27.5	73	91	80
Oral Rehydration	46.2	69.2	+ 23.0	50	91	71
Immunization	60.0	76.9	+ 16.9	28	63	63
Malaria and Parasitic Diseases	35.9	68.3	+ 32.4	90	69	54
Respiratory Diseases	27.5	60.0	+ 32.5	118	80	63
Child Health	34.1	80.0	+ 45.9	135	86	83
Program Design	25.0	74.3	+ 49.3	197	95	88
Needs and Resources Assessment	22.5	80.4	+ 57.9	257	95	93
Planning	17.9	79.4	+ 61.5	344	95	95
Community Participation	20.5	73.1	+ 52.6	257	98	93
Training	39.0	82.9	+ 43.9	113	95	95
Supervision	56.1	78.0	+ 21.9	39	95	95
Information Systems/ Monitoring	22.5	75.0	+ 52.5	233	98	98
Evaluation and Operations Research	19.5	65.0	+ 45.5	233	95	88
Implementation Planning	24.3	74.3	+ 50.0	206	98	95
Development, Law and Policy/Human Rights	7.5	43.9	+ 36.4	485	88	74
Community Financing	7.5	56.0	+ 48.5	647	86	88

3. Pre and Post Knowledge Test

A second workshop evaluation tool was a 50 item questionnaire covering management, training, supervision, primary health care interventions, community participation and law and policy. This questionnaire, developed and used in in-country workshops in Kenya, Tanzania, and Senegal, was administered at the start of the workshop and again at the conclusion of the program. The results are presented below.

For the entire test and for the individual test components, post-test scores show improvement over pre-test scores. The results for law and policy and community participation and focus groups should be regarded with caution as these items were made up of only 3 questions each.

The scores are consistent with those obtained in in-country workshops and in previous New York workshops, and with results obtained when the management test was administered to MPH students at the Columbia University School of Public Health.

COMPARISON OF PARTICIPANT SCORES ON 50 ITEM PRE- AND POST-TESTS

	<u>Mean Score on Pre-test</u>	<u>Mean Score on Post-Test</u>	<u>Absolute Change</u>	<u>Percentage Change</u>
1. All Questions	54.0	62.0	+ 8.0	+ 14.8
2. Management	56.0	62.8	+ 6.8	+ 12.1
3. Training and Supervision	65.7	74.5	+ 8.8	+ 13.4
4. Law and Policy	56.0	58.9	+ 2.9	+ 5.1
5. Primary Health Care	49.0	57.2	+ 8.2	+ 16.7
6. Community Participation and Focus Groups	32.0	48.7	+ 16.7	+ 52.2

4. Preliminary and Final Exercises

Comparative analysis of preliminary and final exercises in program design was carried out using an approach developed in in-country programs in Senegal and Kenya and used in New York in 1984. On arrival in New York, participants were asked to state an objective of their program, the basis for selecting the objective chosen, activities designed to achieve the objective, implications of the activities for training and supervision, and criteria for monitoring and evaluating achievement of the objective. These statements were assessed and scored by two faculty members.

As a final exercise, country workgroups were asked to develop a similar statement for a program or program component in their home countries. These statements were presented to all participants and judged by a panel consisting of three or four participants and at least one faculty member.

For the preliminary exercise, the mean score for all country groups was 3.5 (out of a maximum possible score of 5.0) with a range of 2.9 to 4.2. On the final exercise the mean increased to 3.8 and the range shifted to 3.0 to 4.3.

In general, final scores for all groups increased over the preliminary scores with small gains for Kenya, Sierra Leone, *Niger (including Madagascar) and large gains for Nigeria, Sudan (including CAFS), Tanzania, Uganda, Guinea Bissau and Haiti. The score for the Burkina Faso, Togo, Senegal group was unchanged from pre- to post- exercises and the Zaire group's final score was lower than its initial score. The results are presented in the following table.

COMPARISON OF PARTICIPANTS' GROUP SCORES ON PRELIMINARY AND FINAL EXERCISES ON MANAGEMENT OF A PRIMARY HEALTH CARE PROGRAM (Scores on Scale of 0-5)

<u>Country</u>	<u>Preliminary Score</u>	<u>Final Score</u>	<u>Absolute Change</u>	<u>% Change</u>
Kenya	3.6	3.7	0.1	3%
Nigeria	3.3	3.7	0.4	12%
Sierra Leone	3.7	3.8	0.1	3%
Sudan (including CAFS)	2.9	4.3	1.4	48%
Tanzania/Uganda	3.3	3.7	0.4	12%
Burkina Faso/Togo/ Senegal	3.0	3.0	-	-
Guinea Bissau (MPH students)	3.5	4.0	0.5	14%
Haiti	3.5	4.2	0.7	20%
Niger (including Madagascar)1/	4.2	4.3	0.1	2%
Zaire	4.1	3.3	-0.8	-19%

1/ These groups worked on a training design for their final exercises.

5. Rapid Feedback

Rapid feedback was employed at the conclusion of several sessions to quickly ascertain participant reactions to the material presented and the quality of the presentation. As noted elsewhere, the rapid feedback forms were distributed at the end of a morning session and during the lunch period groups of participants entered the data and produced results using CPFH microcomputers.

In general, for the sessions on which rapid feedback was conducted, two-thirds of all respondents rated the sessions and presenters highly (See table below). While the overall results were positive, some differences between Anglophone and Francophone ratings emerged. Anglophones tended to rate English language presentations somewhat better than did their Francophone counterparts and French speakers tended to rate French language presentations more highly than did the English speakers.

RESULTS OF RAPID FEEDBACK EVALUATION OF SELECTED SESSIONS

% of participants (Total, English, French)
responding 4 and 5 on a six point scale (0-5)

Topic	Needs and Resources Assessment			Nutrition			Training			Supervision			Law and Policy Human Rights			Problems, Objectives Strategies and Evaluation Criteria		
	TOT	ENG	FR	TOT	ENG	FR	TOT	ENG	FR	TOT	ENG	FR	TOT	ENG	FR	TOT	ENG	FR
1. Session worthwhile	76	90	61	79	89	61	91	100	86	97	95	100	78	67	89	76	90	61
2. Personally needed the session	55	80	27	65	84	44	77	79	76	92	95	89	67	55	79	55	80	28
3. Other participants needed the session	74	95	50	78	83	67	88	86	90	94	100	89	79	69	89	74	95	50
4. How well the trainer did his/her job	63	80	44	89	100	72	86	93	81	89	83	95	89	83	95	63	80	45

6. Qualitative Appraisals

At the conclusion of the Workshop, participants were asked to respond to several general questions about the program. The following is a summary of their responses.

a. Most useful concepts and skills:

Management
Evaluation
Program Design
Training and Supervision
Community Participation

b. Least useful concepts and skills:

Community-based Maternity Care
Development Law and Policy and Human Rights
Malaria and Parasitic Diseases, Respiratory Illness

c. Topics needing more attention:

All discussions need to be longer
Sexually transmitted diseases
Family Planning and Contraceptives
Operations Research
PHC Interventions
Management: problem definition, evaluation,
supervision, training

d. Topics to be dropped or modified: Few isolated responses.

e. Audio-visual (films, slides, etc.): Well received, worthwhile, relevant, and reinforcing.

f. Organization and logistics: Favorable comments in general. Frequently repeated suggestions included: extending the length of the course and forming workgroups according to substantive interest and not by country, in order to facilitate a greater amount of exchange and interaction among country teams.

g. Recommend workshop to a colleague: Overwhelmingly, the participants would recommend the program to a colleague (97%).

h. Reading materials. Those found to be most useful were:

On Being in Charge (50%)
Helping Health Workers Learn (25%)
Teaching for Better Learning (20%)
Where There is No Doctor (17%)

- i. Access to Training Staff: Eighty-three percent of the trainees felt that they had good or excellent access to the training staff.
- j. Simultaneous Translation: Only 5 participants (4 Anglophone and 1 Francophone) felt that simultaneous translation should be discontinued in future workshops. The majority felt that the French/English exchange enriched the training experience and that simultaneous translation should be continued. Nineteen percent suggested improvements including a better translation booth to diminish the noise level of the translators in the classroom and special training for translators in technical medical terminology for future workshops.

7. Evaluation Summary

While no one of the evaluation approaches used in this workshop offers a precise measure of achievement, taken together the approaches used and the results obtained combine to produce an overall highly positive picture. The following material presents the results obtained from the different approaches used in the context of workshop objectives.

Objective: To train African participants to conduct community needs and resources assessment.

The pre- and post-workshop survey of participants' self-assessed competence levels in the curriculum areas of needs and resources assessment, villager run programs and community participation, and use of village based workers showed substantial absolute and percentage gains. These areas also showed high percentages of acquisition of general concepts and specific skills. Knowledge testing in these areas showed post-workshop gains in community participation and focus groups. The final exercise included a needs and resources assessment component which also showed improvement over the preliminary exercise. Rapid feedback on these topics was positive.

Objective: To teach African participants to select and develop appropriate program design strategies.

The pre- and post-changes in competence levels for the curriculum area of program design was strongly positive, as were the ratings of this unit in terms of concepts and skills gained. The results of the final exercise indicate that the participants' abilities to design programs increased. Rapid feedback on related sessions was also positive. Qualitative comments indicated that these topics were considered to be the most useful.

Objective: To present the range of specific family planning, health and nutrition problems together with specific interventions so that African participants can implement improved service delivery programs.

This curriculum component encompasses several units including Primary Health Care, Maternity Care, Family Planning, Child Health, Oral Rehydration, Immunizations, Nutrition, Malaria, Parasitic Diseases, and Respiratory Diseases. All areas showed impressive gains in pre- and post- self-appraised level of competence and in post-course acquisition of general concepts. All but Immunization, Malaria and Parasitic Diseases and Respiratory Diseases recorded high percentages in acquisition of specific skills.

Primary Health Care pre- and post- knowledge testing showed moderate post workshop gains. Rapid feedback on related sessions was positive. Qualitative comments confirmed these findings.

Objective: To prepare African trainees to use modern management, evaluation, and research techniques to improve and strengthen their programs.

This curriculum component also encompasses several units including overall Program Design, Management, Evaluation, Problem Definition, Objectives, Strategies, Evaluation Criteria, Needs and Resources Assessment, Training, Supervision, Information Systems, Budget and Finance, Logistics, Implementation Planning, Policy and Legal Issues, and Operational Research.

Management and Evaluation were areas in which participants ranked themselves comparatively low (except for training and supervision) in the pre-course survey. As with Program Design, these curriculum areas were addressed in unit sessions and seminars, but also throughout the course as aspects of Management, Evaluation and Research related to almost all other topics in the curriculum. These were also areas in which most participants had specific objectives in attending the course, no doubt because they overwhelmingly identified themselves as professionals working in these general program areas. The pre and post-course differences (except for supervision) are substantial, and the concepts and skills gained were impressive.

Post-course knowledge testing revealed important gains in Management and Training and Supervision. The Final Exercise (which included these topics) also showed gain over the preliminary exercise. Rapid feedback on Management sessions was highly positive.

Qualitative comments also rated these topics highly.

SCHEDULE 1985 - JUNE COURSE

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SAT/SUN
9:30 - 12:30	3 Welcome Introduction Orientation Pretesting	4 Introduction to Primary Health Care Overview of Program Design, Management, and Evaluation	5 Synthesis Planning: Quantitative and Qualitative Approaches to Needs and Resources Assessment	6 Synthesis Discussion of Exercise Planning: Problem Definition, Objectives, Strategies, and Evaluation Criteria	7 Synthesis Discussion of Exercise Community Based Programs and Community Participation	8/9 (SUNDAY) Picnic
2:00 - 5:00	Banking ID Cards Orientation to Columbia Presbyterian Medical Ctr	Case Study: What is Management? - - - - - 4-7pm Reception	Exercise in Needs and Resources Assessment and Focus Group Demonstration	Exercise in Problem Definition, Objectives, Strategies, and Evaluation Criteria	Community Based Programs and Community Participation (cont'd)	
9:30 - 12:30	10 Synthesis Community Based Maternity Care	11 Synthesis Community Based Nutrition Programs	12 Synthesis Community Based Primary Health Care - Oral Rehydration, Immunization, Malaria, Respiratory Diseases	13 Synthesis Development Law and Policy	14 Synthesis Training: General, Competency Based Training, Training Professionals, Training of Trainers	15/16 (SATURDAY) Boatride
2:00 - 5:00	Community Based Family Planning 8-10PM - Women in Development Recept.	Free or Optional Site Visits	Community based Primary Health Care (cont'd)	Human Rights and Maternal and Child Health	Training Exercises	(SUNDAY) Picnic Raindate
9:30 - 12:30	17 Training Village Workers	18 Synthesis Child Health	19 Synthesis Training Exercises	20 Synthesis Discussion of Exercises Supervision	21 Synthesis Review of Exercise Information Systems and Monitoring	22/23
2:00 - 5:00	Training Village Workers (cont'd)	Child Health (cont'd)	Free or Optional Site Visits	Exercises in Supervision	Exercises in Information Systems and Monitoring	
9:30 - 12:30	24 Synthesis Discussion of Exercises Evaluation and Operations Research	25 Synthesis Programming and Implementation Planning	26 Synthesis Community Financing and Approaches to Self-Sufficiency	27 Preparation of Final Exercise	28 Presentations of Final Exercises	29/30
2:00 - 5:00	Evaluation and Operations Research (cont'd)	Exercises in Programming and Implementation Planning	Free or Optional Site Visits	Preparation of Final Exercise	Post Testing and Closing Ceremonies	

FAMILY PLANNING, NUTRITION, AND PRIMARY HEALTH
CARE FOR AFRICA:
PROGRAM DESIGN, MANAGEMENT, AND EVALUATION

The Center for Population and Family Health
Columbia University
New York

June 3 - 28, 1985

WORKSHOP SYLLABUS AND SCHEDULE

FIRST DAY - MONDAY, JUNE 3, 1985

9:30AM - 12:30 PM INTRODUCTORY AND WELCOMING SESSION

9:30AM

WELCOMING REMARKS

Gorosh
Weiss
Nalder

9:45AM

PHILOSOPHY, GOALS AND RATIONALE OF THIS
TRAINING PROGRAM IN THE CONTEXT OF
INTERNATIONAL HEALTH

Rosenfield

10:00AM

INTRODUCTION OF PARTICIPANTS AND CPFH STAFF

11:30AM

OVERVIEW OF COURSE AND ORIENTATION TO CPFH

- . Course objectives
- . Curriculum and schedule
- . Methods
- . Expectations
- . Logistics
- . Pretesting
- . Distribute management case

1:00PM - 5:00PM

LUNCH, BANKING, IDENTIFICATION CARDS, ORIENTA-
TION TO THE COLUMBIA PRESBYTERIAN MEDICAL CENTER

* Read Management Case Monday evening in preparation for Tuesday discussion.

SECOND DAY - TUESDAY, JUNE 4, 1985

9:30AM	<u>PRIMARY HEALTH CARE: AN OVERVIEW</u>	Wray
10:30AM	<u>INTRODUCTION TO PROGRAM DESIGN, MANAGEMENT AND EVALUATION</u>	Van Wie Gorosh Nalder

- . Introduction of a model analytical framework
- . Planning and decision making
- . Program design
- . Goals, objectives, targets
- . Inputs
- . Processes
- . Outputs
- . Utilization
- . Time
- . Knowledge
- . Attitudes
- . Practice
- . Health
- . Nutrition
- . Fertility
- . Evaluation
- . Population
- . Environment
- . Constraints
- . Total societal context

2:00PM - 4:00PM CASE STUDY: WHAT IS MANAGEMENT?

* 4-7PM Reception

* Read "Fictitia" (through page 30 only) to familiarize yourself with the data-base which will be used in the workshop exercises during the workshop.

THIRD DAY - WEDNESDAY, JUNE 5, 1985

9:30AM - 9:45AM SYNTHESIS

9:45AM - 10:15AM NEEDS AND RESOURCES ASSESSMENT: USING
QUALITATIVE AND QUANTITATIVE METHODS

10:15AM - 10:45AM QUANTITATIVE METHODS: USING
EXISTING DATA

10:45AM - 11:00AM BREAK

11:00AM - 12:30PM QUANTITATIVE METHODS: THE MINI-SURVEY

12:30PM - 2:00PM LUNCH

2:00PM - 2:45PM QUALITATIVE METHODS: OBSERVATIONS AND
INTERVIEWS

2:45PM - 3:30PM INTERVIEW EXERCISE

3:30PM - 3:45PM BREAK

3:45PM - 4:00PM MERGING QUALITATIVE AND QUANTITATIVE
APPROACHES

4:00PM - 4:30PM FOCUS GROUP RESEARCH: INTRODUCTION
AND EXERCISE

Lauro
Shedlin
Ross
Allman

FORMATION OF WORKGROUPS AND EXERCISE IN NEEDS AND RESOURCE ASSESSMENT

The purpose of the work group projects is to engage participants in group activities that address the important issues to be confronted in the programs to which the trainees will return, and to give them an immediate opportunity to begin to apply the concepts, skills, and approaches which will be presented during the course.

Each work group, selected for geographical and/or substantive common interest, is to develop a comprehensive plan for a family planning, nutrition or primary health care program or for a selected aspect of such a program. The plan may be for a particular program design, e.g., Integrated MCH/Family Planning Services, Use of Traditional Birth Attendants, Family Planning and Oral Rehydration, Contraceptive Marketing and Parasite Control, Breastfeeding Promotion, or Nutrition and Family Planning.

Further options for group projects might include in-depth planning for a particular aspect of overall program development. For example, if participants are to be involved in baseline surveys, an appropriate project would be to develop questionnaires, coding systems, samples, interviewer manuals, interviewer selection criteria, field supervision, schedules, survey logistics (transport, housing, food) and data processing and analysis procedures. For participants who will be developing in-country training programs, an appropriate project would involve design of a model training program including task analyses, task-oriented training modules, instructional approaches, pre and post training evaluation approaches, follow-up and refresher training approaches, trainee sectional resource material, etc.

Each work group will be assisted by one or more faculty members serving as resource persons. Work groups will meet during the times set aside in the schedule and will develop their projects following the course syllabus. For example, on Wednesday afternoon, June 5, 1985, workgroups will meet to develop needs and resources components of their projects. On Thursday morning, June 6, 1985, one of the groups will be asked to present the results of its efforts.

This pattern will be followed throughout the course as work group projects are developed and presented (of course groups are free to schedule additional work time outside of the times allotted in the syllabus). At the conclusion of the course, each group will have a fully developed project.

FOURTH DAY - THURSDAY, JUNE 6, 1985

9:30AM COMPLETION AND REVIEW OF NEEDS AND RESOURCES ASSESSMENT EXERCISE

11:00AM PROBLEM DEFINITION, OBJECTIVES, STRATEGIES, AND EVALUATION CRITERIA

Gorosh
Nalder
Van Wie

- . Problem Definition - importance of the problem, causes, magnitude and dimensions statement of goals, statement of immediate and long term objectives, setting and background (including area and population), problem being addressed, solution proposed.
- . Objectives - realistic and achievable, well defined, specific, related to problem, measurable, and acceptable to consumer.
- . Strategies - acceptability, effectiveness, low cost, use of available resources, simple and technically feasible.
- . Criteria for evaluation - objectivity, linked to decision making, linked to methods, timely and useable, use of appropriate methodology, decentralized and useable at all levels, accountability, continuous and periodic, participatory, constructive, non-threatening, self evaluation, simple, and convincing.

2:00PM WORK GROUP EXERCISE - PROBLEM DEFINITION, OBJECTIVES, STRATEGIES, AND EVALUATION CRITERIA

FIFTH DAY - FRIDAY, JUNE 7, 1985

9:30AM SYNTHESIS AND REVIEW OF EXERCISE IN PROBLEM DEFINITION,
OBJECTIVES, STRATEGIES, AND EVALUATION CRITERIA

10:00AM PANEL PRESENTATION ON COMMUNITY-BASED PROGRAMS Halder
AND COMMUNITY PARTICIPATION

2:00PM COMMUNITY-BASED PROGRAMS AND COMMUNITY
PARTICIPATION (cont'd)

SIXTH DAY - MONDAY, JUNE 10, 1985

9:30AM

SYNTHESIS

9:45AM

COMMUNITY-BASED MATERNITY CARE

Rosenfield

Introduction

- . Review of maternity care worldwide
 - Industrialized nations
 - Monitoring and high risk perinatal
 - Monitoring: current debates
 - Non-industrialized nations
 - Urban
 - Rural
- . Personnel
 - Doctors
 - Nurse/midwives
 - Auxiliary midwives
 - Traditional birth attendants
 - Other
- . Rural Maternity Care
 - General
 - High risk assessment
 - Personnel
 - Referral systems
 - Supervision
 - Training
 - Facilities
 - Prenatal
 - Education
 - Diet-Nutrition
 - Iron, Multivitamins
 - Tetanus toxoid
 - Other drugs (teratogenicity)
 - Toxemia
 - Medical complications
- . Delivery
 - Home vs. health center
 - Complications (mother)
 - Obstructed labor
 - Ruptured uterus
 - Placenta praevia
 - Abruptio placentae
 - Toxemia
 - Hemorrhage (intrapartum, postpartum)
 - Other
 - Complications (infant)
 - Difficult delivery
 - Low birth weight
 - Cord around neck
 - Other
 - Traditional cultural practices
- . Breast-feeding vs. bottle feeding

SIXTE DAY - MONDAY, JUNE 10, 1985 (cont'd)

2:00PM

COMMUNITY-BASED FAMILY PLANNING

Rosenfield

Oral Contraceptives

- . Prevalence, ever use and use effectiveness
- . Mechanism of action
- . Side Effects
- . Complications - Risks
- . Benefits
- . Risk-Benefit assessment
- . Checklists for community-based services

IUDs

- . Types
- . Prevalence and use effectiveness
- . Mechanism of action
- . Side effects
- . Complications - risks
- . Benefits
- . Role of Paramedics

Injectables (DMPA or Depo Provera)

- . History of use
- . Mechanism of action
- . Complications - risks
- . Benefits
- . Risk-Benefit assessment

Barrier Methods

- . Diaphragm
- . Foam and jellies
- . Condom

Natural family planning

Sterilization

- . Female techniques
- . Male
- . Facilities and personnel
- . Informed consent

The Future

- . Brief look at the contraceptives of the future for community-based approaches

4:00PM

COMMUNITY-BASED MATERNITY CARE AND FAMILY PLANNING
-- RESPONDENT PANEL

8:00PM - 10:00PM

Reception "Women in Development: An Evening of Networking", Main Lounge, International House
500 Riverside Drive (between 120th and 121st)

SEVENTH DAY - TUESDAY, JUNE 11, 1985

9:30AM

SYNTHESIS

9:45AM - 10:45AM

NUTRITION

Solimano
Wray

- . Magnitude and determinants of priority of dietary and nutritional problems in developing countries
- . Nutrition interventions with particular attention to how nutrition fits into community-based, integrated primary health care programs

11:00AM - 12:30PM

DESIGN AND IMPLEMENTATION OF COMMUNITY-BASED NUTRITION PROGRAMS

2:00PM -

OPTIONAL SITE VISITS

To be arranged.

EIGHTH DAY - WEDNESDAY, JUNE 12, 1985

9:30AM

SYNTHESIS

9:45AM

COMMUNITY-BASED PRIMARY HEALTH CARE

Interventions

- . Oral rehydration
- . Immunizations
- . Malaria and other parasitic diseases
- . Respiratory infections

Waver
Clements
Cunningham
D'Alesandro
Vermund

2:00PM

COMMUNITY-BASED PRIMARY HEALTH CARE
INTERVENTIONS (cont'd)

Participants will present case-studies of intervention programs from their own experiences.

NINTH DAY - THURSDAY, JUNE 13, 1985

9:30AM

DEVELOPMENT LAW AND POLICY

Isaacs

- . Development law and policy in sub-Saharan Africa in relation to family planning, nutrition and primary health care
- . Policy Advocacy

2:00PM

HUMAN RIGHTS AND MATERNAL AND CHILD HEALTH

Cook
Maine

What human rights are relevant to maternal and child health?

- . Right to life
- . Right to found a family
- . Right to health care
- . Right to non-discrimination

How do you prove these rights are violated by, for example, the use of epidemiological data?

What are the most appropriate remedies to redress these violations?

TENTH DAY - FRIDAY, JUNE 14, 1985

9:30AM SYNTHESIS

9:45AM TRAINING

Nalder
Wawer
Gorosh
Bower

Training Program Overview - In Context
of the Model

- . Community context
- . Needs and resources assessment
- . Training design
- . Implementation
- . Evaluation

Competency Based Training Approach

- . What it is?
- . How it compares to the educational approach
- . Ten elements of competency-based training

Making Training Relevant and Appropriate

- . Place
- . Methods
- . Phasing

TRAINING PROFESSIONAL WORKERS

TRAINING OF TRAINERS

2:00PM TRAINING EXERCISES

ELEVENTH DAY - MONDAY, JUNE 17, 1985

9:30AM

SYNTHESIS

9:45AM

VILLAGER RUN PROGRAMS

Bower

- . Villager run health programs
- . Politics of village health child to child approaches
- . Rehabilitation of physically handicapped children

2:00PM

TRAINING VILLAGE WORKERS

Bower

- . Training methods and aids based on problem solving, doing, and thinking
- . Community theatre

TWELFTH DAY - TUESDAY, JUNE 18, 1985

9:30AM

SYNTHESIS

9:45AM

TRAINING FOR CHILD HEALTH

Morley

- . Introduction to Pediatric Priorities
- . Growth Monitoring
- . Oral Rehydration
- . Breastfeeding
- . Immunization
- . Birth Spacing

2:00PM

TRAINING FOR CHILD HEALTH (cont'd)

Morley

6/1

THIRTEENTH DAY - WEDNESDAY, JUNE 19, 1985

TRAINING (cont'd)

9:30AM

SYNTHESIS

9:45AM

TRAINING EXERCISES

Morley
Bower
Nalder
Gorosh

2:00PM

OPTIONAL SITE VISITS

To be arranged.

FOURTEENTH DAY - THURSDAY, JUNE 20, 1985

9:30AM

SYNTHESIS

9:45AM

SUPERVISION

- . Supervision by objectives
- . Roles and responsibilities
- . Routine supervision
- . Selective supervision

Waver
Nalder
Gorosh

2:00PM

SUPERVISION EXERCISES

FIFTEENTH DAY - FRIDAY, JUNE 21, 1985

9:30AM	<u>SYNTHESIS</u>	
10:00AM	<u>INFORMATION SYSTEMS AND MONITORING</u> <ul style="list-style-type: none">. Organization as a communications network. Planning - Management - Evaluation - Informational Needs. Sources of information for management. Quantitative vs. qualitative information. Service statistics systems	Weiss Gorosh Wishik
11:30AM	<u>THE USE OF MICROCOMPUTERS IN INFORMATION SYSTEMS</u>	Weatherby Fenn
12:30PM	<u>OPTIONAL - DEMONSTRATION OF MICROCOMPUTERS</u>	
2:00PM	<u>WORK GROUP EXERCISE IN INFORMATION SYSTEMS AND MONITORING AND DEMONSTRATIONS OF MICROCOMPUTERS</u> <p>Participants will be organized in small groups for microcomputers demonstrations. In addition, all participants will have an opportunity to enter data from daily workshop evaluations (rapid feedback) into a computer and to obtain results and to present findings.</p>	

SIXTEENTH DAY - MONDAY, JUNE 24, 1985

9:30AM

SYNTHESIS AND REVIEW OF EXERCISE/
INFORMATION SYSTEMS

10:00AM

EVALUATION AND OPERATIONS RESEARCH

- . An overview of evaluation with special emphasis on pre and post surveys
- . An introduction to operations research
- . The Childspacing and Fertility Association of Zimbabwe: A case study in developing an evaluation and OR capacity
- . Presenting quantitative data in attractive ways
- . Using microcomputers for program evaluation

Ross
Lauro
Wishik
Gorosh
Fenn

2:00PM

EVALUATION AND OPERATIONS RESEARCH (cont'd)

4:30PM

DISTRIBUTION AND DISCUSSION OF FINAL
EXERCISES

SEVENTEENTH DAY - TUESDAY, JUNE 25, 1985

9:30AM

SYNTHESIS

9:45AM

PROGRAMMING AND IMPLEMENTATION PLANNING

- . Organization
- . Coordination
- . Job description
- . Activities schedules
- . Phasing

**Nalder
Gorosh
Van Wie
Wishik**

2:00PM

WORK GROUP EXERCISE - IMPLEMENTATION PLANNING

EIGHTEENTH DAY -- WEDNESDAY, JUNE 26, 1985

9:30AM	<u>SYNTHESIS</u>	
9:45AM	<u>COMMUNITY-FINANCING</u>	Craig-Huber
10:00AM	<u>SELF-SUFFICIENCY</u>	Craig-Huber
2:00PM	<u>OPTIONAL SITE VISITS</u> (to be arranged)	

Work groups meet independently to work on final exercise.

NINETEENTH DAY - THURSDAY, JUNE 27, 1965

9:30AM WORKGROUPS PREPARE FINAL EXERCISE

2:00PM WORKGROUPS PREPARE FINAL EXERCISE (cont'd)

TWENTIETH DAY - FRIDAY, JUNE 28, 1985

9:30AM

PRESENTATIONS OF FINAL EXERCISES

2:00PM

COURSE EVALUATION AND POST TESTING

CLOSING CEREMONY

WORKGROUP EXERCISES

	Page -----
Introductory Exercise	1
Preliminary Exercise on Management of a Primary Health Care Program	2
Needs and Resources Assessment	5
Problem Definition, Objectives, Strategies, Evaluation Criteria	7
Law and Policy Advocacy	8
Information Systems and Monitoring	9
Implementation Planning	10
Final Exercise	11
Training (to be distributed in class)	
Supervision (to be distributed in class)	

INTRODUCTORY EXERCISE

Form a team with one other participant and interview each other covering items 1-5 below. You will then introduce each other to the entire group using the information obtained during the interview.

1. Name and country
2. Professional training
3. Current position and responsibilities
4. Interests, hobbies, avocations
5. One other interesting item about the person

3. What activities have been designed in order to achieve the objective?

4. What are the implications of these activities for staff training?

5. What are the implications of these activities for supervision?

6. How are the activities monitored or supervised?

7. How are the activities evaluated?

8. What is the current status of progress toward the achievement of the objective?

NEEDS AND RESOURCES ASSESSMENT

Planning Exercise I

As the regional director of a community-based primary health care program scheduled to be launched in six months, you have decided to look at the situation as a first step in planning for a selected component of this program. Using the "Fictitia" database and material on pages 269-277 in "On Being in Charge" as a guide, prepare an outline for this task. Be sure to include a mix of quantitative and qualitative approaches.

Which primary health care component(s) have you selected?

PROBLEM STATEMENT

Quantitative Approaches

Information Needed	Intended Use	Source and Method of Obtaining Information

NEEDS AND RESOURCES ASSESSMENT

Planning Exercise I (con't)

Qualitative Approaches

Information Needed	Intended Use	Source and Method of Obtaining Information
<hr/>		

15

**DEFINING PROBLEMS, SETTING OBJECTIVES, DEVELOPING STRATEGIES,
AND SPECIFYING EVALUATION CRITERIA**

Continuing with your group exercise on needs and resources assessment, specify one major problem being addressed by the program. Then write several objectives for dealing with this problem and for each objective write the strategies to be followed and the evaluation criteria to be used.

PROBLEM:

OBJECTIVES	STRATEGIES	EVALUATION	
		PROCESS INDICATORS	IMPACT INDICATORS

LAW AND POLICY ADVOCACY EXERCISE

1. List policies and laws which impede the provision of information and services in your primary health care program.
2. List aspects of your primary health care program which are not affected by policies or laws but would be facilitated by the development of suitable policies and laws.
3. Outline a plan for changing policies and laws that impede, and for developing policies and laws that facilitate, the provision of primary health care services.

INFORMATION SYSTEMS - MONITORING

Continuing with your community-based program design:

1. Specify the information needed by the following groups in order to coordinate workers and activities.
 - village health workers
 - supervisors
 - managers

2. For each item of information specify the following:
 - data source
 - point of collection
 - frequency of collection
 - analysis (counts, distributions, indices, trends, etc.)
 - the upward and downward flow of the information in the organization

If your group wishes to continue:

3. Design a client record for use in the program. Indicate what information is needed for client care. Indicate what information is to be collected for monitoring activities.

4. Design a summary form for a monthly report of activities using information collected on the client record. What other information should be included in the summary report?

IMPLEMENTATION PLANNING

Using the objectives developed in the previous exercise, we will now consider three important aspects of implementation planning include organizational structure, job descriptions, and activities schedules.

1. Prepare a detailed organizational chart for your primary health care program. Be sure to show the relationships from the Ministry of Health through the village health worker. Include linkages with other health and development programs and relationships with community groups.
2. Prepare a job description (see pp. 88-91 of On Being in Charge) for a village health worker and a supervisory worker.
3. Prepare a 12-month Gantt chart (see pp. 199-200 of "On Being in Charge") which shows implementation planning for planning, service delivery, community participation, health education (IEC), training, supervision, information system, logistics and supplies, transport, monitoring, evaluation, and research.
4. Prepare a budget (showing major categories of expenditures) for your 12-month plan. Be sure to include personnel, supplies and equipment, travel, per diem, and facilities.

FINAL EXERCISE

Country _____

Participants _____

Go back over the exercises you have prepared during the past weeks. Review and modify them and prepare a group presentation as follows:

1. Provide a brief description of your service area.
2. Identify major health problems of your service area.
3. Set priorities among the problems and justify your highest priority.
4. Define one objective according to your priorities.
5. Elaborate a plan of action using the approaches and procedures presented during the workshop.
6. Choose the indicators you will use for monitoring and evaluating progress toward achieving the objective you have set.

Workgroups will meet all day Thursday, 27 June to prepare this exercise. On Friday, 28 June, starting at 9:30AM, each group will have 10 minutes to present the results of the exercise followed by a 10 minute period for critique and discussions. Each group's presentation will be evaluated by a panel of experts.

EVALUATION CRITERIA FOR THE FINAL EXERCISE

1	2	3	4	5
Not Done		Done but needs further clarification		Well Done

1. Description of service area. Population, target groups, health resources, climate, transport, communication, community organizations, etc.
2. Identification of major health problems. Listing of health problems
3. Selection of priorities. Priorities set based on specified criteria.
4. Objectives set according to priorities. Objectives contains statement of:
 - . what
 - . how much
 - . who
 - . when
 - . where

Objective is:

 - . relevant
 - . measurable/observable
 - . feasible
5. Elaborate a plan of action.
 - a. selection of relevant/appropriate interventions and strategies
 - b. numbers of people needed and their qualifications
 - c. training and supervision needed to carry through planned activities
 - d. Needed resources (materials, transport, funds)
 - e. where these activities will take place
 - f. an implementation plan indicating when they will begin and when they will end
6. Define the indicators to be used for monitoring and evaluation.
 - . Is the choice of indicators pertinent (does it correspond to objectives)?
 - . Has information to be collected been itemized?
 - . Did they identify impact indicators which are appropriate for the objectives and activities specified?
 - . Did they identify process indicators which will permit them to make improvements in the program?

EVALUATION CRITERIA FOR THE FINAL EXERCISE

<u>Objective</u>	<u>Criteria</u>	<u>Score</u>				
		1	2	3	4	5
1. Identification of major health problems	- listing of health problems - priorities set based on specified criteria					
2. Objectives set according to priorities	- Objectives contains statement of: what how much who when - Objective is relevant measureable precise feasible					
3. Elaborate a plan of action	a. an explanation of the context, the problem to be resolved, and the reasons for the choice of action b. precisely what you wish to do and the primary objective c. the chosen strategy and how it will overcome the obstacles d. the number of people needed, their qualifications, and the training for them to carry through the planned activities e. the needed resources (materials, available funds, etc.) f. where these activities will take place g. a schedule of activities indicating when they will begin and when they will end					
4. Define the indicators to be used for monitoring	- is the choice of indicator pertinent (does it correspond to the objective) - did you define the information to be collected. and how it will be collected, and where					

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COLUMBIA UNIVERSITY

TRAVAIL de GROUPE

GROUPE

HAÏTI

Dr. Jean Marie JEAN BAPTISTE
Miss. MAUDE Frederic
M. Yves Lionel Metellus.

DISTRICT SANITAIRE de JACMEL
(Region de L'ouest)

Projet : PLANIFICATION FAMILIALE
EXPERIMENTAL
OCT, 85 - SEPT, 86 à base Communautaire
dans la Commune de MARIGOT
zone rurale.

Problème : - Faible Couverture des services de SANTE
- INaccessibilité des services de Planification familiale

DESCRIPTION de la REGION à Servir.

MARIGOT = COMMUNE du DISTRICT SANITAIRE de JACMEL.
- POPULATION Totale : 46811 hab
SUPERFICIE : 281 Km
SECTIONS RURALES : 5
- COMMUNICATION : Route Carrossable : Jacmel à Marigot
Les sections rurales sont

inaccessibles en voiture et ne laisser²
le passage qu'aux piétons et aux mules.

Rivière en crue à la saison pluvieuse:
(Mai - Nov) rend la Communication très
difficile par moment.

Les femmes en âge de procréer re-
présentent 25% de la population totale
des enfants de 0 - 1 an 4% de la
population totale

Les enfants de 0 - 5 ans : 15%
de la population totale

N.B. Il est admis en Haïti, selon
certaines études réalisées que les femmes
haut risque d. Grossesse représentent
12% de la population totale.

Soit : 5817 femmes dans le cadre
de ce programme.

Au niveau de la COMMUNAUTÉ IL EXISTE
des ORGANISATIONS connues sous le nom
de Conseils ou Groupements COMMUNAUTAIRES.

CLIMAT TROPICAL - Configuration Geogr. ⁴Montagne
2. LES PROBLÈMES MAJEURS de SANTÉ SONT
~~REPRÉSENTÉS~~ PAR LES SUIVANTS:

- DIARRHÉE
- MALNUTRITION
- MALARIA
- GROSSESSES NOMBREUSES OU TROP
RAPPROCHÉES, NON DESIRÉES

3. LA PRIORITÉ EST ACCORDÉE à la planifi-
cation FAMILIALE, ~~à base communautaire~~
- à base communautaire -

4. OBJECTIF

RENDRE les CONTRACEPTIFS (Pilule et condom) disponibles et accessibles à 80% de la Population des Femmes en âge de PROCREER à PARTIR de SEPT 1985 en UTILISANT les COL-VOLS basés dans la COMMUNE de MARIBOT.

AUGMENTER L'UTILISATION des CONTRACEPTIFS à 40% des Femmes à risque de GROSSESSE à la fin de SEPTEMBRE 1986.

SOIT : 2327 femmes.

5- PLAN D'ACTION

Vu que les institutions existantes (un Centre de santé, L dispensaire) sont sous utilisées et inaccessibles à la majorité de la population vivant en montagne, le programme se développera à partir des ressources communautaires déjà disponibles, les collaborateurs volontaires œuvrant dans le cadre du programme de Contrôle de la Malaria.

Des 108 recensés, 80 seront retenus pour l'exécution du projet.

Les Col-vols seront encadrés directement sur le terrain par 2 Agents de Compagne permanents (les A.C.-P) salariés pris en charge par le SNEM.

Il est prévu 40 Collaborateurs Volontaires par A.C.P.

~~INFORMATION~~

Pour coordonner le personnel et les activités du programme sur le terrain au cours de la formation les Col-vols et les A-C-P doivent recevoir les informations suivantes:

A. - Col-vols

- But du programme et OBJECTIFS FIXES
- AIRE du PROGRAMME
- Les techniques d'approches pour visites domiciliaires
- DELIMITATION aires de travail / Col-vol.
- OBJECTIFS fixés mois/année / Col-vol
- Les CONTRACEPTIFS à UTILISER
- Mode d'emploi et contre indication.
- LES CIBLES du PROGRAMME.

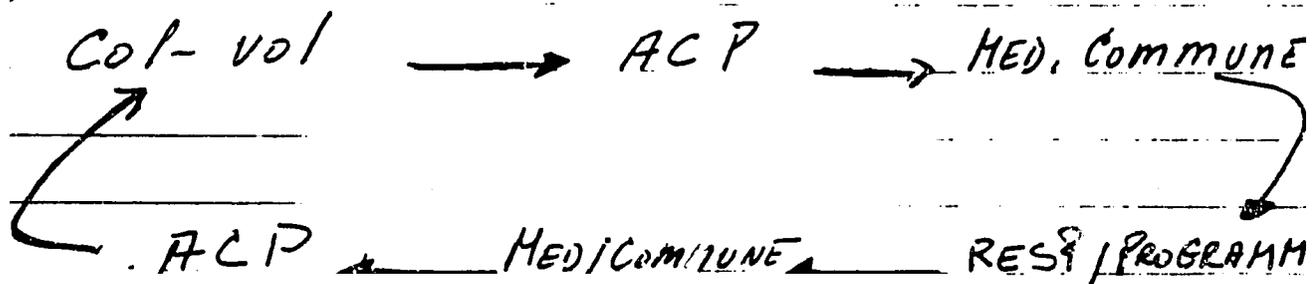
LES FORMULAIRES de RAPPORT MENSUEL à UTILISER

LES SUPERVISEURS du PROGRAMME.

B. A-C-P (AGENTS de CAMPAGNE PERMANENTS

- BUT et OBJECTIFS du PROGRAMME
- les CIBLES du PROGRAMMES
- OBJECTIFS FIXES / mois / année d'activité
- Les CONTRACEPTIFS à UTILISER
- QUANTITE NECESSAIRE / Col-vol.
- MODE d'EMPLoi et contre-indication des contraceptifs
- Nombre de Col-vol à SUPERVISER
- FORMULAIRE de RAPPORT du Col-vol et de l' A-C-P
- TECHNIQUES d'APPROCHE appropriées par Sup. Col-vol
- Le SYSTEME d'APPROVISIONNEMENT
- SYSTEME de FLUX d'INFORMATIONS

MEDECIN de COMMUNE et RESPONSABLES du PROGRAMME Mêmes informations que (A et B)



DESCRIPTION de POSTE

A. COLLABORATEUR VOLONTAIRE

TITRE du POSTE : DISTRIBUTEUR de CONTRACEPTIF

DATE : 1^{er} OCT 1985

RÉSUMÉ du POSTE : INFORMER, MOTIVER et RECRUTER des clients pour la contraception ~~maintenir~~

TÂCHES : - Identifier les femmes de
en âge de procréer 15-45 ans
dans son aire de travail.

- Recruter et motiver des clients en particu-
lier les femmes à haut risque de grossesses
pour la contraception.

- Eduquer les clients sur le mode d'emploi
des contraceptifs.

- Rédiger un petit rapport mensuel qui
doit être acheminé à l'ACP.

- Approvisionner régulièrement les clients
inscrits au programme.

- Adresser requisiions nécessaires à l'ACP.

- Referer les femmes qui veulent se faire
STERILISER.

RELATIONS : LE COL-VOL EST RESPONSABLE
DEVANT L'ACP qui le COIFFE et L'ENCADRE

QUALIFICATION : ETRE FORME et BIEN ORIENTE
SUR TOUS les ASPECTS de l'EXECUTION du
PROGRAMME.

• EXPERIENCE de la COMMUNAUTE 20'

DESCRIPTION DE POSTE
de L'A-C-P

TITRE du POSTE : SUPERVISEUR DES COL-VOLS
DATE : 1^{er} Oct. 1985.

RESUME du POSTE

ORIENTER, ORGANISER, SUPERVISER dans
SON AIRE d'ACTION. Le TRAVAIL des COL-VOLS
POUR LA DISTRIBUTION des CONTRACEPTIFS

TACHES : ASSURER L'APPROVISIONNEMENT
REGULIER des COL-VOLS en matière
de CONTRACEPTIFS, et FOURNITURES NE
CESSAIRES,
- COLLECTER ~~ET~~ ^{COMPILER} ANALYSER LES RAP-
PORTS des COL-VOLS et les ACHEMINER AU
MEDECIN DE COMMUNE
- VISITER CHAQUE COLVOL une fois
PAR MOIS.
- ADRESSER les REQUISITIONS NECES-
SAIRES AU MEDECIN de COMMUNE.

RELATIONS : R_f. ORGANIGRAMME FONCTIONNEL

QUALIFICATIONS : ETRE FORMÉ ET BIEN ORIE
TE SUR TOUTS LES ASPECTS du PROGRAMME
EXPERIENCE NECUE dans la COMMUNAUTE

RESSOURCES REQUISES POUR L'EXECUTION DU PROGRAMME .

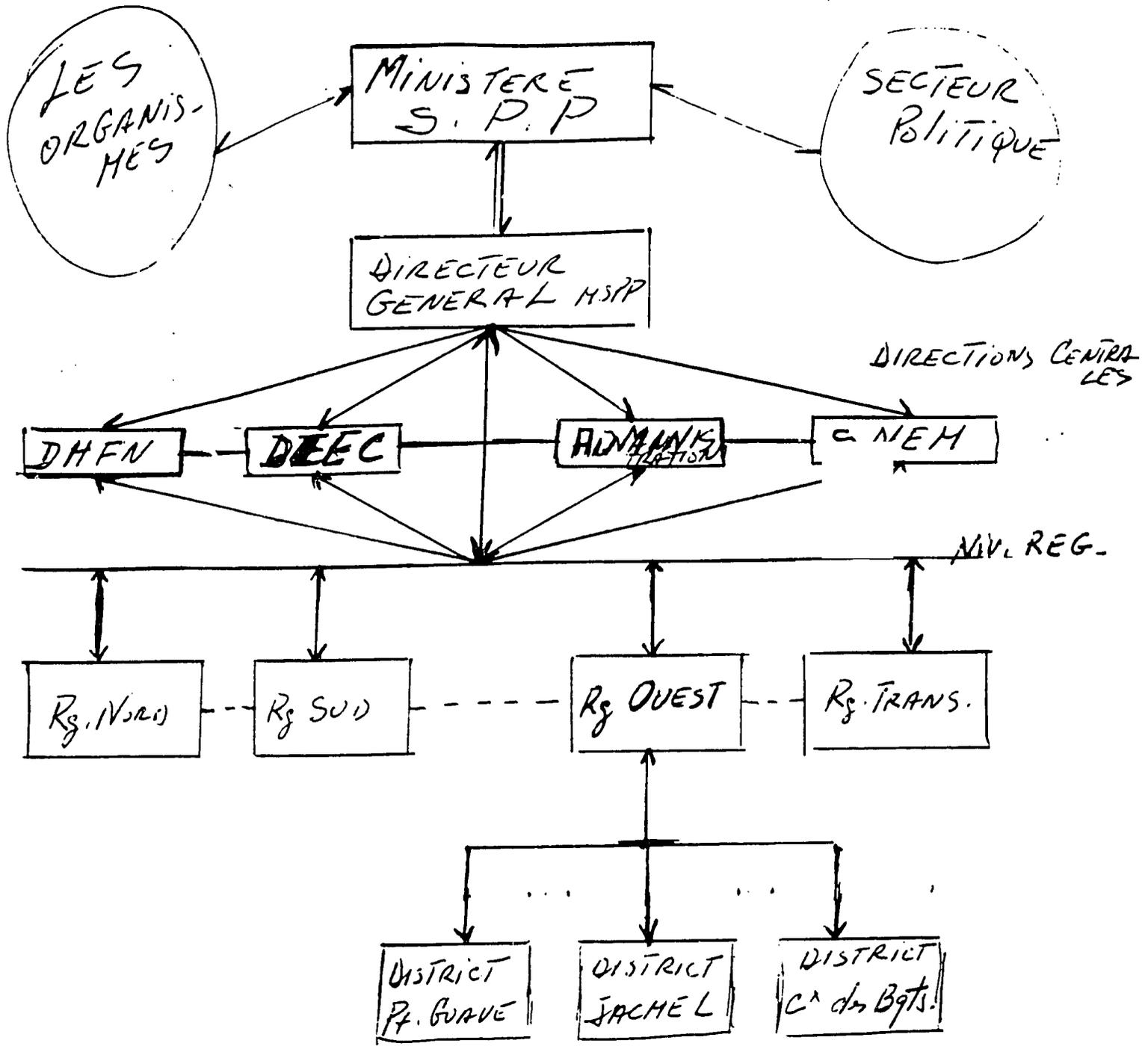
MATERIELLES.

TRANSPORT

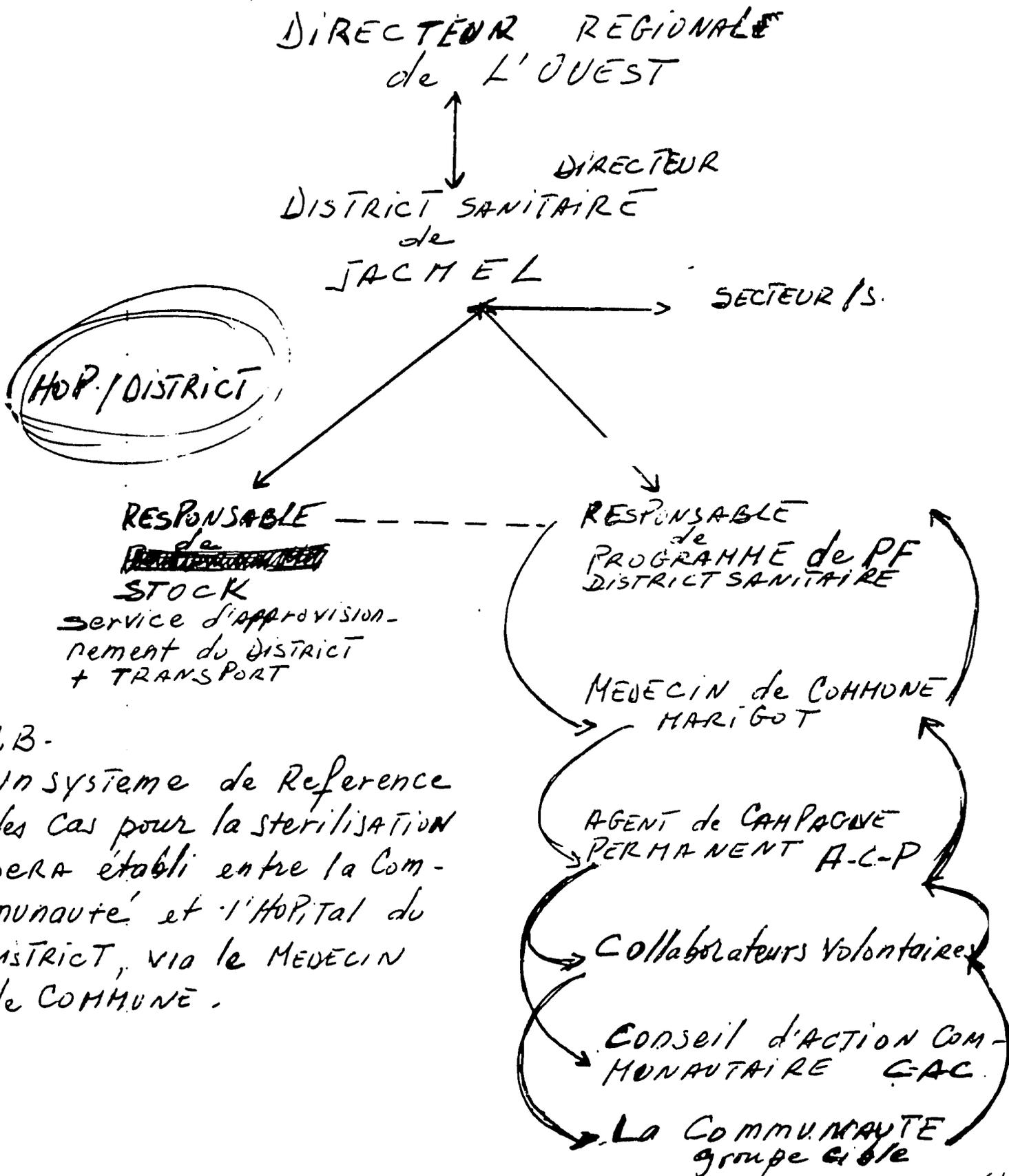
FINANCES

- PILULE ; CONDOM en q.s.
30 Milles cycles à requisitionner. pour l'année
- VEHICULE A PLANIFIER POUR
TRANSPORT.
- FINANCES :

ORGANIGRAMME STRUCTUREL du MINISTÈRE de la SANTÉ PUBLIQUE + POPULATION



ORGANIGRAMME FONCTIONNEL du PROGRAMME de PLANIFICATION FAMILIALE et FLUX d'INFORMATION.



N.B.

Un système de Référence des Cas pour la stérilisation sera établi entre la Communauté et l'Hôpital du district, via le Médecin de Commune.

FOMULAIRE de RAPPORT de l'A.C.P.
 COMPILATION et ANALYSE RAPPORTS des COL-VOL
 DISTRICT SANITAIRE de JACHEL
 PROGRAMME de DISTRIBUTION de CONTRACEPTIFS
 COMMUNE de MARI GOT
 NOM et Prenom de l'A.C.P.

Mois/date	No de Code du Col-Vol.	PILULE		CONDOM		Vis. Dom.		CAS Rapere Pr-STERIL.
		N	A	N	A	V ₁	V ₂	
Oct. 1985								
	01							
	02							
	03							

	37							
	38							
	39							
	40							
	(TOTAL)							

N.B' DES NORMES SERONT ETABLIES POUR la QUANTITE de Pilule (cycles) et de Condom à distribuer, cela PERMETTRA aussi bien à l'ACP et aux Col-Vol. de connaître la quantité de Pilules et de Condom distribués chaque mois, de maintenir la RESERVE NECESSAIRE ou de faire les REQUISITION en temps utile.

CE RESUME de RAPPORT STATISTIQUES PERMETTRE EGALEMENT AUX RESPONSABLES de SUIVRE RIGILIEREMENT le DEROULEMENT du PROGRAMME.

LISTE DES points à considérer pour pratiquer la visite de supervision

- 1- Analyse et Commentaires du dernier Rapport
- 2- Analyse du registre de TRAVAIL de l'Agent de SANTÉ (Comparaison des rapports STATISTIQUES avec sources des données)
- 3- Liste des Tâches pour leur réalisation ou non et discuter des difficultés, Étudier la performance de l'Agent de SANTÉ par rapport aux objectifs.
- 4- Vérifier l'état de stock (l'entreposage des contraceptifs, quantité) Analyse de l'entrée et sortie de stock selon l'utilisation des services (cf. rapports STATISTIQUES).
- 5- Discussion des problèmes éventuels avec l'Agent de SANTÉ et recherche de solutions appropriées. Renforcement de la formation (S.O.S)
- 6- Relations de l'Agent de SANTÉ avec la Communauté
 - Visite de 2 ou 3 colibol en compagnie de l'ACP (si possible)
 - Visite de 3 à 4 utilisateurs des services.
 - Visite aux leaders Communautaires.
 - (POUR DONNER un appui technique à l'Agent de SANTÉ).

LISTE des points à contrôler pour planifier une visite de supervision

- 1- Voir le calendrier pour respecter la date prévue.
- 2- Revenir les notes de ^{service} rapport de visite et les rapports mensuels d'activités de l'AGENT DE SANTÉ pour considérer les problèmes qui ne sont pas encore résolus et pour apprécier la performance de l'AGENT DE SANTÉ par rapport aux objectifs fixés.
- 3- S'ASSURER DE LA LOGISTIQUE (Moyens de transport ^{et}
- 4- Revoir la liste des tâches de l'AGENT DE SANTÉ pour l'ELABORATION DU PLAN DE TRAVAIL AU moment de la supervision.
- 5- Considérer le calendrier de TRAVAIL du superviseur et son emploi de temps afin de le trouver sur les lieux de TRAVAIL.

INFORMATIONS NECESSAIRES
QUANTITATIVES

USAGE PREVU

SOURCES / Moyens / Methodes obt. de données

- 1- Données géographiques
 Superf : 281 km²
 Config : 1/5 plaine
 4/5 montagne
 Densité : 167 hab/km²
- 2- Données géographiques
 Pop. Totale : 46811 hab.
 Pop. 15-45 ans Femmes : 11609 h.
 Taux de natalité : 37‰
 Distribution de la pop. : $\left\{ \begin{array}{l} \text{maït.} \\ \text{maït.} \end{array} \right.$
- 3- RESSOURCES.
 - Physiques $\left\{ \begin{array}{l} \text{Centre de Santé} \\ \text{2 dispensaires} \end{array} \right.$
 - Matérielles $\left\{ \begin{array}{l} \text{Moyens de transport} \\ \text{TRAVAIL} \end{array} \right.$
 - HUMAINES $\left\{ \begin{array}{l} 1 \text{ Médecin} \\ 3 \text{ Auxiliaires} \\ 13 \text{ Agents de Santé} \\ 10 \text{ C.A.E.-COI} \\ 27 \text{ Matrones} \\ 2 \text{ A.C.P.} \end{array} \right.$
 - FINANCEMENT : NSSP / USAID
- 4- STATISTIQUES VITALES
 - Taux de NATALITÉ
 - Taux de mortalité infantile
 maternelle
 - Taux d'utilisation de centres

- Délimiter l'aire du projet
- Définir l'accessibilité
- Définir la population-cible.
- IDENTIFIER et QUANTIFIER les ressources disponibles
- POUR EVALUER les Besoins du MA
+ l'era de P.F

- SERVICE GEODESIQUE NATIONAL
- Institut Haïtien de STATISTIQUES
et d'INFORMATIQUE (IHSE)
Recensement '82 (Actualisé)
- STATISTIQUES du DISTRICT
SANITAIRE
- ORGANISME DE FINANCEMENT
- ENQUÊTE
- STATISTIQUES SANITAIRES.

INFORMATIONS NÉCESSAIRES	USAGE PRÉVU	Source / Moyen / Méthode d'obtention
<p>(suite)</p> <p><u>QUALITATIVES</u></p> <ul style="list-style-type: none"> - Taux d'ABANDON - DISTANCES (communications) - Socio-culturelles et économiques - Religieuses et croyances - Éducation / ALPHABÉTISATION - Organisation communautaire existant - Occupation (Revenu) - Attitudes ou - à - vis de la P.F. et des méthodes MODERNES. 	<p>Pour DÉFINIR l'ACCESSIBILITÉ</p> <p>IDENTIFIER les CONTRAINTES et les ASPECTS FAVORABLES</p> <p>↓</p> <p>Pour créer un climat favorable à l'acceptation des SERVICES</p> <p>→ Pour DÉTERMINER la qualité de vie des FAMILLES</p> <p>Pour définir une Approche acceptable</p>	<ul style="list-style-type: none"> - INTERVIEW - ENQUÊTE - Informants / clé - les ENQUÊTES réalisées - les GROUPES dirigés - OBSERVATIONS.

TANZANIAN - UGANDAN GROUP

PROJECT TITLE: INTEGRATED APPROACH IN

3 PRACTICE INCREASING FAMILY PLANNING ACCEPTANCE
IN ARUSHA REGION.

PARTICIPANTS:

- 1 - A. S. MUFUNJA R.M.C.H. ARUSHA TANZANIA
- 2 - T. MBIRU R.P.H.C. LOKODI TANZANIA
- 3 - OLE SITAYO M.H.S. PROJECT TANZANIA
- 4 - DR. ISRAEL KALYESEBULA
REGISTRAR DEPT. OF PAEDIATRIC
MAKERERE UNIVERSITY K'LA UGANDA
- 5 - PETER OPIO
AREA OFFICER F.P.A.U. UGANDA

(1)

I. PROJECT TITLE: INTEGRATED APPROACH IN INCREASING FAMILY PLANNING ACCEPTANCE IN ARUSHA REGION.

II PROBLEM IDENTIFIED :-

1. HIGH INFANT AND MATERNAL MORTALITY AND MORBIDITY RATES DUE TO PROBLEMS WHICH ARE LINKED TO SHORT BIRTH INTERVAL AND HIGH PARITY.
2. A POPULATION WHICH IS NOT WELL INFORMED OR AWARE OF :-
 - a. BASIC HUMAN REPRODUCTION FACTS OF LIFE
 - b. THE RELATIONSHIP BETWEEN SOCIAL WELL BEING AND REPRODUCTIVE BEHAVIOUR.
3. UNWANTED PREGNANCIES AS EVIDENCED BY CLANDESTINE ABORTION AND ABANDONMENT OF NEWBORNS.
4. HIGH POPULATION DENSITY WITH LESS PRODUCTIVE LAND.

III DURATION: FIVE YEARS (1986-1990).

IV LOCATION: ARUSHA REGION - TANZANIA.

V BRIEF DESCRIPTION OF ARUSHA REGION.

ARUSHA REGION IS FOUND IN THE NORTHERN HIGHLANDS OF TANZANIA MAINLAND. IT IS SURROUNDED BY THE REPUBLIC OF KENYA IN THE NORTH, SHINYANGA AND MARA REGIONS IN THE WEST, DODOMA AND SINGIDA REGIONS IN THE SOUTH AND KILIMANJARO AND TANSA REGIONS IN THE EAST.

IT COVERS 831,162 SQ KM WITH A POPULATION OF 1,167,700 (POPULATION PROJECTION 1984 BASED ON 1980 NATIONAL CENSUS) COMPRISING MAINLY OF PEASANTS FARMERS AND LIVESTOCK KEEPERS (HARDSMEN).

MAIZE (CORN) BEANS, BANANAS AND SWEET POTATOES ARE THE MAIN FOOD CROPS WHILE WHEAT AND COFFEE ARE THE MAJOR CASH CROPS. THE HARDSMEN TEND CATTLE SHEEP AND GOATS

ARUSHA IS FAMOUS FOR ITS ABUNDANT WILDLIFE FOUND IN NGORONGORO CRATER, LAKE MANGARA, ARUSHA NATIONAL PARK, TARANBIRE NATIONAL PARK AND SERENGETI NATIONAL PARK. Q3'

(2)

ARUSHA IS DIVIDED INTO SEVEN (7) DISTRICTS.
SEE TABLE I FOR DETAILS.

DISTRICT	DIVISIONS	WARD	VILLAGES	AREA IN SQ. KM	POPULA:
ARUSHA URBAN CENTRE	3	15	10	88.2	111,321
ARUMERU	6	28	133	2961.0	297,678
HANANG	4	28	111	8987.0	292,083
MONDULI	3	13	37	14201.0	87,017
MBULU	4	21	93	7652.0	244,705
KITETO	4	16	42	34196.15	75,503
NGORONORO	3	12	28	14036.0	59,392
TOTAL	27	133	454	82121.35	1,167,703

TABLE SHOWING ARUSHA DISTRICTS, POPULATION, AREA, DIVISION, WARDS AND VILLAGES.

WEATHER. IN THE HIGHLANDS THE WEATHER IS FAVOURABLE FOR BOTH FARMING AND LIVESTOCK KEEPING WHILE THE PLAINS ARE SUITED FOR LIVESTOCK THOUGH SOME FARMING IS DONE HERE TOO. FIVE DISTRICTS HAVE ALL WEATHER ROADS WHILE TWO CAN ONLY BE VISITED DURING THE DRY PART OF THE YEAR.

DISTRIBUTION OF HEALTH RESOURCES (FACILITIES)

DISTRICT	HOSP		DISP		UHC	MCH CLINIC	
	SVT.	VA	SVT	VA	RHC.	ST	MOBILE
ARUSHA	1	-	3	3	1	7	-
ARUMERU	-	1	15	8	3	27	1
HANANG	-	1	21	7	3	23	15
MONDULI	1	-	15	1	2	19	-
MBULU	2	2	16	4	2	24	3
KITETO	1	-	18	4	1	9	1 (VA)
NGORONORO	-	2	10	3	-	4	-
TOTAL	5	6	98	30	12	113	20

TABLE II SHOWING DISTRIBUTION OF HEALTH RESOURCE IN ARUSHA REGION.

VI. JUSTIFICATION/RATIONALE:

The percentage of females in reproductive age using contraceptive remain as low as 5%, although about 46% of them are estimated to be aware of Family Planning services. In analysing demographic data, Infant mortality rate and Maternal Mortality Rate, it is found these is very high and could possibly be linked with lack of Family Planning.

The Infant Mortality rate is 102 per 1000 live births. This is caused by infectious ~~from~~ preventable diseases eg. measles, polio, diphtheria, tetanus, whooping cough, tuberculosis. Susceptibility and chances of survival always depend on nutritional status of the infant. Malnourished children are more susceptible to the said infection and often die from them. Malnutrition commonly occurs in poorly spaced children. Infants and children from large family size where care and food is inadequate. It can therefore be seen that Family Planning has an important impact on I.M.R.

Maternal Mortality Rate is also high. Maternal deaths related to pregnancies and delivery is believed to be one of the major causes of death of women in reproductive age. The risk of death from pregnancy and delivery is linked with age, parity and the nutrition status of the woman. High risk women under 20 years and for two above 35; higher birth order and malnourished women eg. anaemic ones.

Maternal deaths caused by abortion because of unwanted pregnancy is very common. This is always under-reported. The Family Planning can be seen to have an important impact on M.M.R.

The Natural Population increase is as high as 3.2 and at this rate the population will double in 22 years. This means there will be population pressure on arable land. It also means that if the present ~~pop~~ low standard of living is to be maintained all resources should also double and social services eg. Schools, hospitals; etc.

It can therefore be seen that an integrated approach to increase Family Planning Acceptance and Practice will be an effective means of intervention to health problems related to M.C.H. and population at large.

We intend to integrate Family Planning into M.C.H. because of available personnel eg. Nurses / midwives, M.C.H. Aids and V.H.W who only need to be oriented to F.P. and provide it under Primary Health Care. In this way F.P. can be spread effectively throughout the region and country at large.

PROBLEM: → 1- HIGH IMR AND MMR.
 2- LACK OF I.E.C ABOUT FP.
 3- UNWANTED PREGNANCIES AND ABORTIONS 4- HIGH POPULATION DENSITY IN ARABLE LAND

DESIGN: A PROGRAM TO INCREASE FAMILY PLANNING ACCEPTANCE AND PRACTICE

OBJECTIVES	TARGETS	PROCESS INDICATOR	IMPACT INDICATORS
RAISE THE PERCENTAGE OF FAMILY PLANNING USERS FROM 5% TO 20% IN FIVE YEARS (1986-1990) BY INTEGRATING FAMILY PLANNING INTO EXISTING HEALTH SERVICE SYSTEM (M.C.H.)	1. PLANNING BY: a) ORDERING EQUIPMENTS INCLUDING TRAINING MATERIALS b) ACQUIRING AND MANAGING RESOURCES c) SCHEDULING OF ACTIVITIES 2. RE-ORIENT SENIOR HEALTH AND MEDICAL STAFF TO CONCEPTS OF FAMILY PLANNING SO THAT THEY ACT AS TRAINERS AND MOTIVATORS 3. DEVELOPE A SUITABLE CURRICULUM FOR TRAINING MCH AIDS AND V.H.W TO BE ABLE TO DELIVER F.P. SERVICES 4. SELECT 226 MCH AIDS FOR TRAINING IN BATCHES 5. TRAIN THE SELECTED MCH AIDS AND TRAIN THEM IN BATCHES OF 20	EFFECTIVENESS OF THE PROGRAMME NUMBER OF SENIOR HEALTH AND MEDICAL STAFF WHO ATTENDED THE WORK SHOP CURRICULUM DEVELOPED NUMBER OF MCH AIDS TRAINED ANNUALLY NUMBER OF MCH AIDS TRAINED AND THE EFFECTIVENESS OF THE TRAINING	ACCOMPLISHMENT OF OBJECTIVE ATTITUDE, SUPPORT AND PRACTICE OF FAMILY BY THE TRAINED STAFF ABILITY TO PERFORM TASKS AND ATTITUDES TOWARD FP. 1- INCREASE IN NUMBER OF HEALTH UNITS PROVIDING FP SERVICES 2- INCREASE IN FP USERS. - DO -

PROBLEM 77 - HIGH I.M.R. AND M.M.R.

2 - LACK OF I.E.C. ABOUT FP

3 - UNWANTED PREGNANCIES AND ABORTIONS

4 - HIGH POPULATION DENSITY IN ARABLE LAND

DESIGN: A PROGRAM TO INCREASE FAMILY PLANNING ACCEPTANCE AND PRACTICE

085.

OBJECTIVES	TARGETS STRATEGY	PROCESS INDICATORS	IMPACT INDICATORS
<p>EVERY HEALTH UNIT SHOULD BE ABLE TO PROVIDE FAMILY PLANNING SERVICES BY THE YEAR 1990.</p>	<p>1) APPOINT SEVEN FAMILY PLANNING COORDINATORS FOR SEVEN DISTRICT FROM THE TRAINED SENIOR STAFF.</p> <p>2 - PRIOR JOB DESCRIPTION FOR COORDINATOR DRAWN UP PRIOR TO APPOINTMENT</p> <p>3 - SEEK THE ASSISTANCE OF LOCAL F.P.A. FOR CONTRACEPTIVES/EQUIPMENT</p> <p>4 - SEEK THE ASSISTANCE OF IPPF AND OTHER AGENCIES FOR CONTRACEPTIVES & EQUIPMENTS</p> <p>5 - ORDER & PRODUCE APPROPRIATE SUPPLIES OF CONTRACEPTIVE AND EQUIPMENT</p>	<p>7 SUITABLE COORDINATORS SELECTED</p> <p>JOB DESCRIPTION MADE</p> <p>THE POSITIVE RESPONSE OF F.P.A.</p> <p>THE POSITIVE RESPONSE OF IPPF AND OTHER AGENCIES</p> <p>THE AVAILABILITY OF CONTRACEPTIVES IN HEALTH UNITS</p>	<p>EFFECTIVE F.P. PROGRAMME COORDINATED WITH OTHER HEALTH CARE SYSTEMS.</p> <p>- DO -</p> <p>THE AVAILABILITY OF FAMILY PLANNING SERVICES IN ALL HEALTH UNITS.</p>

PROBLEM: → 1- HIGH I.M.R. AND M.M.R.
 2- LACK OF I.E.C. ABOUT F.P.
 3- UNWANTED PREGNANCIES AND ABORTIONS 4- HIGH POPULATION DENSITY IN ARABLE LAND

DESIGN: A PROGRAM TO INCREASE FAMILY PLANNING ACCEPTANCE & PRACTICE

OBJECTIVES	TARGETS STRATEGY	PROCESS INDICATORS	IMPACT INDICATORS
TO REDUCE TEENAGE PREGNANCY DURING THE SAID PERIOD BY INTRODUCING FAMILY LIFE EDUCATION IN SCHOOLS & INSTITUTIONS AND YOUTH GROUPS AND WOMEN GROUPS.	<ol style="list-style-type: none"> 1. ORGANISE FAMILY PLANNING SEMINARS FOR TEACHING PROFESSIONALS AND YOUTH ORGANISERS 2. DEVELOPE FAMILY LIFE EDUCATION CURRICULUM TO BE USED IN SCHOOLS AND INSTITUTIONS. 3. INITIATE THE TRAINED TEACHING PROFESSIONALS TO INTRODUCE FAMILY LIFE EDUCATION IN SCHOOLS AND INSTITUTIONS 	<p>NUMBER OF TEACHING PROFESSIONALS WHO ATTENDED.</p> <p>DEVELOPED FAMILY LIFE EDUCATION CURRICULUM FOR USE IN SCHOOLS & INSTITUTIONS</p> <p>INTRODUCTION OF F.L.E. IN SCHOOLS & INSTITUTIONS</p>	<p>DATA ON TEENAGE PREGNANCY</p> <p>DATA ON TEENAGE PREGNANCY.</p>

SUPERVISION.

ARUSHA REGION HAS SEVEN DISTRICTS AND EACH DISTRICT IS DEVIDED INTO 20 TO 30 M.C.H AND POSTS.

PLAN: - TO VISIT EACH ONE OF THESE POSTS ONCE IN EVERY TWO MONTHS.
THE SUPERVISOR WILL BE THE MCH COORDINATOR OF THAT DISTRICT
VISITS ARE TO BE CARRIED OUT TWICE A WEEK - MONDAYS AND WEDNESDAYS.
ON EACH OF THESE VISITING DAYS TWO AND-POSTS WILL BE SUPERVISED/VISITED.

SUPERVISION SCHEDULE

DAY	1ST M	1ST W	- - - - -	4TH M	4TH W
AREA (AND POSTS)	1 & 2	3 & 4	- - - - -	11 & 12	13 & 14
DAY	5TH = 1ST M. OF M MONTH 2		- - - - -	8TH 4TH M OF MONTH 2	
AREA	15 + 16		- - - - -		

CHECKLIST OF PLANNING OF SUPERVISORY VISIT.

1. REVIEW THE OBJECTIVES OF THE PROGRAM OF THE AREA TO BE VISITED
2. REVIEW PREVIOUS REPORTS OF THE AREA:
 - a) SUPERVISOR'S PREVIOUS TRIP REPORT
 - b) PROGRESS REPORT OF THE FIELD WORKERS AND PREPARE A FEED BACK REPORT TO THE FIELD WORKER.
3. REVIEW THE JOB DISCRPTION OF THE FIELD WORKER
4. REVIEW SUPERVISION CHECK-LIST.
5. SUPPLIES - DRUGS AND/OR EQUIPMENT REQUESTED OR SITED IN THE PREVIOUS REPORT.
6. PREPARE NEW INFORMATION FOR THE FIELD WORKER TO BE VISITED E.G. NEW METHODS OF CONTRACEPTION COURSES/WORKSHOPS AND MEETINGS.
7. MAKE A LIST OF PROBLEMS AND NEEDS FROM REPORTS.
8. ARRANGE FOR TRANSPORT
9. A. NOTE-BOOK AND A PEN

SUPERVISION CHECK-LIST.

- A. RECORD KEEPING.
- a) REGISTER OF NEW ACCEPTORS
 - b) " " RE-VISITS
 - c) " " DROP-OUTS
 - d) RECORDS OF SIDE EFFECTS (OF EACH METHOD)
 - e) SCHEDULE OF WORK
 - f) RECORDS OF SUPERVISORY VISITS AND OTHERS
 - g) " " HOME VISITS MADE BY THE FIELD WORKER.
 - h) INVENTORY OF THE CONTRACEPTIVES
- B. OBSERVATION OF ACTIVITIES
1. COUNSELLING
 2. ABILITY TO IDENTIFY SUITABLE METHOD(S) FOR EACH CLIENT
 3. ISSUE OF CONTRACEPTIVES
 4. CARE OF THE EQUIPMENT AND STORAGE OF SUPPLIES
- C. MEETING WITH LOCAL LEADERS (OPINION LEADERS)
- ~~FOR UNDERSTAND~~
- TO SEE IF THEY UNDERSTAND AND/OR SUPPORT THE PROGRAM
 - TO GET ANY SUGGESTION FROM THEM TO IMPROVE THE PROGRAM.
- D. HIGHLIGHT ALL THE GOOD ACTIVITIES OBSERVED
TO BOOSTER THE FIELD WORKER'S MORALE
- E. POINT OUT NEED FOR IMPROVEMENT AND HELP TO GO ABOUT IT.
- F. GIVE THE FIELD WORKER AN APPOINTMENT FOR THE NEXT VISIT

INFORMATION SYSTEM - MONITORING.

INFORMATION NEEDED FOR :-

- A. VILLAGE HEALTH WORKER (S)
1. POPULATION OF THE TARGET GROUP
 2. GEOGRAPHICAL DEMARCATION OF THE AREA HE/SHE IS RESPONSIBLE FOR
 3. FAMILY PLANNING USERS - BY METHODS
 4. HOW MANY PERSONS HAVE DISCONTINUED (DISCONTINUER RATE) FAMILY PLANNING SERVICES DUE TO SIDE EFFECTS.
 5. WORK SCHEDULE IN HIS/HER AREA. (OWN + SUPERVISOR'S)

6. COMMUNITY AWARENESS OF FAMILY PLANNING SERVICES AND METHODS AVAILABLE
 7. ATTITUDES OF THE COMMUNITY ~~FORWARD~~ TOWARDS F.P.

B. SUPERVISOR (S).

ALL OF THE ABOVE +

1. WHERE TO REFER DIFFICULT CASES
2. THE AVAILABLE SUPPLIES:
 - A) HOW MUCH
 - B) WHAT IS AVAILABLE

C. MANAGER(S)

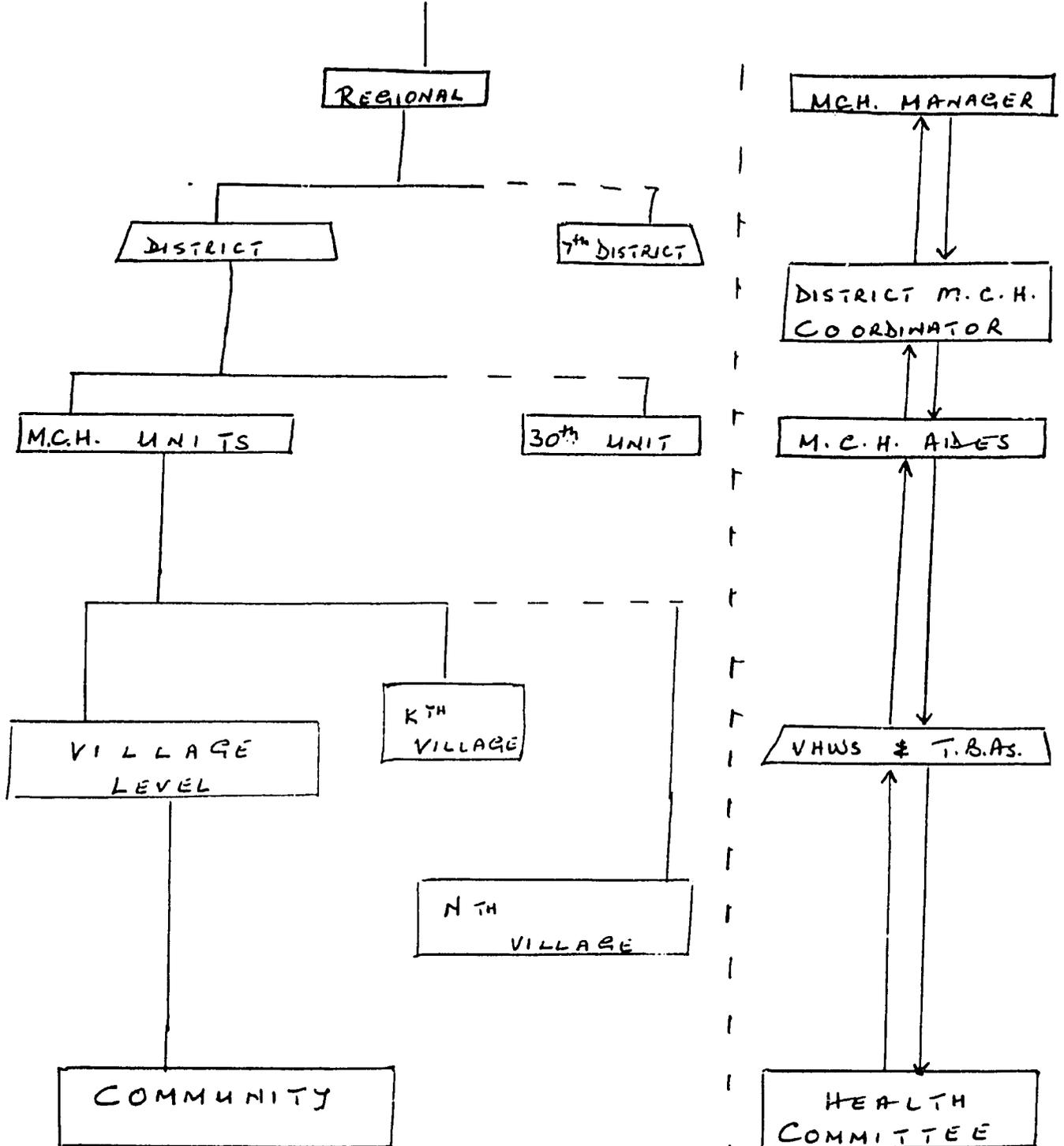
ALL OF THE ABOVE +

THE MEANS OF ACQUIRING MORE SUPPLIES

1	INFORMATION NEEDED	DATA SOURCE	POINT OF COLLECTION	FREQUENCY OF COLLECTION	ANALYSIS	DIRECTION OF INFORMATION
1.	POPULATION (TARGET)	SURVEY (YRLY SENSUS)	VILLAGE TO BE OBSERVED	ANNUALLY	DETERMINE THE BASE POPULATION	VERTICAL
2.	GEOGRAPHICAL DEMARICATION OF THE AREA TO BE SERVED	VILLAGE GOVT	"	ONCE	TO FACILITATE SUPERVISION	"
3.	FP USERS BY METHODS	RECORD FROM MCHAS	MCH UNITS	MONTHLY	ASSESS PROGRESS OF THE PROGRAM AND WHICH METHODS ARE POPULAR	"
4.	DISCONTINUERATE	"	"	"	REASONS FOR DISCONTINUE	"
5.	WORK SCHEDULE (VHW, SUPERVISOR MANAGER)	VHW, SUPERVISOR MANAGER	VHW, MCHAS DMCH RECORDS	"	FOR EASY COORDINATION OF THE PROGRAM	"
6.	COMMUNITY AWARENESS OF FP. SURVICES AND METHODS AVAILABLE	VILLAGE SURVEY FOCUS GROUP	VILLAGE	ANNUALLY	MEASURE EFFECTIVENESS OF INFORMATION EDUCATION & COMMUNICATION	"

	INFORMATION NEEDED	DATA SOURCES	POINT OF COLLECTION	FREQUENCY OF COLLECTION	ANALYSIS	DIRECTION OF INFORMATION F
6.	AFFITUDE OF THE COMMUNITY TOWARDS FP	VILLAGE SURVEY FOCUS GROUP	VILLAGE	ANNUALLY	DISCOVER CONSTRAINTS	VERTICAL
7	WHERE TO REFER DIFFICULT or COMPLICATED CASES	DISTRICT/REGIONAL HOSPITAL	DISTRICT/ REGIONAL HOSP.	ONCE	TO IDENTIFY APPROPRIATE REFERRAL	"
8	AVAILABLE SUPPLIES	MCH AND INVENTORY/DMCH RECORDS	MCH AND INVENTORY/ DMCH RECORDS	MONTHLY	ENSURE ADEQUATE AND CONTINUOUS SUPPLIES	"
9	THE MEANS OF ACQUIRING MORE SUPPLIES	CONTRACEPTIVE INVENTORY	MCH CLINIC AND DMCH OFFICE	"	"	"

ORGANOGRAM.

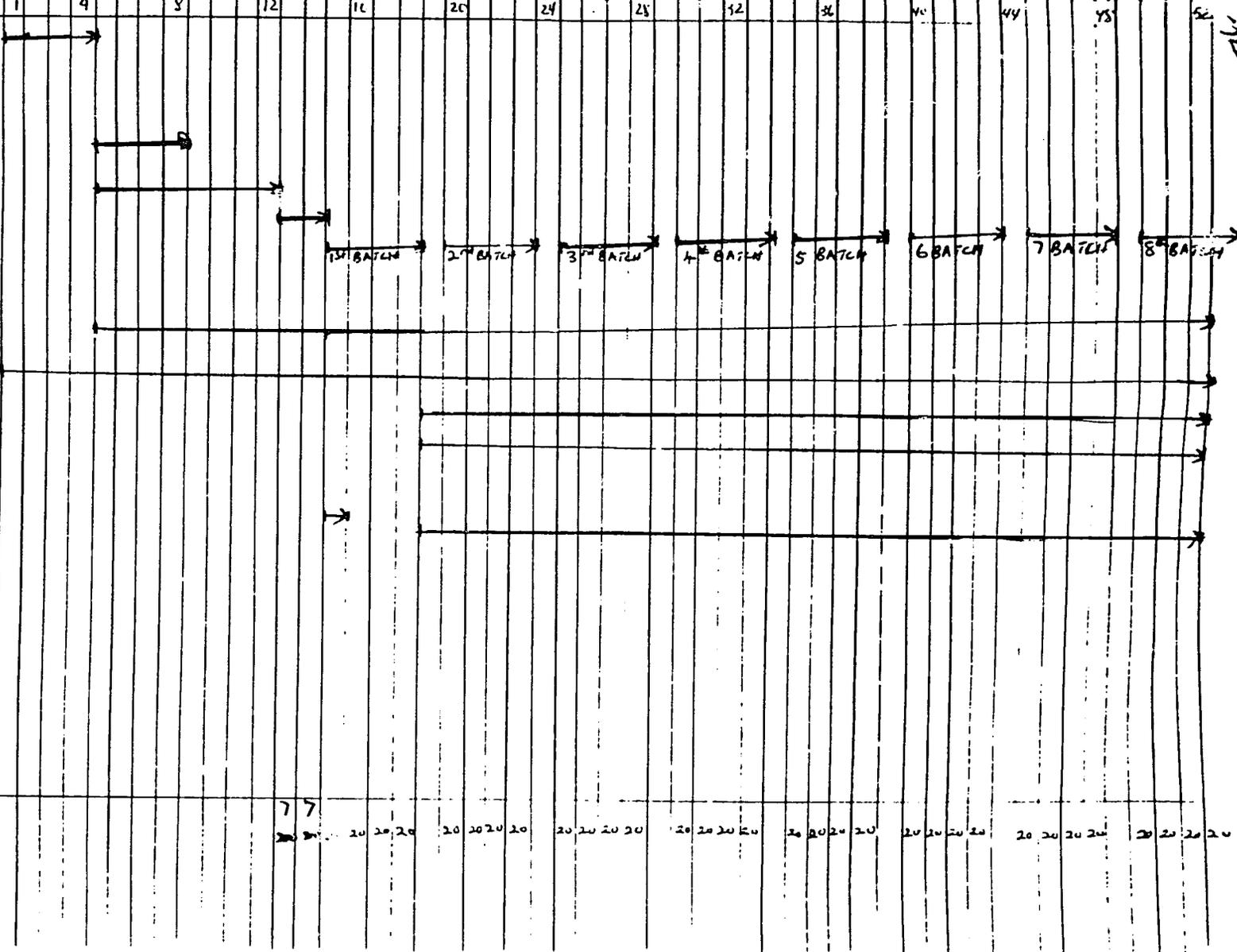


12 GANTT CHART

Enter ->
Schedule week

1986 JAN 4 FEB 8 MARCH 12 APRIL 16 MAY 20 JUNE 24 JULY 28 AUGUST 31 SEP 4 OCT 8 NOV 12 DEC 16 JAN 1987 20

- 1- SURVEYS
 a) To collect information on health problems to help in planning
 b) Local resources available
- 2- PLANNING
- 3- MATERIAL SUPPORT & LOGISTICS
- 4- TRAINING OF TRAINERS
- 5- TRAINING OF MCH AIDS IN BATCHES OF 20
- 6- INFORMATION, EDUCATION AND COMMUNICATIONS
- 7- COMMUNITY PARTICIPATION
- 8- SERVICE DELIVERY
- 9- SUPERVISION
- 10- EVALUATION
 a) TRAINING OF TRAINERS
 b) PROGRAMME



Personnel: PUBLIC HEALTH NURSE/MIDWIVES 7
 MCH AIDS 226
 V.H.W 1,008

12/10

1) TITLE OF PROGRAMME.

A Training Manual for
Primary Health Care and Rural Hospital Manage
Course.

2) JUSTIFICATION

2) DESCRIPTION OF SERVICE AREA:

- Sudan largest Country in Africa.
- With population of about 22 million.
- Of whom about 71% live in Rural areas.
- And the epidemiologic and ~~demographic~~ demographic profile is like in other developing countries?
 - 45% of pop is under 15 yrs of age.
 - With a high infant and maternal mortality rate especially in rural areas.
- Health services are mainly curative oriented and urban inclined.
- Primary Health Care services do not reach the majority of rural population due to a number of factors including
 - poor transportation & inadequate resources.
 - ~~poor working conditions~~
 - ~~lack of appropriate training and knowledge of technical staff~~

3) PROBLEM IDENTIFICATION.

(a) Health problems include

- High prevalence of infectious diseases of childhood and Malnutrition.
- Lack of proper maternal services.
- Lack of family planning education, information and services.
- Poor environmental sanitation and hygiene.
- Malfunctioning and poor utilization of the existing rural health ~~services~~ facilities.
- Lack of ~~appropriate~~ training and ~~shortage~~ orientation of medical officers ~~in~~ and primary other health workers in primary health care service delivery and management.
- Deficient involvement of the rural hospitals in managing primary health care units.

4

(b) Priority Needs Analysis of needs assessment already carried out indicate that the most of the health problems indicated above hinge around lack of training of medical officers ~~responsible~~ running rural hospitals in primary health care and hospital management - hence a need for the proposed training program

OBJECTIVES:

The training manual developed is intended for use as a guide for the management sequence of a three weeks course in which management and primary health care training is integrated. This includes seven units of training, and ~~for~~ each unit provides guidelines pertaining to:-

- (i) Objectives.
- (ii) Content area.
- (iii) ~~Methods~~ Teaching Methodology
- (iv) Suggested evaluation methodology.
- (v) Reference material.

The training objectives concerning management for this program are that by the end of the management sequence, participants should be able to:

- (1) Conduct a community based needs and resources assessment using quantitative and qualitative data and information gathering methods.
- (2) Write a short term (12 months) plan which includes problem prioritization, identification of effective strategies and interventions, objectives and indicators for monitoring-evaluation.

- ③ Write a short term (12 months) program implementation plan which takes into account service delivery, community participation, Health Education, Training, Supervision, Records & Information System, Logistics & administration.
- ④ Plan & conduct supervision visits using principles of supervision by objectives and support of personnel.
- ⑤ Plan for participation in training of personnel in the rural hospital area and describe effective approaches to training.
- ⑥ Conduct a management audit of a rural hospital setting for its in planning, supervision and training.

12

EXAMPLE OF ONE UNIT DEVELOPMENT

UNIT 2 PROBLEM DEFINITION & OBJECTIVE SETTING, ~~PROBLEM DEFINITION~~

OBJECTIVES: At the end of the unit participants should be able

- 1) Distinguish between problems and causes.
- 2) List at least five factors to consider in prioritizing problems.
- 3) Explain the importance of setting objectives
- 4) List characteristics of a good objective.
- 5) Write program objectives
 - 6) Write process and impact indicators for given objectives and targets.
 - 7) Develop strategies for given objectives.

CONTENT AREAS.

- 1) Linkage between ~~Assessment~~ needs and Resource assessment findings, and problem identification.
- 2) Causes and problems - relationship and distinction.
3. Problem definition.
- 4) Objective and target setting.
- 5) Importance of incorporating evaluation component right from the beginning - Process and impact indicators.

Reference: ~~Development of a~~ ~~social management~~
" ~~Management~~ "

SUGGESTED TEACHING METHODS

1. Through lecture and discussion and with reference to the management model ~~part~~ participants ~~then~~ be assisted to learn that:
 - (i) Programmes are developed to respond to ~~human~~ detected human problems.
 - (ii) Because problems are numerous, there is need to select those problems ~~to~~ that fall within our mandate as workers of ^{our} given organizations.
 - (iii) The problems detected should be prioritized so as to identify those which need the most urgent response given the limited resources at our disposal.
 - (iv) No (iii), above necessitates ~~also~~ the setting of clear, realistic and achievable objectives and strategies for achieving the
 - (v) Evaluation starts right from the beginning of programme development.

2. Participants in groups or individually decide on a problem from their respective areas of work and:
 - define it
 - set objectives and targets for it
 - ~~then~~ state the process and impact indicators to be used in measuring the operational targets and terminal objective set.

3. Groups present their work to the whole class for exchange of experience and critique.

4. Facilitator highlights and emphasizes key ^{issues} from presentations ^{clarification} identifying certain points that need ^{clarification}.

EVALUATION OF THE UNIT.

This is to be done mainly through

- (i) Question and answer in class.
- (ii) Assessment of quality of group work presentations
- (iii) Performance on items relating to this unit in the post test compared with performance on pretest.
- (iv) rapid feed back questionnaire at the end of the unit -

4. REFERENCE MATERIALS

Relevant sections from the book 'On Being in charge

PLAN OF ACTION.

- (a) (i) Training of Medical officers who run rural hospitals has been chosen as an intervention for solving the majority of the health problems detected through the analysis of the conducted needs and resources.
- (ii) The proposed training manual is intended to facilitate the conduct of the training referred to above.
- (b) (i) The course is intended to train 25 medical officers drawn from different parts of the country.
- (ii) The training team consisting of 7 members will be required.
- (iii) A number of 6 people will be required to provide logistic and other support services during the preparation and actual running of the course.
- (c) There will be a need for the training team to meet and agree on strategies of conducting the course in line with the training manual.
- (d) (i) A total of \$30,000 will be needed to meet the various expenses of the course.
- (ii) 4 ~~cars~~ cars will be ~~not~~ required to provide transport services during preparation and running of the course.
- (iii) Books, teaching material & stationery in appropriate quantities will be provided.

(e) (i) The Course will take place in the premises of University of Georgia.

(ii) Field training activities will be arranged in appropriate villages and rural hospitals.

(iii) Participants will be accommodated in the students' ~~to~~ halls of residence.

(f) This course will be conducted twice a year. Each time preparation for the course takes place 3 months in advance (see CANTT CHART.)

EVALUATION.

A For the Manual

- (i) Manual developed to be submitted to experts with experience in similar training programme for review and comments.
- (ii) Comments ~~of~~ on the manual by resource people invited from outside.

B ~~(i)~~ For the Course

- (i) Participants gain in knowledge by use of pre and post tests.
- (ii) Quality of practical exercises done and presented during and ~~after~~ at the end of the course.
- (iii) Quality of interviews conducted by participants in the field.
- (iv) Participants and of the course evaluation.
- (v) Supervisory visits twice a year after the course by training team to monitor the impact of the training by checking on:
- Existence of plan drawn by medical officer incorporating P.I.C.
 - whether medical officers have organized and conducted ~~training~~ training programme for health workers.
 - whether hospital management has been improved.

DA SILVA, DRAME, DANIZO, CASSIS.

PROGRAMME DE REHYDRATION ORALE POUR LA REG PLATEAU EN TICITIE

I. SITUATION POLITICO-SOCIO-ECONOMIQUE en gros

II. SITUATION des Services de SANTÉ

a) structures

- 1 hôpital régional
- 8 districts
- 43 centres de santé

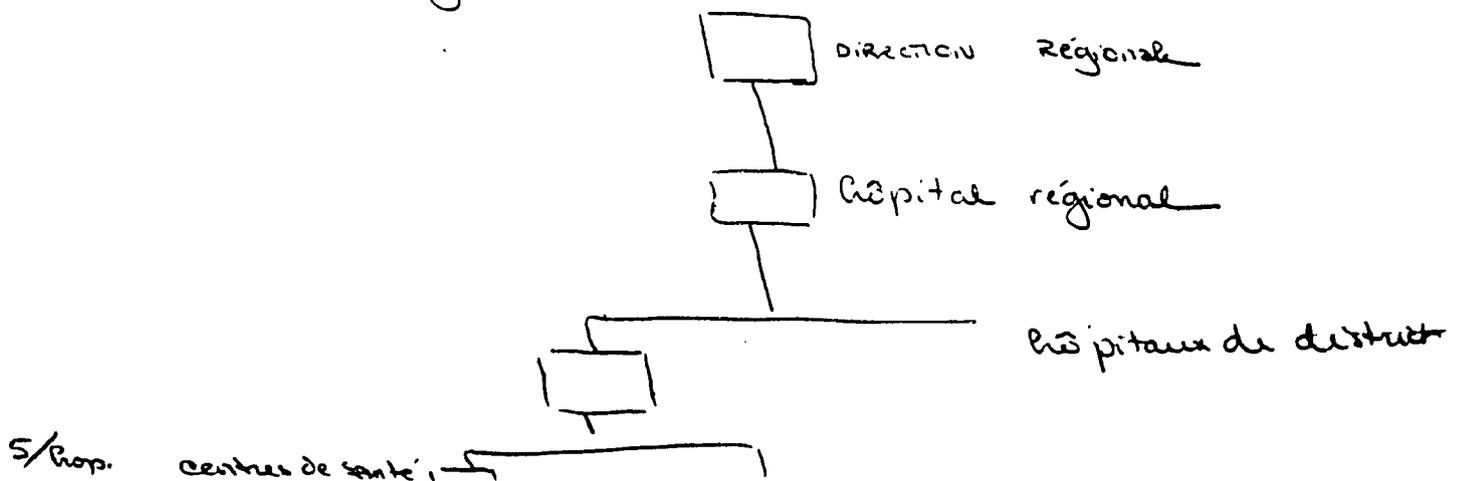
b) accès géographique

40% de la pop. à 5 km d'une structure.

c) personnel

	nombre	ratio
médecin	80	1/500,000
infirmière	500	1/8,000
auxiliaire	2200	1/1820
agents	276	1/4,490

d) organisation des services de santé



III. Problèmes prioritaires
diarrhée infantile

inaccessibilité aux soins médicaux
dans les régions villageuses

III. Solutions

3.1. Objectifs du programme

- A) réduire le pourcentage des ^{des enfants de} ~~de~~ ^{0-5 ans} ~~de~~ mortalité due à la diarrhée de 34% à 17% entre 1985 et 1988 dans la région de plateau
- B) augmenter la proportion de la population villageoise couverte par un travailleur communautaire de 1/4,490 à 1/2050 entre 1985 et 1988

3.1.2 : STRATÉGIES

- A) 1. formation des agents de santé dans la méthode de réhydratation orale et communication de cette méthode aux mères villageoises
2. supervision régulière des agents de santé dans leur travail communautaire
3. supervision régulière au niveau du centre de santé
4. sensibilisation du personnel médical pour l'utilisation de la réhydratation

pour le traitement de la diarrhée

- B) 1. former 276 nouveaux agents comm
2. recyclage de 1400 auxiliaires pour les orienter vers le travail communautaire
3. recyclage de 2 médecins par hôpital et de ~~54 infirmières~~ pour le travail communautaire, ~~la~~ et la supervision des infirmières ~~pour dans le~~ au centre de santé et dans la communauté
4. recyclage de 54 infirmières pour la formation et la supervision des agents de santé et des auxiliaires

3.2 Ressources:

IV Exécution :

Calendrier des activités (voir GRANT)

Supervision

- par l'infirmière-supérieure { mensuelle des nouveaux agents de santé pendant 3 mois
chaque 2 mois pour auxiliaires et agents de santé anciens
- par le médecin { chaque mois pour centre de santé.
chaque 2 mois pour l'infirmière de supervision

VI Evaluation -

nombre d'agents et d'auxiliaires formés ou recyclés

nombre de rapports mensuels remplis régulièrement

nombre de cas de diarrhée

nombre de décès à cause de diarrhée

nombre de décès pour les enfants à l'âge de 0-4 ans

COUNTRY : — KENYA

PARTICIPANTS:

DR MOHAMED H. MOHAMMED.

SULLAH A. NAKHISA. — K R C N

MARGARET M. MWITI — K R C N

Introduction

Kenya is situated in East Africa. It lies along the equator. It is an agricultural country growing & export mainly tea and coffee.

The capital city is Nairobi, with a population of about 1 million people. According to 1979 census, the population was 17 million, and the 1985 projected population is approximately 19 million. Kenya's birth rate is 4.1% and the population is expected to double within 18 years. 15% of the total population are women of child-bearing age. Infant mortality rate is about 87%.

The country's health services are provided by the government, church hospitals, private hospitals, private practitioners & traditional healers.

1. The project we are presenting is under the management of the Protestant Churches Medical Association. The organization runs 17 hospitals, 14 health centres & 60 dispensaries. These facilities are distributed all over the republic serving the rural community. The project is going to be implemented in 10 hospitals only. The average population in the 10 hospitals is about 50 to 100 thousand. In order to run the services the Government gives a grant of about 15% of the total budget. The rest of the funds are donations, both local and international, and patients pay minimal fee for the services.

2 Major problems, according to 1970 survey carried by the Kenya Government and WHO identified the following major problems:

- 1) Excessive population growth rate and associated health problems from large families and close

- spacing of births.
- 2) Malnutrition
 - 3) Environmental sanitation problems.
 - 4) High mortality rate due to preventable diseases especially among the under fives, whose immunization rate is not high.
 - 5) High maternal mortality and morbidity due to poor ante-natal care and close ^{birth} spacing.

Because of the limited resources and unique organizational capability we possess, our area of priority is improvement of family planning services since we are the only organization providing family planning services in these areas. These will contribute directly to the three of the five listed problems i.e.

- 1) Population and family excessive growth rate
- 2) Malnutrition
- 3) High maternal mortality and morbidity

4. To increase number of acceptors by 50% within one year in 10 of the selected areas served by 10 PCM hospitals.

Strategies for meeting this objective

- 1) To improve existing services
 - a) Training nurses in FP
 - b) Integrating services
- 2) Community participation
- 3) Intensifying IEC on MCH/FP

5. Plan of Action:

In the program design and elaboration of plan of action we prepare a schedule covering the following items

I Planning.

- General innovation meetings with hospital staff
- Meeting with Community members.
- Job description for V.H.W.
- Draw Training programs.
- Draw supervisory schedule.

2. Training

- Select nurses for Clinical F P
- Develop training material
- Training of trainers
- Training of V H C
- Training of V H W
- Attend Evaluation seminar
- Attend A V S seminar

3. Community Participation

- Formation of V H Committees
- Select V H W
- C. B. D activities

4. I. L. C.

- Home visits by V H W
- I. L. C. on MCH/FP and other PHC activities through families and community organized.

5. Supervision

- Preparation for check lists
- Information system + monitoring.
- Data collection + report writing and feed

6. Material Support + Logistics

- Equipment stationary + supplies

7. Evaluation

On-going by the implementers and yearly by the donors.

Included detailed planning for training, and personnel including job descriptions, and for our indicators we shall use the following :-

INDICATORSObjectives

To increase the number of new acceptors by 50% within one year after implementation in the 10 of the PHMA hospitals.

Sub-objectives

1. Improve existing services
 - a) Training nurses in IP
 - b) Integration of services
2. Community participation
 - Job description for CHW
 - Selection of CHW
3. Training
 - Train the trainers
 - Train V.H.W.
4. Intensify IEC on MCH/IP

Process

Draw training schedule
staff meetings

V.H.C. formation

prepare job descriptions

V.H.W. select and interview

select trainers from the hospital

and community

Draw training schedule

Draw training schedules

Draw schedule on IEC activities

Impact

5400 new acceptors in the first year of full operation

Trained 30 nurses in IP
All services integrated

10 V.H.C. committees formed and monthly meetings held
completed job descriptions

2 V.H.W. per village selected

Trainers selected
40 trainers trained

100 V.H.W. trained working

12 educational meetings held
and 12 film-shows conducted

PROJET DE FORTIFICATION EN GESTION D'UN PROGRAMME DE SANTE FAMILIALE

I. DESCRIPTION DE LA VILLE DE NIAMEY

1) CADRE PHYSIQUE

Niamey, capitale du Niger, est située au sud-ouest du pays. Elle s'étend d'est en ouest sur 25 km et du Nord au Sud sur 15 km. Elle est divisée en 5 districts totalisant 50 quartiers. Le climat est de type soudanien.

2) POPULATION

Niamey compte 400 000 habitants soit environ 7% de la population totale estimée à 6 000 000 d'habitants.

Quelques statistiques

- Taux de mortalité : 51 ‰
- Taux de mortalité infantile : 15 ‰
- Taux de mortalité maternelle : 1 ‰
- Taux de fertilité : 1 ‰
- Taux d'accroissement naturel : 1,8 ‰
- Nombre de femme en Age de féconder : 30 000
- Enfants de moins de 5 ans : 11 ‰
- Taux de scolarité : 34 ‰

3) ORGANISATION COMMUNAUTAIRE

Les structures d'organisations communautaires sont représentées par :

- AFN = Association des Femmes du Niger
- Samaria = Association des Jeunes
- AIN = Association Islamique du Niger.

Chaque quartier comprend : - un bureau d'AFN
- un bureau de Samaria
- un bureau d'AIN

La religion dominante est l'Islam

4) MOYENS D'INFORMATION

T.V., Presse écrite, Radio

5) RESSOURCES SANITAIRES

Niamey est dotée d'un hôpital national et d'un CHU
- 3 maternités
- 10 centres sociaux et de PMI

- 15 Dispensaires
- 2 cliniques privées
- 1 CHSF

Personnel sanitaire directement concerné par la SMI

- 5 gynéco. obstétriciens (MATERNITE' / CHSF)
- 11 Médecins généralistes (SNI)
- 80 Sage-femmes
- 10 Assistants Sociaux
- 40 Aides Sociales
- 123 Infirmières diplômées et certifiées

II- PROBLEMES SANITAIRES

La santé maternelle et infantile est prioritaire au Niger. Les problèmes sont les suivants:

2-1. Mortalité et morbidité infantile élevées

Les causes les plus communes sont:

- La diarrhée
- le baludisme
- les infections des voies respiratoires
- la malnutrition
- la rougeole

2-2. Mortalité et morbidité maternelle élevées

Les causes les plus fréquentes sont

- grande multiparité et grossesses rapprochées
- Héorragies
- dystociés
- Infections.

III- SÉLECTION DES PRIORITÉS

3-1. Devant ce profil épidémiologique, il est évident que l'espacement des Naissances pourrait avoir un impact indirect sur ces problèmes

3-2 - La stratégie des SSP incluent la lutte contre les maladies diarrhéiques, le PÉV, la lutte contre la malnutrition... Ces programmes sont actuellement en cours au NIGER. La politique Nationale est d'introduire l'espacement des Naissances en vue de renforcer ces programmes.

IV - OBJECTIFS DU PROGRAMME de SMI/PF.

- Intégrer les activités d'espacement des naissances dans toutes les Ini et Maternités de Niamey d'ici 1987.
- Assurer la formation et le perfectionnement d'au moins 20% du personnel cadre et Auxiliaire toutes catégories et des ASV en SMI/PF d'ici 1987.
- Sensibiliser, éduquer au moins 50% des familles de Niamey sur les avantages socio-sanitaires de l'espacement des Naissances d'ici 1987.

V - PLAN D'ACTION du Programme de SMI/PF

Stratégies :

- 1 - Formation du personnel sanitaire
- 2 - Information et éducation des familles et de la communauté
- 3 - Gestion des services de SMI/PF.
- 4 - Supervision du personnel
- 5 - Recherche opérationnelle.

Dans le cadre de notre travail actuel, nous avons choisi de nous pencher sur la formation du personnel sanitaire et plus particulièrement sur le séminaire at de Niamey du 19 au 30 Août 1985.

①

Justifications et but de la formation

Ce séminaire-atelier se situe dans le cadre d'un projet bilatéral ^{entre les} Gouvernement du Niger et le FNUAP pour la santé familiale.

En effet, très peu de cadres socio-sanitaires de Niamey ont bénéficié d'une formation en gestion de programme de santé familiale et en méthodes d'espacement des naissances.

Ce séminaire-atelier s'adresse à 26 participants Médecins, sage-femme et Assistantes Sociales.

2) MATRICE DES AIRES de Responsabilite' pour le Personnel socio-SANITAIRE

TA CHES	Medecin	Sage-femme	A. Soc
1. Motiver, eduquer, informer les groupes cibles en matiere de sante' familiale	-	+	X
2. Donner des services en sante' familiale			
2.1. Accueillir, interroger, orienter les patientes	-	X	X
2.2. Etablir la fiche de sante' familiale		X	+
2.3. Faire l'examen general	X	X	-
2.4. Expliquer et fournir condoms et spermicides	+	X	X
2.5. Prescrire et expliquer l'utilisation des contraceptifs oraux	X	X	+
2.6. Identifier les indications et contre indications du Diu par l'interrogatoire et referer		X	+
2.7. Prescrire et administrer les contraceptifs injectables	X	X	
3. Gerer et administrer les services	X	X	X
4. Superviser le personnel et les services	X	X	X
5. Participer a l'evaluation et a la Recherche operationnelle	X	X	X
6. Former d'autres personnels	X	X	X
6.1. Assurer l'encadrement des stagiaires	X	X	X
6.2. Participer a la formation et au recyclage du personnel sanitaire	X	X	X

X = RESPONSABLE + ACTIVITE OCCASION
- PAS RESPONSABLE DIRECTEMENT

3) OBJECTIFS EDUCATIONNELS

A la fin de la formation les participants doivent etre capables de:
- 1) Decrire le programme de sante' familiale en cou d'execution.

- 2) Etablir la corrélation entre l'espacement des naissances et les autres activités prioritaires de SR (Nutrition, lutte contre les maladies diarrhéiques, vaccinations)
- 3) Organiser des séances d'I.E.C en santé familiale à tous les niveaux.
- 4) Organiser une consultation en santé familiale
- 5) Conseiller et prescrire des méthodes contraceptives modernes et en assurer le suivi
- 6) Tenir à jour les fiches d'inventaire du matériel, équipement et médicaments.
- 7) Assurer la supervision des activités en santé familiale suivant une liste pré-établie.
- 8) Participer à la formation et à la Recherche opérationnelle.

4) CONTENU DE LA FORMATION

- A - Information - Education - Communication
- B - Méthodes de planification familiale ou d'espacement des naissances
- C - Gestion et administration des services de santé familiale
- D - Formation du personnel socio-sanitaire

5) RESSOURCES

- Lieu de formation : CNSF. Niamey
- 1. Ressources humaines :
 - Encadrement : 6 participants au séminaire de CPFH (COLUMBIA UNIVERSITY)
 - Assistance technique : COLUMBIA UNIVERSITY
 - UNICEF.
 - CNS
- 2. Matériel
 - didactique : publications, audio-visuel de démonstration
 - secrétariat ;
 - Logistique et transport = véhicule. Carburant
- 3. FINANCES = budget total évalué à \$ 30.000

⑥ PLAN de mise en Œuvre

- Le séminaire est programmé pour Août 1985.
- Un Emploi du temps provisoire a été élaboré.
- Un GANTT, présenté précédemment, décrit les activités à réaliser avant, pendant et après le séminaire.

VI - INDICATEURS

6-1. Au cours de la Formation

- Pré-test et POST-TEST
- Présentation des travaux de groupe
- Exposés des participants

6-2. Critères de Supervision - Evaluation

Les participants au séminaire vont être suivis mensuellement un mois après leur formation pendant un trimestre et par la suite tous les 3 mois.

Les données suivantes vont être collectées:

- Nombre de séances d'IEC / Nombre de séances planifiées
- Nombre de participantes aux séances d'IEC^{IF} / Nombre de CONSULTANTES en IF
- Nombre de séances d'IEC en IF / Nombre total de séances d'IEC réalisées

L'observation va déterminer:

- Facilité d'échange avec les consultantes
- Qualité de l'accueil
- Déroulement de l'examen clinique

Les services en IF vont être contrôlés

- Nombre de nouvelles consultantes (par type de méthode)
- Nombre d'anciennes consultantes
- Nombre de références effectuées vers les autres consultations.

La Gestion des services va être évaluée:

- TENUE des Fiches d'Inventaire
- Etat du matériel technique
- Conditions de stockage des produits.

6.3. INDICATEURS d'IMPACT

- Enquête et mini-enquête sur la prévalence d'utilisation des méthodes d'espacement des Naissances
- Taux d'utilisation des services de I.F.

Project on ~~Malnutrition~~ Community
BASE Nutrition To REDUCE THE PREVALENCE
OF MALNUTRITION ^{in the under 5's.} IN A Rural
Area in SIERRA LEONE

VICTOR & Sylvetta

INTRODUCTION

SIERRA Leone is situated on the west coast of Africa. It has an area of about 28,000 sq miles. It is bounded on the north west and north east by the Republic of Guinea, on the south east by Liberia and on the south west by the Atlantic Ocean.

The country is divided into four administrative regions, the Northern, the Eastern and the Western area. Freetown is the capital city.

The climate is tropical with two distinct seasons. The dry season from November to April and a rainy season from May to October.

The population of Sierra Leone is estimated as 3.1 million and about 80% are rural. The population density is about 100 per square mile with an annual growth rate of about 2.6% (The population will double itself in about 24 years).

The majority of the working population are engaged in subsistence farming with some additional cash crops for vital expenses. The main cash crops are coffee, cocoa, oil palm and ginger.

Mineral exports are diamonds, bauxite, rutile, iron ore and gold. They yield the greatest revenue and they have accounted for more than 70% of the country's total foreign exchange earnings.

There are road networks linking all the major towns but during the rainy seasons some of these roads are not motorable thus cutting off vital supplies by vehicular traffic. People will have to go on foot.

Demographic data

According to the 1974 census the age distribution is as follows.

- 16.1% of the population is under 5 years.
- 40% are children under 15 years.
- 24% of the population are women of childbearing age (15-49 years)

From the above figures about 65% of the population are women of childbearing age and children under 15 years.

Vital Statistics

Crude Birth rate	47 per 1000 population
Crude Death rate	23 per 1000 population
Infant mortality rate.	130-180 per 1000 live births
Maternal mortality rate	4.5 per 1000 deliveries
Life expectancy at birth	47 years for males 49 years for females

HEALTH FACILITIES.

HEALTH and medical services are provided mainly by the government. Mission groups, mining companies and private organizations also provide some service.

The services are delivered in hospitals, nursing homes, health centers, dispensaries, treatment centres and by mobile clinics which visit selected villages at regular intervals. These services are unevenly distributed they are also understaffed and not well supplied.

Major Health problems.

Because of the high birth rate and the low life expectancy at birth, the people affected most by sickness and premature death are children and women of childbearing age.

The causes of the vast majority of these deaths are

Malaria, malnutrition, infectious diseases, measles, diarrheal disease, neonatal tetanus etc), anaemia, low birth weight, Ante-partum and Post partum haemorrhage, sepsis (Puerperal), Toxaemia of pregnancy.

Selection of Priority Health Problems

Because of the magnitude of the health problems and of limited resources both financially and health manpower, a system will be developed based on the following criteria

4

- (i) Prevalence of the health problem
- (ii) Mortality of the problem if not treated.
- (iii) Morbidity (functional disability)
- (iv) Feasibility of control.

For this project we have identified malnutrition as one of our major health problems. A ^{nutritional} survey carried out in Sierra Leone shows that malnutrition is a problem in 30% of young children. Some of these problems are undoubtedly caused by inadequacy of the quality and or quantity of the children's diet, ignorance and cultural food taboos.

5

Objectives

- (I) To REDUCE THE PREVALANCE OF Protein ENERGETIC MALNUTRITION by 25% in children under 5 years in the project area in 2 years.
- (II) To INCREASE by at least 20% the number of families in the project area growing suitable foods (vegetables, legumes etc) for weaning products in their back yard garden at the end of 2 years.
- (III) To Increase by ~~at least~~ 20% the number of families in the project area with children under ~~five~~^{two} years old who provide at least 4 BALANCED supplementary feeding daily to these children, at the end of 2 years.
- (IV) To Increase by 20% the number of families starting to give ^{balance} supplementary feeding at age 4-6 months in the project area at the end of 2 years.

5 PLAN OF ACTION

a) INTERVENTIONS AND STRATEGIES

- i) Growth monitoring of children under age of five years must
- ii) Food action - assisting families in cultivating vegetable gardens - provide technical support.
- iii) Nutrition education - making use of health workers in the area to educate families on child nutrition

Strategies

1. A planning committee responsible for managing the project at headquarters will be formed.
2. The village elders will be approached by the planning committee to discuss ^{project} initiated. The village elders will be asked to identify an existing committee which will assume responsibility for the project at village level.
3. Several meetings will be held with the village members to sensitize them with the programme.
4. Agricultural extension workers from the ministry of agriculture working in the area will provide basic agricultural training to the villagers and logistical and technical support will be given to the villagers. ~~through the village~~
5. Nutrition sisters & MCH Nurse; and public health inspectors working in the area will be trained on chosen topics to cover child nutrition.
6. The trained health workers will then conduct large scale sessions on child nutrition covering topics in a series that has been outlined during the first
7. Growth monitoring of children under five years will be done by the health workers.

g) Village health Committee members will be motivated to carry out discussions with other Village members on topics covered in the session to reinforce the topics and so promote attitudinal change. Village committee members will also assist in distributing agricultural inputs.

b) PERSONNEL

Nutrition Sister (1)	→	Supervisor
State enrolled Community health nurse (3)	→	Health workers
Public health Inspector (3)	→	✓
MCH aide (3)	→	✓
Agricultural Extension worker (3)	→	field worker

QUALIFICATIONS

(1) State Enrolled Community health nurse
 - An SECHN certificate ~~holder~~
 Should have ~~also~~ completed the two week training for health workers in the project.

(2) Public health Inspector
 - Should possess an RSH certificate or its equivalent.
 Should have completed the two week training for health workers in the project.

(3) MCH aide

- Should have completed primary education and have served as MCH aide in the ministry for at least two years.
 - In addition should attend the two week training for health workers as observer.

(4) Agricultural Extension worker
 Should have completed primary education and the one year training for agricultural extension workers.

8

9) Nutrition Sister-

An SRN Certificate with a one year diploma in child nutrition.
- The one week training for supervisor in the project

c) TRAINING AND SUPERVISION NEEDED TO CARRY THROUGH PLANNED ACTIV

- i) One week training for nutrition sister to plan training for field workers and in supervision
- ii) Two WEEKS training for state enrolled community health nurses and public health inspector working in the area.
- iii) Five training sessions for families on vegetable gardening to be run by agricultural extension worker.

SUPERVISION

i) Annual Supervisory plan

The nutrition sister will be the supervisor for the health workers in the three villages and will be responsible to ensure that they submit their work plan on time. She will make visits to each ~~area~~ village once a ~~year~~ month and submit a quarterly report to the project manager. The supervisor will obtain the health workers' plan of work.

~~ii)~~ A Check list for planning Supervisory visits will be prepared by the supervisor before she makes a visit and she will also make a checklist for conducting such Supervisory visit before the visit.

The supervisor will analyse data ~~for~~ submitted by the health workers in their monthly report to obtain the ~~kecks~~ monthly indices of the various indicators and compile ^{her} a quarterly report. The forms used for recording and report are :- 131

Client Record

This will be in ~~the~~ collected in duplicate copies
 - one copy will be kept by the Clients and
 another by the health worker.
 Both information for Client care and for monitoring
 will be recorded.

D) Monthly Summary Form

This will be kept ^{in duplicate} by the health worker
 who will use the information collected from
 the Client records to complete the form.

It is to be submitted to the Supervisor every month.

Information flow: Community \rightleftarrows Health Worker \rightleftarrows Supervisor \rightleftarrows Manager \rightleftarrows Professional
Needed Resources

1) Materials

Growth Charts
 Scales for weighing babies
 Record forms
 Visual aid materials
 Agricultural inputs
 Cooking utensils for food demonstration

2) Transport

1 vehicle for the Supervisor
 3 motorbikes for the health inspectors

3) Funds

As in budget

LOCATION OF ACTIVITIES

preliminary meeting with village leaders — village Court barrie
 Planning of training workshops — regional headquarters
 Sessions on child health and agriculture — village Court barrie

IMPLEMENTATION PLAN

ACTIVITIES	PARTICIPANTS	DATES	LOCATION
Review Preliminary meetings with village elders and selection of village committee	Planning Committee members, village leaders	January and February	VILLAGE
Plan training workshops for nutrition Education Sisters and health workers	Planning Committee	January and February	Regional headquarters
BASELINE SURVEY	Health workers	February	Village
ORDER OUT SUPPLIES	Planning Committee	January thro' March	Village regional Headquarters
Training of health workers Training workshop for Nutrition Sister	Nutrition Nutrition Sister / Resource people	2nd week March	Regional headquarters
training of health workers	Nutrition - Sister / health workers	3rd and 4th week March	Chiefdom headquarters
Preparation of audio-visual aids	Artist / planning Committee	February and March	Chiefdom Regional headquarters
Information Education Communication Sessions	health workers village committee families in village Agricultural extension worker	April through Oct. project period	Villages

INDICATORS.

The indicators that will be used to show if there is a real change are

(1) Process indicators

- (a) Number of meetings held ^{with Village Elders} at these meetings and Total Attendance
- (b) Number of training sessions held by Agricultural extension workers
- (c) Number of Agricultural inputs delivered to Villagers
- (d) Number of general meetings held with the Villagers and Total attendances
- ~~E No of Health workers / Agricultural~~
- (E) No of growth monitoring done by Health workers

IMPACT INDICATORS

(I) NUTRITIONAL STATUS : IMPROVEMENT IN NUTRITION STATUS WEIGHT FOR AGE LESS THAN 80% OF STANDARD OR HEIGHT FOR AGE LESS THAN 90% OF STANDARD IN AT LEAST 25% OF THE CHILDREN UNDER FIVE YEARS in the Project area after 2 years

(II) 20% increase in the number of families with backyard garden with foodstuff suitable for preparing weaning feeds

At least-
(III) 20% increase in the number of families given daily at least 4 balanced supplementary feeds to children under 2 years of age in the Project area.

(IV) ~~20~~ increase by ^{At least-} 20% the number of women ^{balance} ~~starting giving~~ ~~starting to~~ giving Supplementary Feeding at age 4-6 months or

NIGERIAN PARTICIPANTS PRESENTATION

PROJECT TITLE: IBADAN MARKET WOMEN
PROJECT: AN INNOVATIVE APPROACH
TO FAMILY PLANNING SERVICES
IN URBAN NIGERIA.

PROJECT DURATION: Two and one-half
years, starting July 1985.

Presentation Outline.

- 1). General Description.
 - i). Geographical / Historical background
 - ii). Population / Urban Migration
 - iii). Health resources / family Planning services
 - iv). Transport
 - v). Communication
 - vi). Community Organisation
 - vii). Target groups

2). Problem.

- 2.1). Identification of Major Health Problems
 - i). Malaria diseases
 - ii). Diarrhoea diseases
 - iii). Birth Spacing
 - iv). Immunisation Awareness
 - v). First aid

3). Priorities.

3.1). Selection of Priorities

- i). Oral Rehydration Treatment
- ii). Birth Spacing
- iii). Malaria Treatment
- iv). Immunisation
- v). First Aid.

3.2). Justification of the highest priority.

- i) Reduce morbidity / mortality rates of children > 5 years.
- ii) ORT is cheap.
- iii) Cost of production is low.
- iv) Easy to do — mix and prepare.

4). Objectives

4.1). General Objective.

To establish priority health services in the market at low cost using the market women agents as health providers.

4.2). Specific Objectives.

i). Within 1 yr of initiating services to increase to at least 50% the number of children under 5 years who receive appropriate treatment for malaria and diarrhoea.

ii). To increase within 1 yr of initiating services the number of contraceptive use among market

Women of child bearing age to 30⁺

5. Plan of Action.

- 5.1). Intervention and Strategies
- i). Strategy for General Objective
To establish priority health ser in the market using the market women as health providers.
- 5.2).
- i) To organise, train, supply and supervise selected market women agents (1 agent per every 100 market women), to
 - a). Provide appropriate malaria treatment from their stalls at a low cost.
 - b). Provide oral rehydration salt at low cost and instruct mother how to use it.
 - c). To educate on how to prevent Malaria and diarrhoea from future occurrence.
 - d). Make market women aware of the CBO Services.
 - e). To also refer market women to appropriate health facilities when necessary.
 - f). To provide contraceptive services at low cost.
 - g). To educate mothers about family planning.

5.3a) Number of People needed and their Qualification.

- i). 225 market women as CBD agent from 30 markets.

Pilot Program — Phase I
 Period — 9 months.
 25 market women as CBD agents from 5 markets.

Expanded Program — Phase II
 Period — 21 months.
 200 market women as CB agents from 25 markets.

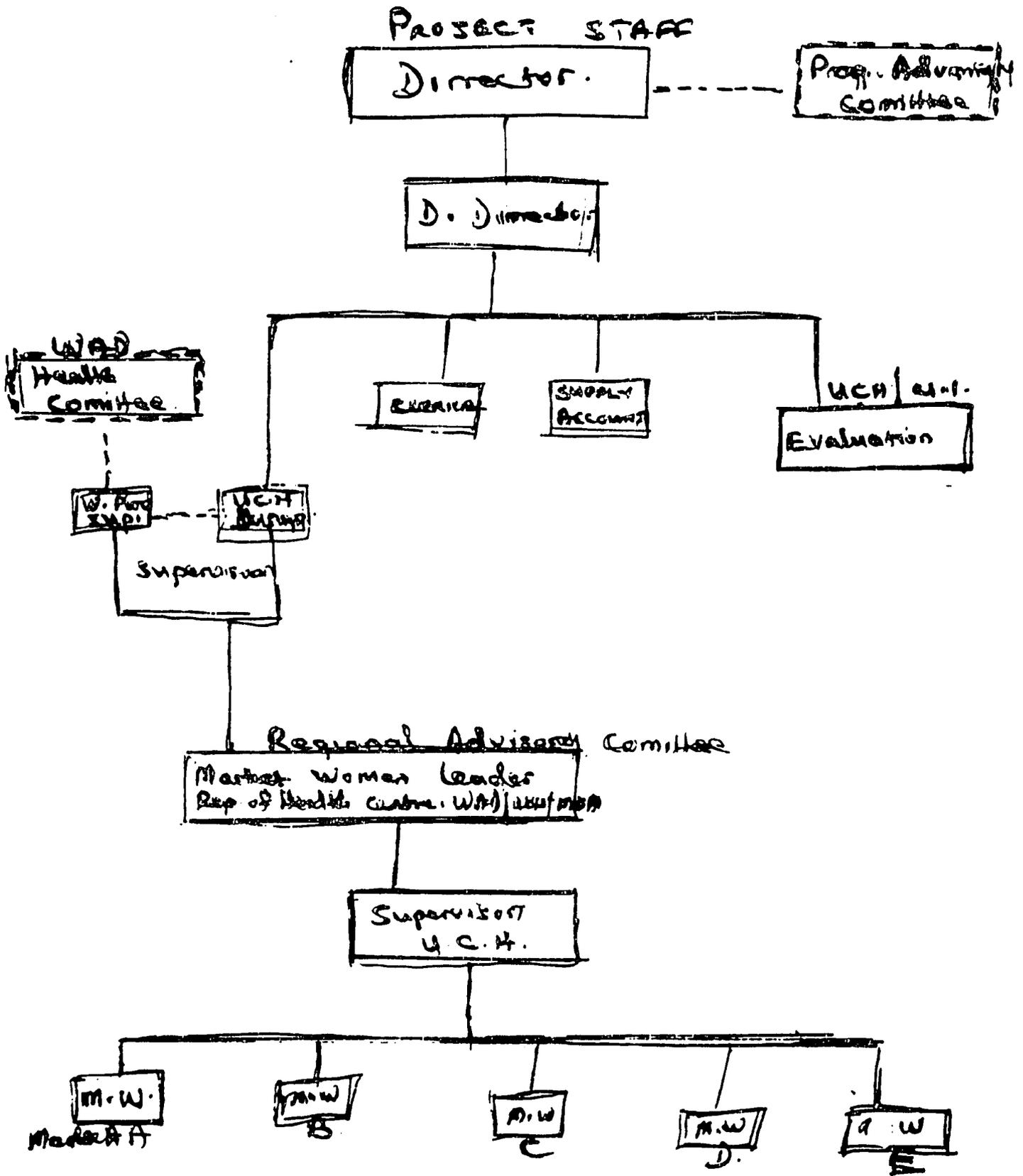
ii). Qualifications.

- A positive interest by the individual in participating in the program.
- Personal attitude of mixing and interacting freely with others.
- Should be active; willing and available to attend training program.
- Should be sponsored by market women leaders.
- Minimal education — but not compulsory.

5-3^b

5

ORGANOGRAM



5.4 Training and Supervision.

Training Schedule - 10 days
 Training of Market Women Agents
 will be for 2 weeks.
 Course Content

Date	Course Content
1st Day.	Management of Minor Ailment e.g. Malaria Signs and Symptoms of malaria Prevention of malaria Treatment of Malaria
2nd Day.	Management of Diarrhoea Treatment of diarrhoea How to mix Oral rehydration s
3rd Day.	Health Talk Advice to mothers on feeding of babies Personal and Environmental Hygiene.
4th Day.	First Aid Treatment Prevention of Home Accidents
5th Day	Revision and Evaluation.
1st Day.	<u>2nd Week.</u> Methods of family planning
2nd Day.	Advantages of family planning Side effects of family planning
3rd Day.	How, where, when to get birth control methods.
4th Day	Referral System: - Immunisation, I.U.C ORT. 2nd others
5th Day.	Review and Evaluation

SUPPLY.

Initially the Project staff will visit each CSD agent regularly, to resupply her, provide supervisory support and record what has been dispensed.

Later, the market women agents will come to a single location, probably UCH (University College Hospital) Ibadan, when they need more supplies.

5.5

+

CHECK-LIST FOR CONDUCTING A SUPERVISORY VISIT.

1. Look at records - If they are well kept and if it agrees with monthly report information.
2. Observe how the market women carry out their activities in a role play - such as demonstration of how to treat diarrhoea with ORT and this serves as an opportunity for re-training if necessary.
3. Talk with leaders of Market-Women so as to reinforce their understanding of the programme and how it is being implemented.
 - Ask if they need other help from the supervisor and that they should talk about
 - Ask of their opinion so far about the programme, their comments, suggestions and recommendations.
4. Any other problems that might arise from activities and other problems from the experiences of the agents.
5. At the end of the meeting discuss if has been observed or found, reward of points on whether the kits are clean & well kept as a sort of encouragement. This will serve to boost their ego.
6. Remind them of the date of next visit.

5.6.

Budget.

The project is planned for two and half years (2 1/2 years) and is budgeted on a total of £ 256,492 for the entire period. An inflation factor of 50% per year is used for salaries in years two and three.

The major costs are for salaries, supplies, training and evaluation.

	Year I (Actual)	Year II (Actual)	Year III (Max.)
Salaries -	35,645	38,703	20,17
Administration -	4,000	4,000.	3,00
Transport -	2,160	3,160	2,00
Supplies/ Equipment medical	26,037	23,063.	—

TRAINING.

5E. All training relating to the project will take place at the staff development training centre Bodija which is managed by the Ministry of Social Development, (also the sponsor of WAD).
 I The services will be given at the market places.

5F. Training has already started on 3rd June here in the Columbia University to end 28th which is the management course.

5F. Management Training course has already started here in Columbia University 3rd - 28th Jun. to be followed by the following:

- b. Training of Trainers - July 11th - 5th
- c. Training of Trainees - July 8 - 22

6, EVALUATION.

The indicators needed for monitoring and Evaluation are: - "PROCESS AND IMPACT INDICATOR"

Process Indicator :- Will help us to measure whether the project is being properly carried out
e.g. Does the market women give the proper treatment for malaria to a 3yrs old.

Therefore in using process indicator we put the following into consideration.

- a, Organise
- b, Training
- c, Supply
- d, Supervision
- e, Appropriate Health Services.

- A. ORGANISE:- Adequate number of market women volunteers for the programme :- i.e. 1/10 client.
- B. TRAINING:- Role play demonstration of appropriate malaria treatment, ORT, family planning education and dispensing.
- c. Supply:- To make sure that 90% of market women do not run out of supply within one year.
- d. Supervision:- Every market women agent expected at least once a month to be seen by the supervisor.
- e. Appropriate health service:- There is a need to interview clients that have been treated to know whether the agents are doing the right thing.

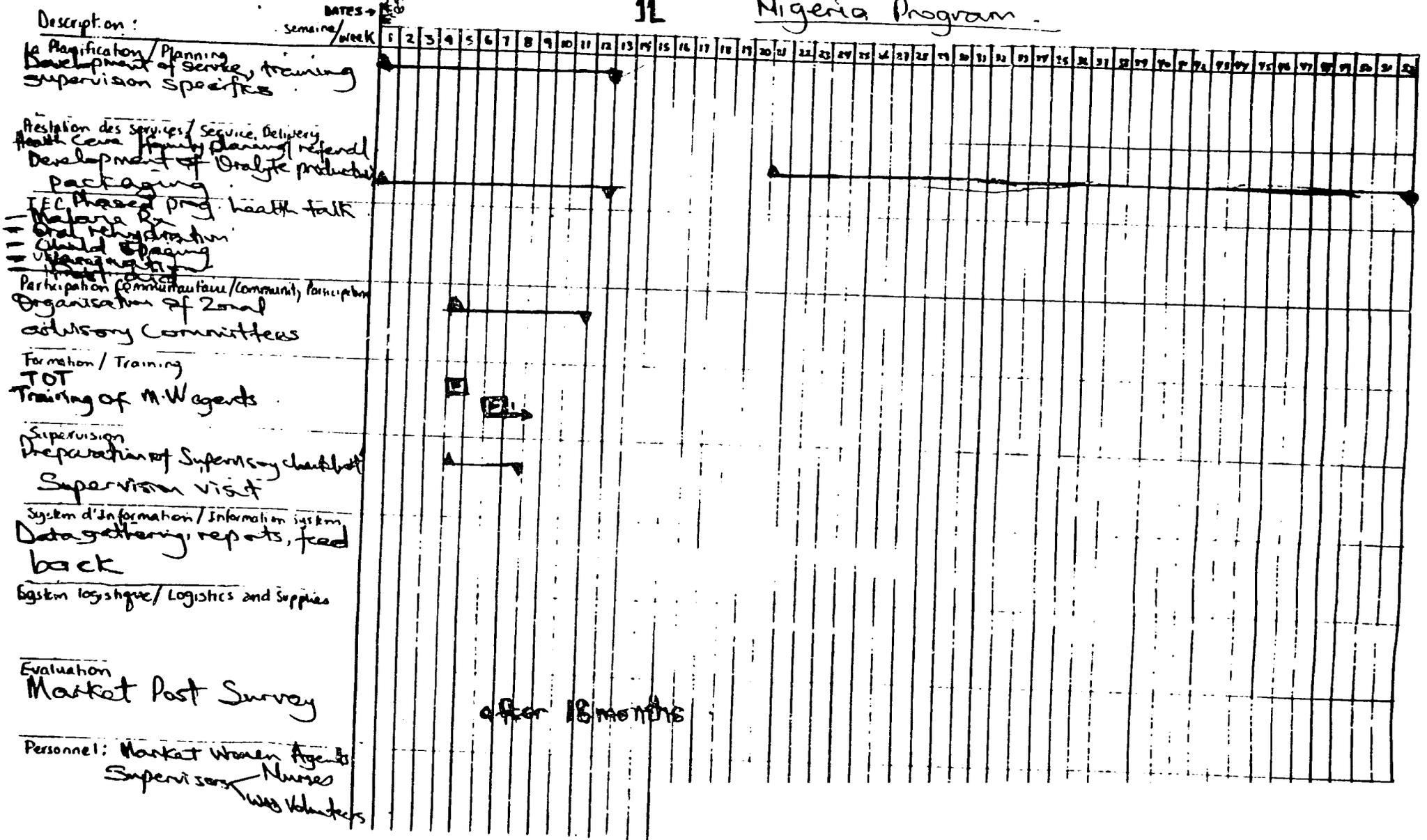
Impact Indicator :- Is quantitative and refers to all components of the programme within specific given time.

- a. To find out whether children under 5 recieve appropriate treatment for malaria or diarrhoea within 1 year.
- b. To know the proportion of illnes and mo who receive appropriate treatment within one year
e.g. for malaria and diarrhoea.
for mother ~~family planning~~ skill on chil. bearing age who receive contraception.
- d. Monitoring :- Certification by competent Obes that appropriate treatment were given.
- e. To ask the mother whether the nurse women have given appropriate treatment
e.g. whether chloroquine was given for the treatment of malaria etc

GANNT CHART:

11

Nigeria Program



Rapport du Groupe

1.

République du Zaïre

Introduction

I. Titre du projet : PROJET D'EDUCATION FAMILIALE 1986

1. Localisation: • Collectivité de NSONA - MPANGU, Zone de SONGOLOLO. Située à l'ouest du Zaïre, dans la Région du Bas-Zaïre à environ 250 kms. de KINSHASA.

• Population: communauté de 30 villages avec une population de 36,000 habitants dont 20% de femmes dont en âge de procréer

• Ressources sanitaires: 1 hôpital général de référence + 15 centres de santé

• Personnel: 1 médecin + 5 superviseurs + 30 infirmiers (AS)

• Climat: tropical et humide caractérisé par 2 saisons (de pluie et sèche)

• Transport & communication: route nationale Matadi - Kinshasa qui constitue l'épine dorsale de la Région, soit 1.425 kms. Il y a chemin de fer soit 365 kms.

• Organisation communautaire: constitution des comités de développement.

• Economie: vente de produits vivriers la pêche et l'élevage.

• Religion: 60% catholique; 20% protestant; 10% Kimbanguiste et 10% autres animistes.

2. Identification des Problèmes Sanitaires majeurs

Une enquête a été menée au 2^{ème} semestre de 1985 dans tous les villages de notre champ d'action pour recenser les besoins de la population. Selon les données récoltées sur le terrain, il a été constaté que la majorité de la population n'utilisait pas les méthodes contraceptives modernes pour 3 raisons: première est que selon les coutumes, c'est un devoir d'avoir beaucoup d'enfants (riches). Deuxième raison est que selon la religion éviter une grossesse est une péché; et la troisième est l'ignorance de ces moyens modernes. Soit 85% de femmes de zone rurales connaissent au moins un moyen traditionnel de contrôler leur fécondité (abstinence sexuelle, retrait, ceinture traditionnelle, allaitement au sein)

- Le niveau d'éducation est relativement bas soit 40% des interviewées rurales n'ont jamais été à l'école.

- La mortalité est élevée parmi les enfants et les bébés, soit 43% d'interviewées rurales ont perdu au moins un enfant (paludisme, rougeole, diarrhée, etc.)

- Manque de service d'information en P.F. en planning familial, et de personnel formé en P.F.

3. Sélection des Priorités

Intégration des services de P.F. dans les 30 centres de Santé existants.

4. Objectifs

A la fin de l'année 1986, les 50% des femmes en âge de procréer, soit 396 femmes de NSONA-MPARIGU utiliseront les méthodes modernes de l'espacement de naissances.

5. Plan d'Action

a) sélection des stratégies :

- mener une campagne d'éducation et de sensibilisation en matière de santé familiale avant le début du programme proprement dit au moins une fois pendant les 6 premiers mois dans tous les villages
- organiser des visites à domicile porte par porte une fois par mois et par village.
- intégrer nos services de P.F. dans 15 centres de Santé
- former les infirmières accoucheuses (A3) en matière de P.F. pour assurer la prestation des services cliniques et IEC.

b) ressources humaines : Nombre de personnes et leur qualifications

- 1 médecin chef de zone de Santé Rurale (Docteur en Médecine)
- 5 superviseurs (infirmiers diplômés - A2)
- 15 infirmières (accoucheuses A3)

- 1 secrétaire du projet (humanités complètes)
- 1 chauffeur du projet (chauffeur-mécanicien)

c) matériels

- Kits 1, 2, 3, 6
- gants
- films
- projecteur
- tensiomètre
- pese-personne
- table gynécologique
- stéthoscope
- teinture d'iode
- véhicule + 5 vélos.
- contraceptif - pilule, injectable, DIU, préservatif, spermicide.

d) finances

- salaires	z	1.096.000
- avantages sociaux	z	210.200
- formation	z	89.000
- entretien véh + carburant	z	500.000
- fourniture, manuels, mat. didact.	z	30.000

Total z 1.925.200

Soit \$ 38,504.00

II Indicateurs à Utiliser Pour Contrôle et Evaluation

Informations nécessaires à rassembler :

1. données démographiques
2. espacement des naissances
3. infrastructure existante
4. traditions, coutumes (religions)
5. répartition des acceptantes par méthode, âge, religion, profession, état matrimonial, statut, etc.
6. quantité des contraceptifs distribués par l'unité, et matériels.
7. visites des acceptantes par méthode.
8. N^o centres opérationnels
9. N^o personnel sanitaire formé et leurs qualifications.

Indicateurs d'impact appropriés à l'objectif et activités :

1. N^o femmes recrutées pour la contraception
2. N^o d'unités équipés et approvisionnés
3. N^o participants aux séances de l'EC
4. N^o certificats de participation à la formation
5. N^o infirmières (As) formés.

Indicateurs de processus appropriés à l'amélioration du programme :

1. N^o visites effectuées à domicile.
2. N^o réunions tenues.
3. quantité de contraceptifs et de matériels et fournitures distribués.

Sommaire

I. Titre du projet

1. Localisation
2. identification des problèmes
3. sélection des priorités
4. objectifs
5. plan d'action
 - a) sélection des stratégies
 - b) ressources humaines
 - c) matériels
 - d) finances

II Calendrier d'activités

III Indicateurs à utiliser pour contrôle et évaluation.

Composition

- . Fatumata BATA - Assistante sociale
- . Bassant BOMA : Sage-femme
- . Seun Nikey NAMAH = Sage-femme
- . Alimata TRIANDÉ : Sage-femme
- . Issaka COMPAORÉ : MEDECIN
- . Aboubakry THIAM : MEDECIN

Titre : Projet de Planification familiale
dans la Province de KENEDOUGO
BURKINA FASSO . Juin 1985

I Description du terrain.

KENEDOUGO Province est située au Sud-est du pays, couvrant 25 000 km² pour une population de 70 000. Le Groupe C. bis de femmes a été créé à Bobo Dioulasso. Les enfants de moins de 5 ans sont chiffrés à 14 000. Les femmes éduquées pour l'essentiel sont tirées de l'agriculture et l'aquaculture. Le climat est semi-aride avec de précipitations importantes par rapport au reste du pays. Un axe routier principal traverse la province et relie Bobo Dioulasso (2^e ville) à Sikasso au Mali. Il existe un aéroport et une ligne téléphonique. Les axes routiers secondaires relient les di-

ceux de départements de la province, complètement
efficacement le réseau de communication avec
les Ressources sanitaires se résument ainsi
suit :

- | | | |
|----------------|---|--|
| Infrastructure | { | - 1 Hôpital Provincial |
| | | - 3 Centres Médicaux |
| | | - 18 Postes de Santé abritant des
Maticines |
| | | - |
| Personnel | { | - 2 Médecins dont 1 chirurgien |
| | | - 9 IDE (Imprimier d'Etat) |
| | | - 2 SFE (Sage-femme d'Etat) |
| | | - 28 Imprimiers Brevetés (IB) |
| | | - 24 Maticines |
| | | - 2 chauffeurs |
| | | - 24 Danseuses |
| | | - 2 Aids-Sociaux |

Il existe des comités de santé au niveau de
les villages, qui soutiennent les techniciens et
ASC dans l'exécution des SSP.

II Identification des problèmes de Santé dans la zone d'étude

Les problèmes sanitaires suivants
ont été identifiés :

- les diarrhées infantiles liées au froid,
et au manque d'eau potable.
- les grossesses à haut risque chez
grands multipares
- Malnutrition chez le groupe en

- sexe, rapproches et au serrage précoc
- Abortements clandestins.
 - Problèmes sociaux des mères célibataires
 - taux de mortalité infantile liés à la malnutrition et aux familles nombreuses: niveau de vie très bas
 - la rougeole
 - le paludisme
 - la tuberculose pulmonaire
 - les anémies carencielles
 - les parasites intestinaux

III Choix des Priorités.

Nous retiendrons comme problème prioritaire celui évoqué ci-dessus.

Dans la région de KENE DOUON les grossesses à haut risque constituent la principale cause de mortalité maternelle (cours du travail ou au moment de l'accouchement) la mortalité infantile y est liée aux grossesses rapprochées.

80% des décès de femmes, recouverts à une grossesse compliquée sont des multipares (au moins 6 gésites)

Les grossesses multiples présentent des risques élevés. Nous estimons que ce problème peut trouver une solution facile et peu chère, par la planification familiale.

IV OBJECTIF

Assurer des prestations en planning familial à ~~20~~ 50% des femmes en âge de procréer de la province de Kénouédougou dans les 5 provinces avoisinantes, à raison d'un 20 villages / au (couverture géographique) 10% de femmes cibles / au, par les Accoucheuses traditionnelles.

V Plan d'Action.

V.1. Sélection de stratégies

- Formation de Formateurs
- Formation des accoucheuses en P.F.
- Utilisation des Comités de Santé
- Renforcement du niveau de structure déjà existant en matière de P.F.

V.2. Sélection de actions

- Séminaire de formation en P.F.
- Cours de recyclage en P.F.
- Prise de contact avec les organes Communautaires.

V.3. Personnel exécutant le programme

- Un Médecin directeur provincial de
- deux Sages femmes Supérieurs et
- deux aides sociales
- Vingt Accoucheuses de village cibles de l'exécution du programme au

de la communauté.

- Un chauffeur pour le véhicule de supervision

IV.4. Formation et SUPERVISION

IV.4.1. Formation

a/ Formation de Formateurs

Agent à Former	Contenu du Programme	Objectifs spécifiques
Sage femme Aide Social	<ul style="list-style-type: none">- Méthode d'enquêteur en planning familial- Utilisation de matériel audio-visual pour la PF- Méthode d'enquête et d'entretien de terrain	<ul style="list-style-type: none">- Enseigner à la direction des groupes- Comment faire un plan graphique- Sensibiliser la communauté- Faire un rapport statal

b/ Formation de AV

Agent à Former	Contenu du PRG	Objectifs spécifiques
Accordeuses villageoises	<ul style="list-style-type: none">- Technique de recensement- Collecte de données- Planification familiale	<ul style="list-style-type: none">- Assurer des visites éducatives aux groupes cibles- Tenir des fiches statistiques et statistiques- Proposer et distribuer des méthodes contraceptives et qualis

IV.4.2 Supervision

a) Activités

1- Contraception

- nombre de contraceptifs → tous les mois pendant la

premier trimestre le reste tous les 2 mois

- nombre de femmes cible tous les 2 mois

2 - Distribution de contraceptifs

- Condom

- pilule

} tous les mois pendant le 1^{er} trimestre
le reste tous les 2 mois

3. Gestion du stock tous les mois pendant le 1^{er} trimestre le reste tous les 2 mois

b) Points à contrôler lors de la supervision Cf tableau

- Quantitatifs

Statistiques sur

- Nombre de femmes venues au projet
- Nombre de petites distributions
- Nombre de femme ayant abandonné
- gestion du stock etc.

- Qualitatifs

- Contenu des messages
- Niveau de l'utilisation des techniques d'éducation etc.

c) Ressources Requises

- Lots de contraceptifs (Condom, Pilules avec 10 000 tablettes/an)

- Matériel éducatif (film et graphique, appareil audio visuel)

- fiches de rapport mensuelle à temps

Transport - L'ensemble de supervision et de distribution 200 litres/mois

Best Available Document

- Financie

1/3 financé par l'état (locaux, salaire de personnel, moyen de transport) et la participation communautaire

2/3 financé par le projet : contributions, fournitures, matériel d'éducation, etc.

V5 Diagramme de GANTT

Confère diagramme de Gantt

VI Les indicateurs utilisés pour le contrôle et l'évaluation

VI 1 Planification de la supervision

- Permet de contrôler

Ex: Nombre de femmes venues au projet

• de pesticides distribués

• la gestion du stock

VI 2 Organisation en catégories de l'information

- Au niveau des bénéficiaires de village

Ex: Nombre de demandes éducatives effectuées dans le mois

• Nombre de femmes venues au projet

- Au niveau de supervision

Ex: Synthèse statistique des données recueillies au niveau des responsables de village

• Etat du stock au niveau de village

- Au niveau de l'Administrateur

Ex. Situation du budget

. taux de progression ou de régression
du projet

Vi 3 Identification des Indicateurs d'Impact

- Diminution de taux de mortalité infantile
- " " du taux des enfants mal nourris
- " " du taux de mortalité infantile
- " " du taux de grossesse à haut risque

Vi 4 Indicateurs de Processus

- . Nombre de réunions éducatives effectuées par semaine
- Nombre de brochures distribuées
- Connaitre le nombre de personnes formées par catégorie : sages-femmes, Accoucheuses de village, etc.

Conclusion

Le programme pour l'action familiale simple beaucoup plus dynamique que celle faite par les femmes. Les bases de la santé sont les efforts. Les hommes sont avec nous la participation communautaire. Tout en montrant les résultats que nous

Best Available Document

1985 JUNE WORKSHOP

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GUIDE TO READINGS

During the workshop, you will receive a large quantity of reading materials. We hope you will find them useful and that you will refer to them upon return to your countries. While we do not expect you to read all of the materials during your stay in New York, we suggest you try to familiarize yourselves with selected items in preparation for the following workshop topics.

FOR

READINGS

TUESDAY, 4 JUNE

- o Case Study, Guadeloupe Family Planning Clinic, Part A.
- o PHC Charts
- o Analysis of Eight Essential Ingredients of PHC

WEDNESDAY, 5 JUNE

- o Ficticia
- o The Focused Group Discussion: An Overview
- o Taking Soundings for Development and Health (Pacey)
- o Protocol for the Design of Focus Group Program Research
- o Mini-Survey in Matrix Format: An Operations Research Tool
- o Guidelines for Survey Methodology (H. Elkins)
- o Guidelines for Sampling
- o Guidelines for Placing Microcomputers in the Field
- o Qualitative/Survey Research
- o Comparisons of the Qualitative and Quantitative Research Paradigms
- o Checklist for Evaluation Situations for which Qualitative Methods are Appropriate
- o Guidelines for Needs Assessment
- o Some Practical Suggestions for the Use of Qualitative Methods
- o Needs and Resources Assessment - Quantitative Aspects

THURSDAY, 6 JUNE

- o On Being in Charge, 267-310, 329-344

FRIDAY, 7 JUNE

- o Community-based Health and Family Planning (Population Report L-3)
- o Selections from Assignment Children 59/60 on Community Participation

MONDAY, 10 JUNE

- o Family Planning: Its Impact on the Health of Mothers and Children (CPFH Chartbook)
- o Traditional Midwives and Family Planning (Population Report J-22)

TUESDAY, 11 JUNE o Family Planning Methods and Practice: Africa
o Guidelines for Incorporating Nutrition into the
Design of PHC and Related Projects (INU Technical
Report #10)
o Design and Implementation of Community-Based
Nutrition Programs Integrated in PHC
o Nutrition Programs Handout

WEDNESDAY, 12 JUNE o State of the World's Children (UNICEF)
o Oral Rehydration Therapy for Childhood Diarrhea
(Population Report L-2)
o Where There is No Doctor (Werner)
o Why the Other Half Dies (Rhode)

THURSDAY, 13 JUNE o African Charter on Human and Peoples Rights
o Convention on the Elimination of All Forms of
Discrimination Against Women
o Laws and Policies Affecting Fertility: A Decade of
Change (Population Report E-7)
o Spousal Consent Letter

FRIDAY - WEDNESDAY
14-19 JUNE o Helping Health Workers Learn (Werner and Bower)
o Teaching for Better Learning
o Training Checklist (CPFH)

THURSDAY, 20 JUNE o On Being in Charge, 186-202, 312-328

FRIDAY, 21 JUNE o Service Statistics: Aide for More Effective Family
Planning Program Management (Population Report J-17)

MONDAY, 24 JUNE o On Being in Charge 44, 61-124, 323-328

TUESDAY, 25 JUNE o On Being in Charge 329-344
o Manual on Operations Research (Population Council)



**Center for Population and Family Health
Columbia University, June 1985**

THE CENTER FOR POPULATION AND FAMILY HEALTH
and
THE SCHOOL OF PUBLIC HEALTH
of
THE FACULTY OF MEDICINE
of
COLUMBIA UNIVERSITY

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in The Training Workshop

FAMILY PLANNING, NUTRITION, and PRIMARY HEALTH CARE
IN AFRICA:

Program Design, Management, and Evaluation
given in New York, June 3-28, 1985



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