

Program for International Training in Health
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Report on the Proceedings of the
Fourth INTRAH Anglophone Africa

TECHNICAL ADVISORY COMMITTEE MEETING

Nairobi, KENYA

Report on the Proceedings of the
Fourth INTRAH Anglophone Africa
Technical Advisory Committee Meeting

Intercontinental Hotel

Nairobi, Kenya

May 23 - 25, 1989

Submitted by:

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INTRAH/ESA Director

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INTRAH/ESA Regional Projects Officer

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
CHW	Community Health Worker
D	Delivery
IST	In-Service Training
L	Labor
MCH/FP	Maternal/Child Health and Family Planning
MOA	Ministry of Agriculture
PHC	Primary Health Care
PST	Pre-Service Training
S	Service
TAC	Technical Advisory Committee
TB	Tuberculosis
TBA	Traditional Birth Attendant

EXECUTIVE SUMMARY

INTRAH/ESA hosted the fourth Anglophone Africa Technical Advisory Committee (TAC) meeting from May 23 - 25, 1989 at the Inter-Continental Hotel, Nairobi, Kenya. The 17 TAC members represented Botswana (2), Kenya (2), Liberia (1), Somalia (3), Tanzania (2), Uganda (3), Zambia (1), Zimbabwe (2), and REDSO/ESA (1). Fifteen members represented government training and service programs; an NGO and REDSO/ESA were represented by one member each. The TAC meeting was facilitated by Ms. Lynn Knauff, INTRAH Deputy Director, Miss Pauline Muhuhu, INTRAH/ESA Director, Mrs. Grace Mtawali, INTRAH/ESA Regional Training Officer, and Mrs. Jedida Wachira, INTRAH/ESA Regional Projects Officer.

The goal of the TAC meeting was to identify trends in MCH/FP service delivery and training systems within the region in the 1990s in order to develop strategies to address emergent family planning needs. Themes were decision-making for change, FP integration into MCH within a primary health care framework, lessons learned regarding linkages between pre-service training, in-service training and service systems, and training for results. Recommendation for changes in pre-service and in-service training of service providers for integrated FP/MCH/PHC services were made (see Appendix I). The TAC meeting achieved all objectives.

Fourth INTRAH Technical Advisory Committee MeetingNairobi, KenyaMay 23 - 25, 1989AGENDA

**Tuesday
May 23**

8:30	Call to Order	Wachira
8:35	Official Welcome	Muhuhu
8:45	Welcome	Knauff
8:55	Review of meeting agenda	Mtawali
9:00	Housekeeping and Logistics	Muhuhu/Waiyaki
9:10	Lecturette: Change	Knauff
9:25	In pairs, share an experience of one planned personal or professional change you have made. What helped? What was difficult? What is the experience of the change so far?	
9:35	Sharing in plenary	Mtawali
9:50	Lecturette: Change/PHC/Integration	Knauff
10:05	Plenary: What would service integration look/feel like if we had it?	
10:30- 10:45	B R E A K	
10:45	Integration of MCH/FP and/or FP/MCH from service perspective and service provider perspective.	Knauff
11:15	Lecturette: Quantity, locales and quality of services	Knauff
11:30	Quartets: Why don't people use services? What can be done about it?	

12:15	Sharing in plenary	Mtawali
12:30- 2:00	L U N C H	
2:00	Introduction to video: "Why Did Mrs. X Die?"	Muhuhu
2:30	Trios: What were the causes of Mrs. X's death?	
3:00	Sharing in plenary	Muhuhu
3:15	Video summary	
3:30- 3:45	B R E A K	
3:45	Introduction to Fishbowl Issue: In our system, what can we do to prevent other Mrs. Xs from dying?	
3:55	Service	
4:10	Policy	
4:25	PST	
4:40	IST	
4:55	Fishbowl Summary	Wachira
5:05- 5:15	Review, feedback and closure	Knauff

**Wednesday
May 24**

8:30	Sharing feedback results.	Wachira
8:40	Purpose of Day 2.	Wachira
8:45	Reflecting on group results: What each system can do to prevent death of Mrs. Xs.	Wachira
	Sharing some characteristics of integrated MCH/FP services.	Wachira
9:00	Introduction to case studies.	Wachira

9:30	Identification of components and parts of truly integrated MCH/FP services in each situation presented in the case study.	Wachira Muhuhu Mtawali Knauff
10:30	T E A B R E A K	
11:00	Group presentations.	Wachira
11:45	Sharing implications/insights drawn from case study group work.	Wachira
12:00	Identification of parts of the components of MCH/FP.	Wachira
12:45	L U N C H	
2:00	Case studies continued.	Wachira
	- Selection of one part of a component.	
	- Characteristics of service sites.	
	- Types of service delivery modes.	Wachira
	- Types of service providers.	
3:30	T E A B R E A K	
4:00	Sharing in plenary.	Muhuhu
5:00- 5:15	Summary and feedback.	Mtawali

**Thursday
May 25**

8:30	Review of feedback from Day 1.	Mtawali
	Review of insights on integrated MCH/FP.	Mtawali
8:40	Overview of lessons learned in training in the region.	Muhuhu
8:50	Introduction to task.	Muhuhu
9:00	Implications for training: Case study groups.	Muhuhu

10:00	Group reports. (10 minutes each)	
10:30	T E A B R E A K	
10:45	Introduction to task.	Muhuhu
11:00	Changes in the training systems for realization of integrated MCH/FP services.	Muhuhu
12:00	Group reports: PST/IST	1+2+3+4
12:30	L U N C H	
2:00	Introduction to group task.	Muhuhu
2:15	Recommendations to: - System - IST/PST - Training assistance agency	Muhuhu
3:30	T E A B R E A K	
3:45	Group reports.	Knauff
4:30	Summary.	Wachira
4:45- 5:00	Feedback and closure.	Muhuhu Mtawali

I. PURPOSES

1. Provide a forum for sharing/discussing lessons learned in FP training during the past 5 years for application in the future.
2. Explore changes required in FP service delivery and training systems in the region during the next 5 years.
3. Provide an opportunity for TAC members to forecast training and technical assistance requirements to effect change.

II. OBJECTIVES

1. Review crucial lessons learned in training for family planning service delivery in the past 5 years that could be applied to future FP training activities.
2. Identify FP service strategies, types of service modes and providers, target groups to be served and expected results of activities planned for the 1990s and their implications for training.
3. On the basis of (2) above, to make recommendations on changes required in training and technical assistance in the next 5 years.

III. BACKGROUND

See TAC proposal in Appendix B.

IV. DESCRIPTION OF ACTIVITIES**A. Selection of Participants**

The 1989 TAC participants were selected from those countries with current collaborative training activities with INTRAH, or who have had past or potential collaborative experience with INTRAH.

The composition of the TAC group was predetermined in order to achieve a balance of MCH/FP training project coordinators, key policy personnel and PST tutors. There was a total of 17 participants from 8 countries: 11 nurse-midwifery personnel, 5 physicians and 1 adult

educator. Among the 11 nurse-midwifery personnel, there were 4 project coordinators, 3 PST tutors, 1 service supervisor, 1 policy level personnel, 1 program assistant and 1 IST trainer. Four of the physicians were MCH/FP directors or a deputy director, and 1 was a service provider/supervisor. The adult educator was a volunteer member of an NGO executive committee.

B. Preparation

Preparation for the TAC meeting began four months prior to the meeting with a proposal and budget, information sent to and requested from invited members and their supervisors, and general planning of an agenda and choice of venue. Information requested from TAC members focused on strategies each country was planning to implement in FP service delivery and training activities during the next 5 years. Four countries (Botswana, Kenya, Tanzania and Uganda) submitted the information for analysis prior to the TAC meeting. TAC members from Somalia and Zimbabwe brought the requested information with them. Available country development plans for the 1990s, recommendations from Family Health Surveys and other relevant documents were reviewed during the week prior to the meeting. A phenomenon common to all country information provided, and clearly reflected in the country planning documents which were reviewed, was that FP should be integrated into MCH and other PHC components. It was also evident that service providers of integrated FP/MCH and/or FP/PHC services should include a variety of health professionals as well as a variety of community health workers, including traditional birth attendants and volunteers.

During the preparation/planning phase in Nairobi, May 18-20 and 22, the 4 INTRAH TAC facilitators identified meeting themes and objectives, and developed an agenda and materials to be used during the TAC meeting.

C. Day 1 May 23, 1989

Miss Muhuhu's welcome address to participants highlighted the strategic position and responsibilities of TAC members in FP service provision and therefore the importance of in-depth awareness of service and training needs in their respective countries in order to guide and direct technical assistance for best results. The address also underscored the need for TAC members to utilize the many opportunities they have for effecting change at their specific levels of operation via MCH/FP policy making and/or interpretation with respect to service delivery, pre-service and in-service training. Miss Muhuhu also commended those countries represented which had provided third country training in the region in the past 5 years.

INTRAH Deputy Director Lynn Knauff also extended a welcome to TAC participants. In her welcome address she told a story of the king's 3 daughters and asked the TAC members to emulate the third daughter who exemplified courage, purpose and vision, demonstrating that these are essential factors in achieving multiplier effects.

The morning of the first day was devoted to pace setting through introduction of the major themes of change, primary health care framework, why people do not use current MCH/FP services, integration in MCH/FP, and service modes, quantity and quality indicators of services in MCH/FP. Use of lecturettes to introduce the content and small and large group discussion to explore the concepts generated content areas for reference, and a common understanding of these concepts was developed.

In the afternoon the video-taped case study on "Why did Mrs. X die?" provided an opportunity for back home

application of the concepts of PHC, integration of services in MCH/FP, service modes, quantity and quality and the implications for training of service providers.

In 4 groups representing PST, IST, service delivery and policy level systems, participants explored ways and means of preventing the death of other women in situations similar to that of "Mrs. X." Group views from the 4 systems are presented in Appendix F.

Feedback for the day indicated a high level of satisfaction with both content and process. (See Appendix J for results of the daily feedback.) Facilitators reviewed and made minor modifications on day 2 plans in response to the group work outcomes.

D. Day 2 May 24, 1989

The second day focused on the features of truly integrated MCH/FP service and the changes required in terms of scope, service delivery sites, modes and the potential service providers. Working in 3 small groups and in the context of 3 different case study descriptions of communities -- an urban slum of high density, a rural high density/highly productive area, and a rural low density/nomadic life style -- participants identified the components and parts of integrated MCH/FP services, service delivery sites, modes and service providers. Insights developed through the exercise resulted in the conclusions that a truly integrated MCH/FP service system must consider the general and special health, physical and social characteristics of the people to be served. In addition to the service delivery sites, the modes and service providers must be of those varieties which maximize availability, accessibility and acceptability of the integrated MCH/FP services (see case study descriptions and group work results in Appendix F.1).

Participants stated that the new way of thinking/looking at integrated FP into MCH brought home the fact that presently many of the "integrated MCH/FP services" are not yet truly integrated.

Feedback results at the end of the day indicated that the group work sessions that enabled active and free exchange and reinforcement of ideas, and the discussions or comments during plenary sessions on integrated MCH/FP services were highly valued. In addition, the case study method and all the sessions which provided opportunities to think through and clarify different perspectives of integrated MCH/FP services were among those liked most.

However, participants recommended that group task instructions be made more clear.

The products from the group work and the feedback results were used in rescheduling the activities of day 3.

E. **Day 3 May 25, 1989**

The final day concentrated on identification of changes in the training systems to enable realization of integrated MCH/FP services.

Following review of day 2 outcomes and feedback, the INTRAH/ESA Director presented highlights of lessons learned in training over the past years relevant to training for MCH/FP integration (see Appendix G).

Thereafter, on the basis of the case studies, each group identified changes that should occur in the preparation of service providers for MCH/FP integration aimed at the specific community cited in the case. The results were shared in plenary.

Highlights were the realization that explicit policies on service and training for integrated MCH/FP services and skills to interpret and apply policy to service programs, and training curricula by policy-makers, supervisors, providers and PST and IST trainers are essential. The TAC members also agreed that policies and policy interpretation and application should reflect varied situational, cultural and geographic characteristics of those to be served.

Finally, two IST and two PST groups worked separately at first to formulate recommendations on changes that should occur in each of the following areas in order to support MCH/FP integration: trainee selection; trainers and tutors; curricula; frequency of training; graduate follow-up; supervision; measuring training performance results; and, technical assistance.

These discussions were followed by IST and PST groups' sharing and then a plenary session was held where the recommendations made by each training system were presented. See Appendix I for the recommendations made by all 4 groups.

F. Closure

Activities and themes of the meeting were summarized. Written feedback was obtained on what TAC members would take back home, and they were requested to note the number of PHC seminars, meetings, conferences et al they had attended during the past. The most prominent "take home" from the meeting was a better and in-depth understanding of ways and means of how MCH/FP can be truly integrated using the PHC framework, and the important implications for pre-service and in-service training in FP. Appendix J shows all the comments/statements and frequency with which these were made.

In response to the PHC query, attendance ranged from 0-27 events with 6 as the average.

Miss Muhuhu closed the meeting at 5:15 p.m. Her address reiterated INTRAH's appreciation of the past commitment of TAC members to MCH/FP training for service delivery as well as the support of their individual organizations. In addition, TAC members' attention was called to the recommendations made during the meeting, after much thinking and reflecting on back home situations. The address noted that the TAC members now have identified ways in which training should respond in the preparation of service providers in order for integration to take place and therefore, they are well equipped to guide donor and technical assistance agencies on the most appropriate assistance.

TAC members were informed they would receive a TAC report containing the summary of the proceedings as well as handouts and the materials produced during group work, and a package of the country position papers.

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APPENDIX A

1989 INTRAH Anglophone Africa
Technical Advisory Committee Members

APPENDIX A

1989 INTRAH Anglophone Africa
Technical Advisory Committee Members

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1. Mrs. Neo MOKGAUTSI
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KENYA

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LIBERIA

5. Dr. Patricia DIVINE
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UGANDA

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12. Mrs. Specioza MBABALI
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APPENDIX B

TAC Proposal

PROPOSAL FOR 1989 TECHNICAL ADVISORY COMMITTEE
(ANGLOPHONE)

NAIROBI, KENYA : MAY 23 - 25, 1989

I. SUMMARY

The 4th INTRAH Anglophone Technical Advisory Committee (TAC) meeting will be conducted in Nairobi, Kenya from May 23 - 25, 1989. TAC members will consist of 20 MCH/FP Directors/Managers, Project Coordinators and key trainers from Botswana, Kenya, Liberia, Somalia, Tanzania, Uganda, Zambia and Zimbabwe.

The aim of the TAC is to provide guidance and direction to INTPAH in establishing training and technical assistance priorities in the region.

The 1989 TAC meeting will focus on exploring the trends in family planning service delivery and training in the 1990s and the sharing of lessons learned in the past five years in order to develop perspectives for planning training and technical assistance requirements within the region in the next decade.

II. BACKGROUND

The INTRAH (Anglophone) Technical Advisory Committee was established and first met in 1986 (see Trip Report No. o-255). Since then, annual meetings were held (see Trip Reports No. 0-432 and 0-391) for the purposes of obtaining guidance about training and technical assistance priorities in the region and to update TAC members on important training issues (desired linkages among professional education, in-service training and services, and training materials needs assessment) and in skills related to training (consultation skills and training needs assessment skills). These skills training sessions followed the TAC meetings of 1987 and 1988, at the request of TAC members.

III. GOAL

To identify trends in MCH/FP service delivery and training systems within the region in the 1990s in order to develop strategies to address emergent family planning needs.

IV. OVERALL OBJECTIVES

- A. To review lessons learned in training for family planning service delivery in the past 5 years that could be applied in the next decade.
- B. To explore FP service delivery modes, types of providers, target groups and expected results planned for the 1990s.
- C. On the basis of (B), to determine focii, persons to be trained and training strategy and modalities.
- D. To forecast changes required in training and identify technical assistance and/or consultation requirements in the 1990s.

V. SUB-OBJECTIVES

- A. To examine and discuss highlights of lessons learned in FP training for service delivery within the region.
- B. To examine training impact on improvements in the quality and quantity of family planning services in order to determine how impact can be better measured and more sharply focused.
- C. To discuss and arrive at general agreement on the extent to which other elements of MCH service delivery should/can be integrated into training in family planning.

VI. METHODOLOGY

A. PREPARATION

1. TAC members will submit a position paper following guidelines sent by INTRAH.
2. Position paper information will be categorized into 5 areas: FP service delivery systems, FP training, technical assistance/consultation, lessons learned on project development process, and, other issues.
3. Issues for discussion will be elicited and additional content and guiding questions developed.
4. MCH/FP service and training strategies outlined in national development plans and other official documents from participating countries will be reviewed for trends and used as reference.

B. IMPLEMENTATION

1. Introductory sessions will include an overview of INTRAH's geographical area of operation, the target trainee groups, the preparatory purpose of the TAC meeting for both INTRAH and TAC members.
2. Introduction of concepts of change, PHC, MCH/FP Integration, service quality and quantity indicators and service delivery modes will set the meeting themes.

3. Small groups will work, in sequence, on issues identified in position papers and introductory concepts using guiding questions, case studies, and adopting PST, IST, S and policy level perspectives.
4. Small group reports will be made in plenary, followed by discussions and resolutions/recommendations from TAC, in total for PST, IST, Service delivery/policy level systems.
5. A TAC report will be prepared by the INTRAH/ESA staff for distribution to TAC members, AID/W and USAID missions, by August 1989.

VII. MATERIALS FOR REFERENCE

1. Country position papers
2. Summary of country training achievements
3. INTRAH TIPS

VIII. FACILITATORS

INTRAH RO/ESA : Pauline W. Muhuhu
Grace Mtawali
Jedida Wachira

INTRAH/Chapel Hill : Lynn Knauff

IX. PARTICIPANTS

Sierra Leone	-	1
Botswana	-	3
Kenya	-	3
Liberia	-	1
Somalia	-	3
Uganda	-	3
Tanzania	-	3
Zambia	-	1
Zimbabwe	-	2

REDSO/ESA will also be invited to participate

TAC MEMBERS 1989 (Proposed)Botswana

1. Dr. V.N. Ngcongco, Undersecretary, Manpower Development and Training, MOH
2. Mrs Daisy Mosieman, Deputy Principal, NHI
3. Mrs Neo Mokgautsi, MOH/INTRAH Project Coordinator

Kenya

4. Mrs Margaret Ngure, Deputy CNO, MOH
5. Mrs Peninah Njoka, Deputy CNO in-charge of Eastern Province.
6. Dr. M.O.H. Kayo, ADMS, Provincial Medical Officer Western Province.

Uganda

7. Rachael Rushota, FHI Project Coordinator
8. Mrs Specioza Mbabali, Acting Principal, Mulago School of Nursing.
9. Dr. E.M. Kaijuka, ADMS, MCH/FP (or Dr. Katumba)

Tanzania

10. Miss Joyce Safe, Principal Nursing Officer, Preventive Health Services

11. Mrs Elseba Delem, Trainer, UMATI
12. Dr. Fatuma Mrsho, MCH/FP Advisor in MOH

Liberia

13. Dr. Patricia A. Divine, Chairman, Department of Obstetrics and Vynaecology, College of Medicine, Monrovia

Somalia

14. Mrs Halima A. Sheikh, Coordinator, Public Health Sector, FH/FP Division.
15. Zeynab Mohamed Afrah, Director, Post Basic School of Nursing
16. Dr. Asha, Family Health Division, Deputy Director, MOH

Zambia

17. Mrs Veronica Manda, Assistant Director of Programs

Zimbabwe

18. Mrs Lucy Botsh, Head of Training, ZNFPC
19. Dr. A. Zinanga, Medical Director, ZNFPC

Sierra Leone

20. Mrs Val Gilpin, Senior Nurse Tutor

APPENDIX C.1

Welcome Address - INTRAH/ESA Director

APPENDIX C.1

1989 Anglophone Technical Advisory Committee Meeting

Welcome Address

By

Pauline W. Muhuhu
INTRAH/ESA Director

Ladies, gentlemen and colleagues, it gives me great pleasure to welcome you in Nairobi and to INTRAH in particular. Although this is an annual event since 1986, there are many new faces and new countries represented here today. To the new people I give a very special welcome and to the not-so-new, karibu tena. For the second time in the history of INTRAH Technical Advisory Committee, we are privileged to have among us the INTRAH Program Deputy Director from Chapel Hill, North Carolina. Lynn you are most welcome.

INTRAH has been providing training assistance in this region for the past ten years. Most countries represented here today have received varying types of training and technical assistance over that period and this group in turn has contributed considerably in the INTRAH/country projects. There are also countries here who have provided training and other forms of assistance to other countries in the region with INTRAH as an intermediary. To those countries, we take our hats off and urge you to continue in the same spirit.

Looking back in those 10 years, there are many lessons we have learned, some when repeated would strengthen the ongoing projects and if applied to the new projects the outcomes could be even better. Each country must make efforts to identify the most helpful aspects of the assistance received to date and make plans to use them to gain better heights in provision of training for family planning services.

INTRAH activities are funded through a contract with USAID. The present contract expires in four months time and another 5-year phase is expected. The goal of this meeting is to assist INTRAH or the next USAID contractor for the next PAC-IIB project to shape the technical assistance required in order to meet the emerging trends in family planning service delivery.

For the next three days, therefore, we have a hard task of prescribing the direction training and technical assistance for FP/MCH should take in the next 5 years. In

carrying out this task we must base our arguments and decisions on our past positive and negative experiences as the guiding stars.

Most of you in the papers you submitted to INTRAH in preparation for this meeting, have indicated clearly that your countries plan to integrate family planning into MCH services and PHC among others. The magnitude of effort required to achieve this goal is enormous. This gathering will, in the next 3 days, deliberate on best ways to integrate MCH/FP services and how training will respond to the preparation of service providers in order for integration to take place.

Donor and technical assistance agencies provide assistance to countries through provision of materials and technical assistance support in order for countries to achieve their health goals. You are in the frontline in provision of family planning service and in preparation of service providers. In this capacity then, you have an opportunity to guide these agencies on the most appropriate assistance.

These three days provided a forum for you to do just that. In particular, the group will:

Examine change as it affects our work;

Integration of MCH/FP services; quality and quantity of services;

Changes in integrated family planning training.

It is INTRAH's hope that in addition to receiving guidance from you, will also gain something that you can take back home for application in your organizations.

APPENDIX C.2

Welcome Address - INTRAH Deputy Director

APPENDIX C.2

Welcome Address to Technical Advisory Committee Participants of Ms. Lynn Knauff, Deputy Director

Welcome from INTRAH: Chapel Hill

Karibu

Bienvenu from the INTRAH office in Abidjan

Namaste from Nepal

Sawadi ka from Thailand

Mabuhay from the Philippines

Greetings from the INTRAH staff and from Dr. Lea, in particular, to you all.

Because in this year's TAC meeting there are many new members, it may be helpful to them to know more about INTRAH. So, let me present INTRAH to new colleagues and perhaps refresh and update our regular TAC members.

The Program for International Training in Health -- INTRAH-- began in 1979 with funding from the Agency for International Development. For the past 10 years --in two 5-year contracts-- INTRAH's work has been devoted to developing in-country capacities, capabilities and confidence to design, organize, manage, conduct and evaluate training directed toward an expansion of FP service delivery points, an improvement in the quality of FP services, and recognition of training's role in improvement of the quality and quantity of FP services.

We see training as a means to an end --not an end in itself-- and we therefore devote attention to training's role in countries' development, health and service plans so that training may be appropriately directed to those plans' goals and objectives.

Over the past 5 years, INTRAH has served countries in sub-Saharan Africa and Asia, contributing to the training of over 30,000 persons -- all but 1% of whom have been trained in the countries in which they live and work.

How is so much work undertaken -- and, I would say, so well? The quality and dedication of the INTRAH staff and those with whom we work in-country are the answer. We have also benefitted from the advice and ideas of the Technical Advisory Committees in Africa and Asia.

The Nairobi office has a counterpart office in Abidjan, which serves Francophone countries. The Chapel Hill office handles the Asia program and has overall responsibilities for management, reporting and financial accountability, and has various technical specialists -- in evaluation, training materials and clinical services.

We shall soon be concluding this five year contract. We shall, most certainly, be bidding on a contract for the next 5 years. And, we wish to be guided by your plans, ideas and program innovations as we think and write. But whether it is INTRAH or another organization that is awarded the next contract for assistance in the region, it is extremely important that you who constitute the leadership in training and services are clear about what is wanted, needed and most helpful and are ready to use that assistance to further your countries' aspirations, plans and programs.

We wish to be of service -- that is the correct and proper role of assistance. We shall also be asking you -- during these next three days -- to help guide the course of assistance efforts in this region and in your countries. May we be courageous, purposeful and visionary in our tasks.

As an example of all three -- courage, purpose and vision. I'd like to close with a story. Perhaps told in your countries, also, with different characters. The setting of this one is in India, during the time of powerful kinds, perhaps a thousand years ago.

A king had three daughters and no sons. He was growing old and a successor had to be chosen. He was a wise and practical man -- and an enlightened fellow, having dedicated his life and his fortune to his people. Thus, his decision about a successor was crucial if progress was to continue in the kingdom. He called his three daughters to meet him. He told them of his dilemma and the decision he must make and he gave them a task and told them of the follow-up plan -- an early trainer, no doubt. He gave each a big bag of wheat seeds. He told them to do whatever they wanted with the seeds -- the task -- and to return in 1 year with whatever they had done -- the follow-up plan.

The eldest daughter immediately sold her bag of seeds and put the gold she'd earned in a safe box to take to her father in 12 months. The second daughter divided the seeds into many equal amounts, placing each pile on a square of gold embroidered silk, and tying each with pure gold thread -- and placed those precious little bundles in a safe place for the next meeting with her father. The third daughter planted the seeds, and tended her fields during the next 12 months.

At follow-up time, one year later, the king called the three together and asked for the daughters to show him what they had done with his gift of a bag of seeds. The eldest daughter gave him 20 gold coins, the second opened a large jeweled box and produced the many precious bundles. The third and youngest daughter, was empty-handed. "My daughter," said the king, "what have you done with my gift?" "Oh, father," she said, "I cannot carry it. Come with me outside." There he saw a hundred carts full of wheat and bags of wheat seed from two great harvests of the seeds he

had given her. So many multiplier effects from a bag of seed! And, so the successor was easily chosen.

And, what does that have to do with us? Surely, if we can be most like the third daughter in everything we do, our harvest and that of our programs and countries will far exceed the initial resources made available to us -- but that takes courage, purpose and vision. May all three be our watchwords during these next three days as you have time to think -- often a rare opportunity -- and to plan -- and to share here and when you get back home for multiplier effects.

APPENDIX D.1

Lecturettes and Visuals

APPENDIX D.1

Lecturettes and Visuals

Lecturette on Change

Today, tomorrow and Thursday we will be reflecting on the past, the present and the future. We will be discussing, describing and planning changes that we hope, we think, we believe should be made to move our programs closer to excellence and greater effectiveness and efficiency.

Generally, we are seldom satisfied with things the way they are -- woe be unto us when we are satisfied because something or someone comes along to upset the status quo. Change is continually in our midst -- from the condition of our bodies to the weather to the condition of the world. These changes result in many feelings: relief, satisfaction, disappointment, discomfort, fear, happiness, excitement. How often we react by saying -- "how interesting," or "that is interesting." This or that holds our attention and arouses our interest -- the current meaning of the word.

There is a Chinese curse: "May you live in interesting times." What does interesting mean to the Chinese? An unsettling, ambiguous period, which is more akin to the roots of the word "interesting:" inter - between, and esse, to be; thus, to be between.

Surely we live in interesting times that are characterized by change, challenge, unpredictability and opportunity -- everything but the status quo. Reflect on what has happened in your own lifetime to you and your family, in your communities, and cities and countries.

To be comfortable "to be between" requires a vision of the future, a good understanding of the present and an appreciation for the lessons of the past and their applicability to the present and the future. Holding on to the past and present is a fatal error: change not permanence, ambiguity not certainty, characterize our world. History may repeat itself, but under very different conditions.

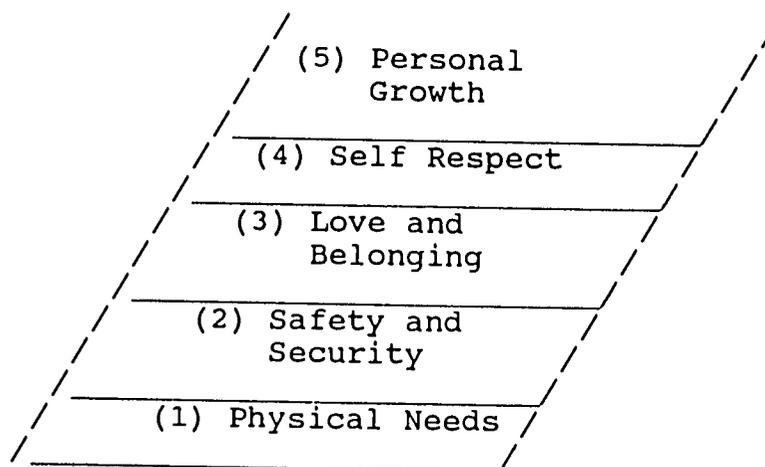
Let us look at the present and future with attention to 3 domains of change. First our pocketbooks. The cost of living must be the first, second or third most frequent topic of conversation, worldwide. Perhaps it always has been, yet we fondly remember the good old days when we got more for our money or we did not have to buy so much, or the government gave us more, or expectations and standards were not so high. Well, most of our governments are in heavy

debt trouble. A recession in the early 80's is acutely felt by countries that took out loans and now have to service that debt. As a result, there is less government money available for health, social and other services that people had come to expect. And, there are more people than there used to be. One does not have to be an economist to figure out that we have to do more, with less, for more people.

Demographically, the population centers of the world are changing. Now, the so-called developing countries have 80% of the world's population and 90% of the population under 15 years of age. Of the 25 most populous countries in the world, 64% are in the developing world, led by China and India. By the year 2025, only 36 years from now, 80% of the most populous countries in the world will be in the developing world -- or, what we now call the developing world. Nigeria will be among the top 4.

Think about what the change in demographic centers will mean for shelter, transportation, food production and distribution, waste disposal, education, diplomatic treaty relations, and of course, health care. The sheer numbers and the changes they will bring will most certainly be interesting. This is the reality of the future -- and we must be ready and responsive.

A third domain of change is personal. We make changes and we are affected by changes that are made. We act and react. We sometimes control change and sometimes it controls us. What is at the heart of our reaction? What causes us to make change? One explanation was offered by Maslow when we examined needs and aspirations: you may remember Maslow's hierarchy of needs:



Changes we make may arise as a result of threats to basic physical needs. Changes by which we are adversely affected may threaten our needs for safety and security. We go back and forth on the ladder, acting and reacting. Change is always in our midst.

Our professional needs and aspirations also can be seen within and reflected by these categories of needs. Can we, for example, expect that when professional standards are lacking or seldom observed, that health workers will feel a sense of self-respect or close affiliation with the service which employs them? If their salaries are always late, they have no supplies with which to work, or they are ignored, can we expect them to be active and to grow professionally? Basics must be attended to.

If we are to participate in and take leadership in change -- rather than change always "happening" to us -- we need to be attentive to the dynamics of it. What need, problem or opportunity is the change based on? How carefully and thoughtfully has the need, problem or opportunity been examined? What are the risks involved? What will the consequences and benefits of the change be? What support is needed?

To begin our examination of change, may I ask that you take the next few minutes to think about a change you have made fairly recently. Think about what precipitated it, what helped you, what were problems, and what the consequences and benefits were.

(TAC members worked individually, then shared in pairs, and finally shared in plenary).

Results of Large Group Sharing

Deciding to Make a Personal or Professional Change: Helping and Hindering Factors

A. Helping Factors	B. Hindering Factors
<u>Courage to plan something new</u> Peer pressure analysis and	<u>Lack of time as a resource</u> Fear of loss of what you had
Understanding purpose 7 kids, economic situation, job in FP, decided to	Reform or revolution Didn't consult involved persons family
Alternative to current yield of the change situation Setting a goal, economic situation	What will happen to ...? Difficulties in saving
Participation of/encouragement from other people, faith in you or others Economic situation, worked with someone else	Self-doubt
Encouragement Support/help from elders	A different point of view Opposition, may be

Lecturette on Review of Primary Health Care

Primary health care is the philosophical and program basis of our work. In my opinion, we are on the right track with primary health care, with its emphases on prevention, community-level action and basic interventions. Let us briefly review the philosophy, approaches, and components.

Visual I

Primary Health Care Frame of Reference

Primary Health Care is "Essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford."

The Components/Elements of PHC are:

- Prevention and control of communicable and endemic diseases.
- Sufficient and safe water supply and basic sanitation
- Improved nutritional status through improvement in food supply and proper nutrition.
- MCH services, including family planning.
- Prevention and control of diarrheal diseases.
- Health education and health information.
- Provision of essential medicines.
- Treatment of common diseases and injuries.

Visual II

Primary Health Care

What it is, What it does, How it Works

- Is both curative and preventive
- Is multi-sectoral, multi-disciplinary
- Is decentralized
- Involves communities in identifying and solving problems they identify
- Is provided closest to where people live
- Screening takes place at lowest level of health care system
- Uses auxiliary and community workers for services, education and information

Good ideas, we agree. Integration, however, has been difficult. My diagnosis is that integration like community participation is accepted at the idea level, but as behaviors they require very profound changes in the status

quo. And, not surprisingly, this has been at the heart of the problem. Neither funding sources nor entrenched leadership has basically acknowledged what integration requires.

The leadership of primary health care is typically centralized and medicalized, the antitheses of PHC. It is certainly true that one has to start somewhere, but for how long must we be at the starting blocks of centralization and hospital-based programs?

What have we learned from the past?

1. We must make an accurate and comprehensive assessment of the extent of unmet needs for services and where those needs exist -- and why those needs exist.
2. We need to think strategically and realistically: how can we target services to underserved and unserved groups and what results should we expect?
3. The leadership -- health and political -- must be committed philosophically and actively so that sufficient resources are made available to achieve results.
4. Program management must be intervention-oriented, strategic in its thinking, skilled in translating ideas into informed action, and flexible to change when change is indicated and resources must be re-directed, accordingly.
5. When we are uncertain about probable outcomes, we should try ideas out small.

Small is definitely beautiful in this case. The mistakes are small, the risks are small, the potential is great.

What are the current realities?

1. Fiscal austerity.
2. Funding streams tend to compartmentalize programs, promote competition and fragmentation, and lead to jealousy and petty feifdoms.
3. Incorrect, inaccurate, incomplete, or incomprehensible conception of problems that programs are expected to resolve resulting in unrealistic objectives, based on faulty assumptions and lack of realism about what can be accomplished in the time and with the resources allocated.

4. Failure to include beneficiaries and other sectors in planning, although they will be expected to be involved in implementation and in sanctions and program promotion.
5. Bureaucratic lags and snags that sap implementors' energies and lower morale.
6. Retirement and promotion policies and practices that do not reward skills, experience and results.
7. Lack of attention to cultural and linguistic features of the people to be served, and their expectations about acceptable and accessible services.
8. Civil and political disruptions that cause adverse impact on services, not resolvable by a return to peace; there are orphans, dislocated families, refugees, urban migrants seeking safety, old people left alone, and not enough to eat and no place to live.

All of those factors result in people not being served at the level of quality we consider optimal, that we value, and that people should be getting.

Our job as MCH, FP and training leaders is to figure out how to surmount these impediments, make the most out of little or nothing in the way of resources, turn problems into opportunities, and have a vision and work toward that vision. There will never be enough money, enough time or enough persons to do the job 100%.

Lecturette on Integration in MCH/FP

The position of every government represented here is that FP and MCH services will be integrated. For those in vertical FP programs that has meant promotion of FP in existing MCH services, IEC and training. Yet we find that the MCH service system is quite incomplete in scope, inaccessible, sometimes unacceptable to clients and sometimes poorly staffed. From the perspective of those who provide services, clients for MCH and FP are one and the same: mothers who bring their children for immunization are potential clients for family planning -- why is it that they, in fact, are not actual FP clients?

Very few health personnel in so-called integrated services behave in an integrated fashion. This owes, no doubt, to lack of integration in the mind. Their preparation, their supervision, their supplies, their reporting forms, their clinic facilities, and so on have all contributed to vertical thinking and subsequent vertical service provision. We in family planning have also made a contribution to this verticality: our services and training programs rarely reflect the MCH linkages with family planning. We easily see how other vertical programs can help us, but the reverse?

What are the components of MCH services, in fact?

What are the accompanying behaviors of MCH/FP personnel that can promote integration of those services?

Lecturette on Modes, Quantity and Quality of Services in MCH/FP

Three interrelated factors in our efforts to make MCH/FP services more accessible, acceptable and available have to do with the location, quantity, and quality of services. We believe that a variety of service modes, in sufficient quantity, and of high quality will contribute to wider coverage of those currently underserved and unserved.

Service Quantity

What is known about who is being served, who is underserved, who is unserved? Where should services be located? How many to be served at each locale? Should all sites provide the full range of services? Which sites should provide which type of service?

With what frequency should services be offered: days, hours?

What types of providers are needed: type, numbers, cultural and linguistic requirements?

What must be done to supply and equip service sites? service providers?

How will potential clients know where the services are, which ones are where, when the services are available, what they have to do/be to qualify for services? Who should be involved in client outreach?

Service Quantity Factors

- How many persons to be served?
- Where are they? What is known about who is being served, who is under-served? who is unserved?
- Where should services be located?
- Should all sites provide the full range of services? Which sites should provide which services?
- How many persons to be served at each site?
- With what frequency should services be offered?
- What kinds and how many providers should be at each site?
- What cultural and linguistic similarities should be sought?

- What and where is most reliable supply source? What equipment and supplies are needed?
- How are clients to know which services are where, the frequency, and any eligibility requirements?

Service Delivery Modes

- Community based: room, school, community hall, small shop, under a tree, house-to-house
- Commercial pharmacies
- Industrial health units
- Public and private clinics
- Hospital out-patient units
- Bedside in hospitals
- Mothers' centers
- Storefront/"Depot"

Service Quality (Adapted from A. Jain)

Choice: The number of methods offered on a consistent basis so that all types of clients are competently served. The minimum and optimal levels of methods that program should offer, and management capabilities that will assist users to switch easily among available methods.

Information to Users:

1. Information given about methods available and where to go for methods that are not available at the site visited.
2. Information about contraindications, risks and benefits of various methods.
3. Information on how to use the methods, the potential side effects and how to manage them.
4. Information about what users can expect from service providers regarding advice, support, supply and referral to other services, if needed/perceived.

Provider Competence: Skills and experience of providers including their use of sterile technique during IUD insertion and administration of injectibles.

Client/Provider Relations: Perceived and received effective content of contacts between providers and clients and potential clients. Clients should feel positive about the service system, particularly about the personnel with whom they interact, and should trust their capacity and their good will. If management is equally concerned about these positive relationships, the results should be an optimal number and type of providers at each site, adequate training and updates for the providers, helpful supervision, and timely and sufficient quantities of supplies and basic equipment. The condition of the facility and its cleanliness also affect the clients' satisfaction with the competence of service providers.

Re-Contact and Follow-up Mechanisms: The program's interest in and ability to promote continuity of use, through helping well-informed users to manage on their own, or through formal mechanisms that help others.

Appropriate Constellation of Services: Situating services so they are acceptable and convenient to users: see Modes.

Given these quality factors, and their relationship to the modes of service and the quantity of services, why don't people use services? What can be done about it?

APPENDIX D.2

**Group Discussion Results on MCH/FP Services
(Group Tasks 1-2)**

General Components of MCH/FP to Services

ANTENATAL CARE

Examples of parts of ANC component:

- Screening for high risk and referring special high risk cases
- Routine examinations, laboratory examinations
- Monitoring pregnancy progress
- Health information and education about pregnancy, high risk factors, nutrition, breastfeeding, personal and environmental hygiene, preparation in safe delivery, family planning, spacing, care of newborn.
- Supplemental food
- Mother craft skills
- Record keeping

Labor and delivery

Follow-up after delivery

Post-natal care

Child care

Family Planning

Infertility screening and counselling

Screening for gyn. problems

Screening for STDs including AIDS, and treatment for minor STDs

AIDS education/information

Referrals for ... to ...

Follow-up of ...

GROUP TASK 2

LARGE GROUP DISCUSSION RESULTS

WHY DON'T PEOPLE USE MCH/FP SERVICES?	WHAT SHOULD BE DONE TO IMPROVE SITUATION?
Community has mis-conceptions about the services.	Health educate Give correct information
Taboos, cultural and religious beliefs.	Learn what they are: Use positives, discourage negatives
Providers don't know cultural beliefs of the people	Use community resources to learn, more community involvement in planning, give formal orientation to providers.
Lack of adequate information to the public about services	Intensify and diversify IEC
Poor relationship between provider and clients	Strengthen training and practice in interpersonal communication, change current teaching methods to more community exposure, better feedback from supervisors.
Provider attitudes and behaviour cold, disinterested sometimes hostile to FP	
Private/public/GNO/parastatal coordination poor	
Lack of commitment from leadership affecting staffing, policies, training, morale, supplies	

Service priorities are not community priorities or individual client/family priorities.

Services are fragmented	Utilize community level for some services
Range of services too narrow	Improve PHC integration
Lack of community involvement in planning services	Get communities involved
Service hours not convenient to clients	Work with community to agree on service hours - Revolutionize work schedules
Waiting time too long	
Lack of privacy and confidentiality	Improve clinic lay out and client flow
Inadequate supplies of medicines	
Client recruitment procedures poor	
Lack of follow up mechanism	
Provider skills are inadequate	Update, refresh: IST and on-the-job. Change PST
Staff shortages	Mobilize multi-sector Multi-discipline
Staff overworked low morale	
Services poorly organized	

Lack of policies, standards,
and procedures to guide providers
who then feel frustrated.

APPENDIX E

Group Discussion on Why did Mrs. X Die?

- Group Task 1: Why did Mrs. X Die?
- Group Task 2: What each system should do
- Group Task 3: What it would feel like to have integrated services

Group Task 1

Why did Mrs. X Die? - Video Film (Who)

Group Work Result

- Poor MCH/FP services
- She had no information on high risk factors or on FP
- Nutrition education inadequate
- Lack of outreach services
- Lack of community participation in case finding
- Lack of monitoring in pregnancy; no timely interventions
- Inadequate hospital care
- Lack of AN care
- Lack of FP
- She couldn't read or write
- Lack of transport to hospital
- She was poor, lived/born in a poor community
- Too far from hospital
- Roads poor
- Husband poor and not connected to information

Was anyone there in her community to help her at time of labor, during her pregnancy, during screening?

Was there any emergency set up in her community?

Hospital may not be able to manage emergencies.

No blood in the blood bank.

May be a coincidence?

May be acceptable or gift of blood not culturally acceptable.

Untreated anemia.

No follow-up system to find her.

Ended to death because: all of the above.

History of earlier bleeding episodes obtained when it was too late to refer her to hospital.

Risk factors: She had all of them.

2. Who was Responsible for the Death of Mrs. X?

Husband

Mrs. X herself

Doctor

Blood Bank

MOH

Community

Relatives

Her own children

Hospital Administrator

Religious persons: didn't inform her about health matters

Donor agencies

Nurse/midwives

Traditional practitioner

TBAs

Ministry of Transport

GROUP TASK 2SUMMARY OF POLICY SERVICE PST-IST FISH BOWL1. HOW WOULD PST SYSTEM CONTRIBUTE TO PREVENTING DEATH OF OTHER MRS X'S ?PST

T.N.A to determine who to be trained.

- o Revise curricula to include:-
 - community assessment knowledge/skills.
 - community orientation
 - change from hospital based to community based training
 - totality of training - integration
- o PST trainees - what are the right mix? what *cadres* need to be trained together?
- o Involve trainees/service providers in T.N.A.
- o Involve service providers in curriculum revision
- o Trainers - review their skills in training for PHC service sites
- o Follow up and evaluation of graduates.
- o Provide input to IST on areas of IST concentration focus.
- o Supervisors to be re-oriented to integrate MCH/FP - PHC approach.
- o Familiarization of PST programmes to service delivery modes/systems.
- o Use multi-sectoral personnel as PST resource
- o Establish links between different PST e.g professional and TBA/CHW.

2. WHAT WOULD POLICY SYSTEM DO TO PREVENT DEATH OF OTHER MRS X's?

POLICY

- o Clear definition of MOH policies regarding PHC.
- o Clear definition of policies on what integrated approach means and include who is involved e.g multisectoral composition.
- o Clear definition of multisectoral mix and functions at National, district and grass-root level;.
- o Define policies to guide deployment of staff and Health information systems.
- o Play advocacy role at MOH and strengthen support to provinces with training, materials/supplies.
- o Obtain input on needs from all levels before planning.

3. WHAT WOULD SERVICE (S) SYSTEMS DO TO PREVENT DEATH OF MRS X's?

- a) Conduct community needs assessment to find out who is served, who is not served, what are the needs.
- b) Provide a service for creating awareness in the community for importance of specified MCH/FP services.
- c) Establish CBHS services in a comprehensive way.
- d) Identify existing structure and resources.
 - who are the service providers
 - what extra skills do they require to function adequately to meet new needs.
 - Involve community in selection of the trainees and personnel.
- e) Strengthen tertiary care system to cope with referrals and emergency services (Manpower, Blood Bank, facilities).

4. WHAT WOULD IST DO TO PREVENT DEATH OF MRS X?

IST

1. Conduct T.N.A
2. Assess impact of PST in community practices.
3. Review curriculum with PST and S where to concentrate on IST training.
 - focus on content of early identification of high risk.
4. Involve community development for input in curriculum.
5. Aim at integration curriculum that incorporate TBAs
6. Monitor progress and follow-up.
7. Identify who else to assist in training. What training needs do they have, and plan to meet these through IST.
8. Liaise with service on types of existing follow-up.
9. Provide hardware resources for client follow up.
10. Ensure service providers ^{KNOW} who when and where to refer.
11. Provide a support system for graduates.
12. Provide a community orientation to trainees.

GROUP TASK 3

BRAINSTORMING IN LARGE GROUP

IF SERVICES WERE FULLY INTEGRATED : HOW WOULD IT FEEL LIKE?

Feels good to see benefits to others

Challenged to keep things going/moving

Feel less pressure in hospitals so I can do my own work there.

Half of health problems would be dealt with.

Job improved: Satisfied and interested.

Time to think of improvements.

Feel good that training is having impact.

APPENDIX F.1

Case Studies 1-3, and Group Products

EXPLORING CHANGES REQUIRED IN SERVICE DELIVERY MODES,
SETTINGS, SERVICE PROVIDERS FOR TRUE MCH/FP INTEGRATION

CASE STUDY 1

- (i) A team of key personnel in N country charged with service and training responsibilities for integrated MCH/FP services has set aside 5 days for the purpose of planning integrated MCH/FP service for a 5 year plan period.

The team, under the chairmanship of MOH/FP director, is determined to implement the national goal of providing integrated MCH/FP services in the context of primary health care. As a first step, the team decides to review existing MCH/FP service policy guidelines for clarity and as a basis for planning the services and training. One such policy guideline, written in the national development plan, states that an integrated MCH/FP service site will cover every 1,000 population.

The first question the team decides to answer is: What is the interpretation of this policy guideline/service standard in the establishment of integrated MCH/FP quality and quantity services for populations with characteristics such as the following.

URBAN SLUM

- o High density 1,600 persons per sq. km.
- o Shelter - temporary housing
- o High degree of mobility/migration.
- o Food difficult to obtain
- o Population 200,000 out of 2.m in the city
- o Many traditional healers
- o Pit latrines over flowing and so not used
- o People buy unprescribed medications for common treatments.
- o TBA not trained by MOH
- o STD a big problem in adolescents and adults.
- o Many parasitic infections

MCH/FP INTEGRATION IN URBAN SLUM/HIGH DENSITY

Components of a Truly Integrated MCH/FP Service for this Community

- o Health Education - all PHC aspects.
- o Ante-natal care
 - immunisation
 - provision of essential drugs
 - treatment of common diseases e.g kwashiorkor, (PCM) diarrhoea and vomiting.
 - STD screening
- o Labour and delivery care
- o Post natal care
 - FP
- o Child care
 - diarrhoea control
 - treatment of common diseases
 - nutrition supplement
 - immunisation
 - family planning
 - HE on home accident prevention
- o Family Planning
 - STD screening and treatment
 - Prevention and control of communicable and endemic diseases.
 - Infertility service
 - Control of diarrhoeal diseases
 - Nutrition
 - Immunisation
 - Screening as a preventive measure
- o Referral and follow up

NB: Use PHC as focus and show which MCH/FP components are relevant.
- o Municipality

(URBAN, SLUM, OVERCROWDED, MANY PARASITIC INFECTIONS)

SELECTED COMPONENT

FAMILY PLANNING

- o Family Planning IEC to motivate clients - increased FP acceptance.
- o Health Education in STDs, AIDS, Immunization, CDD, CDC, Personal and environmental hygiene, Nutrition, safe water, and safe medication doses.

NB: H/E will be related to family planning and vice versa.

- o Consult and work with Ministry of Education, Agriculture, and social workers in planning, conducting and evaluating H/E

Target groups

Adolescents, men and women.
Women in reproductive age

- o Training of
 - Service providers
 - CHWS
 - Other community workers
 - TBAs, herbalists, traditional healers
 - Medicine stores-keepers
 - Shopkeepers
- o Screening patients/clients for STDs, infertility, nutritional diseases e.g. kwashiorkor and other illness.
- o Counselling
 - adolescents
 - FP clients for methods
 - AIDS victims
 - Menopausal women
- o Assessment of patients/clients for treatment of common conditions and FP methods.
- o Provision of FP methods
 - use of mobile clinics
 - static clinics
 - CBD
 - shops or other strategic places for condoms distribution

FL

- o Immunization against the 6 immunizable diseases and T.T for women in the reproductive age.
- o Treatment of minor common diseases and complications.
- o Management of services e.g supplies, equipment and record keeping.
- o Referrals and follow up of patients/clients including drop outs.

OTHER RELATED SERVICES

- o Improvement of housing
 - consult municipality authorities
 - involve local community leaders
 - involve religious leaders.
- o Encourage income activities and cooperative activities.
- o Case finding for diseases e.g T.B and others (because of density and the high degree of mobility/migration into and out of the area)
- o Consultation with MOA for encouraging food production and supplementary foods from NGOs.
- o Provision of condoms through vending machines and strategic places like bars to prevent STD and AIDS.
- o Liaise with municipality to provide safe water points and security lights to curb.
- o Liaise with the public health department to assist the community in construction of VIP latrines or deal with the filled ones.

The Urban/High Density Community: What should be the service settings; Who should be the service providers; What should be the service delivery modes?

<u>What Part</u> FP	<u>Where</u> (Site and time)	<u>Who</u>
Provision of FP methods.	o Clinic (NGO) 8.00-600	N/M, MD MA/CO
- pills	o Drug store (shop) 8.00-10.00	Shopkeeper Pharmacist
- injectable		
- IUCD	o Homes anytime suitable	TBA, CHW Housewife
- vaginal spermicides		
- tubal ligation/ vasectomy	o Market 6.00-6.00pm	Womens group Youth group
- condoms		
- CMM (NFP)	o School and other workplaces up to midnight	School teacher
	o Bars	Bar men and women
	o Under a tree (except when raining) 8.00 - 6.00 pm	TBA, CHW, N/M
	o Traditional healers home 24 hours (on call)	-Traditional healer - Volunteer (church or mosque)
	o Local beer site	Brewers
	o Static/mobile community based including social marketing.	- N/M, MA/CO /MD - Women - CHW

CASE STUDY - 2

- (i) A team of key personnel in N country charged with service and training responsibilities for integrated MCH/FP services has set aside 5 days for the purpose of planning integrated MCH/FP service for a 5 year plan period.

The team, under the chairmanship of MOH/FP director, is determined to implement the national goal of providing integrated MCH/FP services in the context of primary health care. As a first step, the team decides to review existing MCH/FP service policy guidelines for clarity and as a basis for planning the services and training. One such policy guideline, written in the national development plan, states that an integrated MCH/FP service site will cover every 1,000 population.

The first question the team decides to answer is: What is the interpretation of this policy guideline/service standard in the establishment of integrated MCH/FP quality and quantity services for populations with characteristics such as the following.

B. RURAL

- Scattered villages (5-10 persons per sq.km)
- Population mainly herdsmen who move from place to place in search of pasture along with their families.
- Earth roads, people mainly walk.
- Motorised transport rare - weekly transport between one major town to another.
- No electricity
- No piped water supply - area generally dry
- Income available only if cattle sold
- High level of safety and security
- Food scarce
- Some older male children (14-17 yrs) go to boarding schools.

- Smaller children do not generally go to school.
- TBA are operating in area (not trained by MOH).
- No CHW
- Temporary housing
- Health post (dispensary) available at administrative headquarters.
- Occasional mobile tuberculosis Program teams visit depending on where families are living at any one time Location changes from time to time.

(ii) Working step by step the team has first to agree on what should be the components of an integrated MCH/FP services.

- a. What should be the components/elements of an MCH/FP service that is truly integrated - which means:
- o uses a PHC framework
 - o one component is not more prominent than another unless it is based on a specific, widespread problem in the area.
 - o all of the service providers share a common purpose.
 - o designated service providers transfer skills for multiplier effect.
 - o providers and community consult to establish priorities service modes, service range and service quality standards.

GROUP 

COMPONENTS OF TRULY/INTEGRATED MCH/FP SERVICES

IN LOW DENSITY, PASTORAL, SCATTERED, NO WATER, PEOPLE MOVE WITH CATTLE COMMUNITY

- o Initial and continuing needs assessment
- o Collaboration for technical and other help from Ministries of Education, Transport, Communication, Water Supply, Planning, Finance, Community Development, Agriculture, Veterinary.
- o Promotion of safe, traditional practices
- o Health education (include IEC)
- o Reliable water supply for people and cattle
- o Animal husbandry and veterinary services.
- o Referral source: Improve health post
- o Antenatal, labor and delivery care for women and cattle
- o Post natal care
- o Immunization for women, children and animals
- o Food production appropriate to climate
- o Improved food preservation and storage
- o Income generating activities for women
- o Primary and nursery schools and hostel
- o School health
- o Child nutrition and family life education
- o Child care
- o Promotion of breastfeeding
- o Family planning including infertility services
- o TB treatment and control
- o Sanitation services appropriate to climate and water supply

COMPONENT

PART (s)

ANTENATAL, LABOR AND DELIVERY AND POST NATAL

- A. Health Education
1. Family life education that includes risk factors, course of pregnancy, ANC
- boiling of milk, pre-pregnancy counselling
 2. Preparation for pregnancy includes nutrition (what are the good foods) and for labor and delivery.
 3. Personal hygiene as ANC, L & D and during post partum for mother and infant.
 4. Information about FP methods, infertility and STDs
 5. Information about child care
 6. Promote breast feeding
 - * 7. TB prevention, control, treatment information
- B. Find out and promote safe practices relating to ANC, L & D and PNC.
- C. FP methods: Information and provision of mini-pill, condom, breastfeeding
- D. Immunization for ANC and post natal (children) BCG, II, DPT, Measles, Polio.
- E. Referral or high risk ANCs, high risk L & D and complic..... of labor delivery to health post (mothers and newborns) and follow up of referrals.
- F. Provision of safe delivery services
(attended delivery) - women
- cattle
- G. Antenatal screening pregnancy monitoring, treatment of minor illness.
- H. TB treatment and prevention
- I. Post natal exam for mother and baby.
Treatment for problems.
- *J. Outreach for

SERVICE SITES, PROVIDERS AND DELIVERY MODES FOR PASTORAL
NOMADIC SCATTERED COMMUNITY

ANTENATAL	CHARACTERISTICS OF SERVICE SITES	WHO
o Screening, pregnancy monitoring and treatment of anemia bronchitis, cold, treatment of TB and Health Education and Outreach	(Most are 24 hrs/day	
	o Home of client	TBAs (trained)
	o Home of TBA	1 person per family group
	o Homes of traditional healers.	Traditional healers
	o Health post for referrals	CHW, Enrolled nurse, TBA (trained)
	o Watering hole Make shift hut	Mobile TBA Team
	o Village market or square: make shift hut	
	o Health center (2) for referral	N/MW, sanitarian, may be a lab technician
o Communication centers		

CASE STUDY - 3

- (i) A team of key personnel in N country charged with service and training responsibilities for integrated MCH/FP services has set aside 5 days for the purpose of planning integrated MCH/FP service for a 5 year plan period.

The team, under the chairmanship of MOH MCH/FP director, is determined to implement the national goal of providing integrated MCH/FP services in the context of primary health care. As a first step, the team decides to review existing MCH/FP service policy guidelines for clarity and as a basis for planning services and training. One such policy guideline, written in the national development plan, states that an integrated MCH/FP service site will cover every 20,000 population.

The first question the team decides to answer is: What is the interpretation of this policy guideline/service standard in the establishment of integrated MCH/FP quality and quantity services for populations with characteristics such as the following.

C. RURAL

- High density (500 persons per sq.km)
- High yields of sugarcane and cotton from large and small scale farming.
- Two thirds of population made up of women and children.
- Men mainly employed at the few sugar and cotton industrial factories.
- Few all weather roads, mostly earth/sand roads
- Transport - public transport along all weather roads (day service only) bicycles, walking, donkey carts.
- Heavy rainfall, seasonal rivers, few bridges, tendency to flooding.
- Endemic malaria, trypanosomiasis and worm infestation
- Adequate food and shelter

- Children many or may not be attending school
- Health services: some MOH hospitals and dispensaries, private clinics, traditional healers, sugar factories health clinics, and untrained TBAs. There are no CHWs.
- Piped water and electricity only in major towns.
- Financial income a one time event depending on cash crop yields.
- Population with characteristics similar to above represent 60% of the total population of 22 million in the country,

(ii) Working step by step the team has first to agree on what should be the components of an integrated MCH/FP services.

- a. What should be the components/elements of an MCH/FP service that is truly integrated, which means:
- o uses a PHC framework
 - o one component is not more prominent than another unless it is based on a specific, widespread problem in the area.
 - o all of the service providers share a common purpose.
 - o designated service providers transfer skills for multiplier effect.
 - o providers and community consult to establish priorities service modes, service range and service quality standards.

CASE STUDY

GROUP 3I

COMPONENTS OF TRULY INTEGRATED MCH/FP SERVICES IN A RURAL
DENSELY POPULATED COMMUNITY

- o Antenatal care, labor and delivery
- o Immunizations and growth monitoring
- o Family planning
- o Treatment and control of
 - malaria
 - parasitic infections
 - trypanosomiasis
- o Environmental health and sanitation
- o Provision of safe water supply
- o Post natal care
- o Health education
- o Nutrition education
- o provision of essential drugs

OTHER COMPONENTS IMPLIED

- o Control of communicable diseases
- o Treatment of minor ailments
- o Occupational health
- o Training

SELECTED COMPONENT: FAMILY PLANNING

- o Needs assessment for FP
- o IEC: Information on benefits and advantages of FP and general health education
 - control of malaria, trypanosomiasis
 - environmental hygiene, parasites
 - nutrition etc
 - AIDS
- o Recruitment of clients
- o Counselling of clients
- o Screening/examination of clients
- o Provision of FP services/treatment or referral for existing complaints.
- o Treatment of STD
- o Follow up/tracing of defaulters
- o Supervision of service providers
- o Infertility services
- o Record keeping
- o In service training

SERVICE SITES, PROVIDERS AND DELIVERY MODES FOR RURAL,
HIGH DENSITY COMMUNITY

TARGET	SITES	WHO GIVES INFORMATION
Women young mother old mothers	Individual homes Village centers Women's clubs Clinic	Midwives, Nurse Midwives, Women leaders, Commercial workers, Doctors/TBA Religious leaders, FP field workers, PH environmental officer, Nutrition technicians
Men	Sugar/cotton plantations, Industries, Churches, Mosques, Organized meeting, Centres, Homes Agricultural Shows Public vehicles	Doctors, Nurse Midwives, Religious leaders, community Ext. workers, Men, Community leaders, Trade unions, spouses, environmental officer, traditional healers.
Employers	Plantations, factory officers, clubs, industries	Doctors, nurse midwives, colleagues, FP field workers, spouses, professional associates.
TBAs/Healers	Homes clinics	EHO, Nutrition technicians
Decision makers in community	Homes, Village meeting Places	FP field workers Doctors, Religious leaders, colleagues
Religious leaders	Homes, Church halls, offices	FP field workers Doctors, Nurse midwives, colleagues, spouses.
Youths	Schools, Youth clubs, centres Churches, Mosques Homes	Teachers, parents, nurse midwives, Youth leaders, religious leaders.
FP providers	Health facilities Homes, Professional meetings	Doctors, Colleagues Consultants
Taxi/Bus drivers	Taxis, buses	Association leaders

APPENDIX F.2

Insights/Implications from the Case Studies

INSIGHTS/IMPLICATIONS DRAWN FROM THE CASE STUDIES

INTEGRATED MCH/FP SERVICES

1. Current country-level MCH/FP components appear to be guidelines to be used or interpreted according to the needs of the people, place and situation
2. Establishment of integrated MCH/FP services required:
 - a) Time to think about what's going on in policy and in a place.
 - b) Tailoring priority MCH/FP components to the situation.
 - c) Tailoring the range of the services to the situation, as well as the service sources and the service providers.
3. MCH service is not just ANC, child health, PNC, but is a complex of services including all aspects of health.
4. Currently, there are unintegrated services, but not by deliberate design/planning.
5. Planning for MCH/FP service has not included service providers.
6. It also seems that Integrated MCH/FP Services :
 - o Are concerned with the total well-being of the client.
 - o Occur in a variety of settings.
 - o Provide for basic needs; focus on community needs.
 - o Produce aware informed clients.
 - o Encourage client independence
 - o Take more than 1 sector or 1 discipline to plan and deliver.
 - o Depart from past / SOP and thinking.
 - o Demand service providers who act and behave in "an integrated" way in the course of MCH/FP service provision

7. In a system of integrated MCH/FP services everyone has opportunity to be a provider and a recipient. Consider who should/can participate in:
- Assessment of community needs, problems, opportunities.
 - Planning of service range, service sources, who will provide what and when.
 - Identification of prevailing beliefs, practices, traditions and reinforcement of the positives while discouraging the negatives.
 - Orientation and training of providers.
 - Health education/IEC.
 - Outreach
 - Follow up
 - Service delivery
 - Service evaluation
 - Inter-sectoral activities

APPENDIX G

**INTRAH Observations of Lessons Learned
from Training Experience in the Region**

TRAINING

INTRAH TRAINING OBSERVATIONS (LESSONS LEARNED)

Best results achieved when:

- o training is directed towards post training functions; trainee selection and post training placement are guided by post training functions.

When no deliberate effort is made to seek service feedback on training performance and also community input in identification of training needs, training becomes inappropriate - specifically -

- o It remains ^{the} same even when recipients needs and demands change.
- o IST always catching up with the deficiencies of PST.
- o PST misses opportunities for change
- o IST programs become unnecessarily long and fail to address emerging needs.
- o Duplication of training continues.
- o Most service programs give no indicated performance targets; training also does not prepare personnel in that direction.
- o Many changes occur in service areas. Effective mechanisms of communicating changes in service arena to training do not exist. Results are:
 - inappropriate training
 - inadequate personnel
- o Trainers/tutors are removed from service settings.

Do not have access to update on changes in service demands yet expected to effect change in training and ultimately in service.

POINTS ABOUT PROPER TRAINING

- o Is directed towards specific expected service results
- o Is guided by service quality and quantity expectations in the achievement of the health goal.
- o Results are measured not in number trained but the effects those trained have on service recipients and the service as a whole.
- o Is a means not an end
- o Like Mrs. X, walks through a path leading either to expected performance results or to performance death.

APPENDIX H

Results of Large and Small Group
Discussion of Truly Integrated
MCH/FP Services on PST and IST

GROUP TASK 1

LARGE GROUP DISCUSSION RESULTS

WHAT ARE IMPLICATIONS FOR TRAINING IN RESPECT TO INSIGHTS AND CONCEPT OF TRULY INTEGRATED MCH/FP SERVICES ?

Training for MCH/FP Integration has implications for policies in respect to :-

- o Re-orientation in selection of trainees to include multi-sectoral approach.
- o Who are to be the trainers?
- o Training has to go outside the classroom setting and the usual institutions.
- o Wide range of trainers required.
- o Decentralization of training crucial
- o Training materials to suit situations.
- o Re-orientation of training of current nursing/midwifery and medical personnel to local situations.

Training for integrated services

- o Needs - skills - means equipment - placement
- o Elements of service integration in service in a variety of settings
- o Internalization of integration
- o Content and orientation of training has to change
- o Supervisors expectations

GROUP TASK 2

PST GROUP 1

Nurse/Midwife

Training selection

- A. Academic performance
- B. Geographical representation
- C. Involve community and MCH department e.g formation of criteria for selection.

Trainers and tutors

1. TOT workshop/seminar to re-orient tutors and trainers to MCH/FP integration (KAP skills).
2. Change curricula of trainers/tutors to include MCH/FP integration.
3. Inter-sectoral training encouraged e.g Agriculture, water, etc.

Curricula

Content, organisation and method change from tailored curricula to one that meets the need of community i.e MCH/FP integration.

GROUP TASK 2

PST GROUP 2

IDEAS

Curriculum

Include community needs assessment as a subject and practicum

Result: Community needs likely to be identified to be included in curriculum and service.

Include the ideas of other sectors and what they do in the curriculum.

Include graduates ideas in the curriculum.

Establish baseline of students (entry level knowledge, interests ideas, skills).

Multi-disciplinary content + practice that permits multi-disciplinary training.

Update, revise per - policy
- new approaches
- materials
- feedback

Tutors and trainers

1. Re-orient tutors and trainers
2. Tutors will serve on community
3. Job descriptions need to be changed.
4. Identify and get support/money for action research that will involve tutors in communities.

Frequency

PST institutions should provide continuing education to graduates and obtain ideas of graduates for curriculum update. Include IST trainer in the instructional program.

Graduate follow up

1. Figure out how to use service personnel to follow up and provide feedback to PST institution.
2. Tutors to initiate graduate follow up.

TASK 2

GROUP 2

Supervision

1. Train service people as preceptors for student field placements.
2. Tutors to be attached to field placements.

Measurement

1. Community in which student was/is placed will evaluate student performance. Service personnel will also evaluate.
2. Results of evaluation will be communicated to PST institution as a measure of performance achievement and curriculum effectiveness.
3. Student self assessment and faculty evaluation.

Student recruitment

PST institutions should present the purpose and content of the PST program and the outcomes of it. what you do, Career ladder, what is expected.

Entry requirements

The PST institution should establish academic and professional entry/selection criteria which will be shared during recruitment.

GROUP TASK 2

GROUP 3

CHANGES THAT NEED TO OCCUR FOR INTEGRATION TO BE
EFFECTIVE

1. POLICY - clearly defined policy on the changes to take place e.g involvement of non health personnel.
 - policy of who will do what, where
 - decentralization of training
 - post training functions of trainers and trainees
2. IMPLEMENTATION OF TRAINING
 - Curriculum changes
 - Development of appropriate teaching materials
 - establish linkages and feedback
3. TRAINERS - Establish criteria for selection, re-orientation
4. TRAINEES - Establish criteria for selection
5. COMMUNITY - Re-orientation/involvement in planning and implementation
6. RECIPIENTS - Re-orientation

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GROUP 2: IST

TBA TRAINING

Antenatal screening pregnancy monitoring, treatment of Anemia/Bronchitis/TB and Health Education and outreach and referrals.

IMPLICATIONS

PST

Introduce TBA functions/responsibilities to the cadre who will train them (on continuing basis):

- train them to train
- have the students with the TBAs during community placement

Needs assessment to know what the practices are

- could be done by trainers prior to training.
- could be done by students' field placements

IST

Train TBA to screen pregnant women for high risk. Treat minor illness.

Provide health education in nutrition, personal hygiene, preparation for delivery and for newborn care.

Encourage breast-feeding to promote FP.

Train N/MWs/MCH Aides to train TBAs.

APPENDIX I

Recommendations to PST and IST Systems

fb

RECOMMENDATIONS TO PST SYSTEM AND ASSISTANCE REQUIREMENTS

PST (GROUP 1)

RECOMMENDATIONS

1. Needs Assessment for all PST training programmes to be conducted.
2. Identify all those requiring training.

Curriculum

3. Strengthen MCH/FP content in PST
4. Increase time for theory, field work and clinical exposure using integrated approach in PST and IST.
5. Policy changes
 - guidelines
 - support) technical
 financial
6. Programme implementation
 - new integrated approach.

PST SYSTEM

RECOMMENDATIONS

1. Train the tutors/trainers in community needs assessment.
2. Introduce community needs assessment as a subject in the curriculum.
3. Revise the current PST curriculum to reflect the needs/hopes/aspirations of the country.
4. Training of PST should be changed from hospital/institution to community.
5. Development of new curricula for new types of workers.

6. Curricula should have multi disciplinary content and practicum, with in PHC framework.
7. Selection of students should
 - start with community input about desired characteristics of service providers.
 - also depends on meeting selection criteria
8. Re-orientation of tutors/trainers on concept of integrated MCH/FP: need skills, need materials.
9. Establish a feedback mechanism and develop a tool from the field to PST.
10. Revise tutors curriculum to enable them train others for MCH/FP integration
11. Measure the impact of the revised curriculum on ?(TBD)
 - a. how to measure? Indicators
 - b. skills to measure
12. Tutors and trainers should get funds, time, other-support to conduct community level operational research

Assistance in

1. Curriculum development
2. Production of materials
3. Community needs assessment skills
4. Re-orientation of tutors, trainers



IST (GROUP 2)

RECOMMENDATIONS TO IST

CHANGES IN IST

I. Trainee selection

- o A collaborative two way process by IST-service staff - IST initiator of the process.
- o Develop selection criteria as IST/S team to cater for:
 - post training functions
 - community needs
 - technology change
 - trainees K.A.S and expectations
 - who identifies and/or actually select

II. Trainers/tutors

- o Trainer's participate in clinic/community or appropriate multisector oriented field service.
- o PST/IST trainers must be competent in MCH/FP integration skills and other IST related skills (FP)
- o Service providers trained as preceptors through an organised systematic, on the job skills and attitude training.
- o A formal feedback mechanism of IST/PST/S to be established.

III. Curriculum

- o To enable a multiplier effect and establishment of decentralising curriculum implementation.
 - IST trainee for MCH/FP integration include preceptorship skills (where necessary)
- o Orientation/training of appropriate multisector curriculum designer to MCH/FP integration and curriculum development process.
- o Curriculum to reflect multi-sectoral approach to MCH/FP integration.

IV. Frequency of training

Should respond to:

- o Number of people to be trained.
- o Types of trainees
- o Policy changes e.g on MCH/FP integration
- o Community needs
- o Technology change
- o To allow review of curriculum materials used, facilities, mechanisms, design and use of follow up to system and tools and use of results from review and follow up.

TRAINEE FOLLOW UP AND SUPERVISION

- o Allow collaboration time (PST, IST and multisectoral agencies) system and formal mechanism developed.
- o Team consist of IST/service supervisors.
- o Preparation in follow up skills for both IST and service supervisors.
- o Tools to be used.
- o Include trainees own perception of competence.
- o Develop feedback mechanism (IST - S)
- o measuring training performance results.
 - define how MCH/FP integration skills, attitudes and knowledge will be measured (e.g in which component or part of MCH/FP, when during training.
 - Team approach (multisectoral) in developing a strategy for using results.
 - Incorporate in planning, conducting refresher/update courses.

RECOMMENDATIONS TO IST SYSTEM AND ASSISTANCE REQUIREMENTS

IST GROUP(3)

I. Selection of the trainees to IST

1. There should be a multi-sectoral IST/S committee to select trainee for in service training using a set of criteria.
2. The IST initiate the appointment of the selection committee.

II. Trainers and Tutors

1. The inservice program for tutors should be instituted to orient them to the integrated approach.
2. The tutor/trainer curriculum should be revised to include the concept of integration in training and service delivery.
3. Formal feedback mechanism between PST/IST and service should be established.
4. A mechanism should be designed to prepare service providers to provide practical instruction.

Curriculum

1. The revised and new curricula should address the integrated MCH/FP post-training functions of the trainees.
2. The curriculum designers to be multisectoral and be prepared in the integrated approach.

III. Technical Assistance

1. In the development of an integrated curricula and skills.
2. Training assistance in:
 - a) Training needs assessment
 - b) Training impact evaluation
 - c) Supervisory skills for MCH/FP
 - d) Training materials development skills
 - e) Training in the use of training materials
 - f) Development/revision of procedure manuals; service standards and policy guidelines.
 - g) Development of preceptorship skills.
3. Provision of training materials.
4. Training of trainers.

IV. Frequency of training

1. There should be a policy requiring in-service training for all service providers and the frequency of such training in order to update the knowledge and add on skills.

V. Graduates follow-up

1. Every IST program should have a follow up mechanism of the graduates by trainers and supervisors to reinforce the trainer, trainee and supervisors linkage and assessment of training performance.

VI Supervision

1. Supervisors should receive re-orientation to integration of service.
2. Be prepared in follow up and supervision skills.
3. There should be standadized supervisory tools/check list which should be revised from time to time.
4. There should be a feedback mechanism (PST/IST/S)

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VII. Measuring training performance results

1. There should be a standard procedures for practice which should be used as a measure.
2. Establish training impact evaluation.
3. Preparation of personnel: teams of providers, trainers and supervisors.
4. Service recipient be included in the evaluation of training impact.

PST (GROUP 4)

RECOMMENDATIONS TO PST SYSTEM

PST

I. Selection of trainees

- o It should be based on what the trainees have to do after training.
- o Should focus on the integrated approach.
- o Should ensure proper coverage with strained staff in a given area.
- o There should be multisectoral selection committees at various levels.

II. Trainers/tutors

- o Re-orientation to the integrated approach.
- o Prepared so that they can train service providers in the integrated approach.
- o Should work closely with service providers.
- o Maintain follow up system of trainees/service providers.

III. Curriculum - revision and development

- o Needs assessment which should include all the people from relevant settings for linkage improvement.
- o Should include all components of MCH/FP integration.
- o Service providers should be involved in curriculum review.
- o Role of service providers in training should be formalised so that they recognise training as their responsibility.
- o Curriculum to emphasize field practice.

IV. Frequency of training

- o Institutions can set the frequency.
(will depend on community needs and new development/technology)

V. Follow up

- o Trainers have a role following up their trainees to see their performance on the job.
- o To detect areas needing improvement.
- o Give trainers a closer link with supervisors in the field.

VI. Supervision

- o Re-orient supervisors so that they can look at all services in total.
- o Should have a standard format (checklist) for supervision.
- o Should have feedback mechanism between supervisors, trainers, service providers to discuss weak and strong points.

VII. Measuring training performance results

- o Observation of proper use of procedures.

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APPENDIX J

Results of Daily Feedback: Day 1, Day 2, Day 3



DAILY FEEDBACK : Methods and Results

DAY 1

1. Indicate how you feel about the content presented and generated today.
2. Indicate how you feel about the process used to present and generate the content today.

RESPONSES

N = 16

	Content	Process
Very satisfied	14	10
Satisfied	2	6
Unsatisfied	0	0

DAY 2

What I liked most about the meeting today

<u>COMMENT/STATEMENT</u>	<u>NUMBER</u>
o Group work (opportunity to exchange ideas actively and freely) learned a lot/ideas reinforced.	9
o Discussions/comments during plenary sessions.	6
o Use of Case Study maintained interest and kept group discussion on right track.	5
o Prioritizing/clarifying integrated MCH/FP components and parts.	2
o Clearer picture of integrated FP/MCH service.	1
o Thinking day took us through the process of integrating services.	1
o Approach and interpretation of integration.	1
o Identifying community needs in a particular situation (Case study).	1
o Change of group members	1

What I wished for about the meeting today

o Materials on the wall to be typed and distributed.	5
o Clearer group task instructions.	4
o More/adequate time for group work and summary on parts of integrated MCH/FP components.	1
o More clarity on characteristics of an integrated service.	1
o Insight into other group's case histories.	1
o Group reports were not always case study specific - confusion.	1

DAILY FEEDBACK

DAY 3

END OF MEETING FEEDBACK RESULTS

Number indicates frequency with which point was stated.

<u>COMMENT/STATEMENT</u>	<u>NUMBER</u>
o Better or new grasp/insight/ in-depth analysis/understanding/ ways and means of how MCH/FP can be trully integrated using the PHC framework.	19
o Insights that training for integrated MCH/FP and PHC have implications on present PST and IST.	9
o Better understanding of relation- ship between policy PST-IST-S in relation to training for results.	5
o Integrated MCH/FP within PHC framework implies a variety of MCH/FP settings and service providers whose identity depends on the local situation.	3
o Need for clear policy guidelines on integration concept.	3
o Clear understanding/better conviction of technical assistance needs.	3
o Meaning of "change" in relation to PHC concept.	3
o Importance of links between PST-IST-S.	2
o Small and large group idea sharing	2
o Reference material for future.	1
o Need for clear post training functions of IST and PST graduates.	1

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- o Better understanding of INTRAH and its wonderful managers. 1
- o Insight into MCH/FP integration problems in the region. 1
- o Why Mrs. X died 1
- o Made new friends 1

Question 2

Number of PHC meetings/conferences/workshops/seminars attended.

Respondents

16

Range 0-27
Average - 6

APPENDIX K

Norms of Small Groups

APPENDIX K

Norms of Small Groups

1. Choose/have someone volunteer to be a recorder.
2. Someone state the purpose of the task and what the product is/might be chairperson.
3. If you disagree, say so, but have an alternate proposal.
4. "Check out" whether silence indicates agreement.
5. Observe time limitations.
6. Try for one person speaking at a time.
7. Just because one group is doing something, your group doesn't have to do the same thing.