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**REPORT OF THE INDONESIA CHILD SURVIVAL WORKSHOP:  
"BUILDING ON LESSONS LEARNED IN CHILD SURVIVAL"**

**DECEMBER 5 - 12, 1989**

A regional training workshop for managers of  
child survival health projects carried out by PVOs  
in Southeast Asia and the Pacific regions.

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**A special note of thanks to Steven Robinson, M.D., M.P.H., Ph.D. Country Director, Project Concern/Indonesia, whose superb efforts contributed to make the workshop a smoothly run and successful event.**

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## **EXECUTIVE SUMMARY**

Project Concern International and the Johns Hopkins University Institute for International Programs co-organized the first Asia Regional Private and Voluntary Organization Child Survival workshop entitled "Building on Lessons Learned" from December 5 - 12, 1989, in Kendari, the provincial capital of Southeast Sulawesi, Indonesia. Workshop participants included country nationals involved with 13 PVO Child Survival projects in five Asian countries. The PVO participants were from the Adventist Development and Relief Agency in Indonesia and Pakistan; the Aga Khan Foundation in Pakistan; CARE in India and Indonesia; Freedom from Hunger in Nepal; Helen Keller International in Indonesia; the Rotary Club's Polio Plus Program in India; Save the Children Federation/USA in Bangladesh, Nepal and Indonesia; World Vision in Bangladesh and a representative of their Asia Regional Office; and Project Concern International in Indonesia.

The workshop was funded through a cooperative agreement between the Office of Private and Voluntary Cooperation, Bureau for Food for Peace and Humanitarian Assistance, Agency for International Development and the PVO Child Survival Support Program at the Johns Hopkins University Institute for International Programs. Assistance for the workshop was provided by both Project Concern International, an Diego headquarters and Indonesia field staff and also staff of the Johns Hopkins University Institute for International Programs. The workshop staff included: Ms. Dory Storms Sc.D., Mr. Robert F. Cunnane M.P.H., Johns Hopkins University; workshop facilitator Ms. Barbara Greig, Ph.D.; two technical assistants, Mr. Steve Solter, M.D., M.P.H. of MSH, and Mr. John Quinley, M.D., M.P.H., of UNICEF China; Ms. Jennifer Brinch, USAID Indonesia; Mr. Dean Millslagle, Mr. Moises Nagiel MD, MPH, Mr. J. Stephen Robinson MD, PhD, MPH and Mr. Natali Ikawidjaja, Project Concern International.

The goals of the eight day workshop were:

- 1) to share current information and materials among Asia region PVO Child Survival projects in order to provide possible solutions to specific problems encountered during project implementation.
- 2) to present innovative approaches to training and support of semi-literate village health workers and traditional birth attendants in order to strengthen efforts toward improving maternal care, prenatal care and child spacing.
- 3) to increase awareness of the different means to improve project sustainability in Child Survival projects.

The Governor of Southeast Sulawesi assisted with accommodations and transportation, provided the hall for the opening ceremony and presented a cultural event of local music and dance. Because of this strong government support and Project Concern's early accomplishments in Child Survival I, such as improving tetanus toxoid coverage among pregnant women and more recently its success with intersectoral cooperation in health development, Kendari was favored as the site for the workshop.

Child Survival materials from the participating PVO's were shared along with the lessons learned from their experiences. The workshop was further enriched with an Indonesian panel presentation, video lectures on Social Marketing, Collaboration and Problems in Management and Supervision, group discussions and interviews with intersectoral teams. Site visits were arranged to experience "posyandu" operation.

At the end of the workshop, each participant developed a 90-day action plan which not only addressed a problem whose solution they control but also incorporated information and techniques discovered during the workshop. These plans addressed ideas such as: improving family/community involvement, improving information systems, project expansion with continued quality, problem solving through force-field analysis using HIS to examine causes of development problems, enhancing awareness of ORT, increasing communication and supervision within programs, developing unity and team work, increasing immunization coverage, integrating child survival programs into government health systems, training village health workers to manage health services in their area, creating a supervisory manual for field staff, evaluating cost effectiveness of immunization programs through cost analysis, conducting surveys to evaluate effectiveness of programs, improving systems for project reporting from the field, improving program quality through use of financial information for decision making and designing refresher courses for health workers.

In addition to developing 90-day action plans, the participants gathered for a "Next Steps" luncheon during which they planned "joint" next-steps to implement upon their return home. To accomplish this they met in six groups by country.

The participants then re-grouped into their original small groups, wherein at the outset they discussed lessons learned, to re-visit lessons learned. They reviewed and prioritized and the entire group reconvened to reach consensus on the lessons learned making recommendations to child survival PVO's for the future.

The workshop's success is attributed to the quality and commitment of the participants involved. Thorough meticulous planning and implementation by the workshop staff created an atmosphere conducive to participation and unity. Support from and the accommodating attitude of the Indonesian provincial government added to the spirit of acceptance and hospitality.

The Asian Regional Child Survival Workshop was a remarkable collaborative effort which was enhanced by the rural atmosphere and the "posyandu" visits. Regional workshops in the field offer a unique opportunity for sharing successes and challenges while transferring quality technical information to PVO child survival projects while considering the local culture.

## **I. INTRODUCTION**

Since 1985, Congress has annually appropriated funds to be used for child survival activities throughout the world. Congress stipulated that a major portion of these funds should go to PVOs because of their proven ability to reach those without health services, and to mobilize public, private and local organizations to support their activities.

The Office of Private and Voluntary Cooperation of A.I.D./Washington, through its PVO Child Survival Support Program at Johns Hopkins University, has sponsored workshops to strengthen PVO country national staff in technical areas related to project implementation. In addition, these workshops have promoted regional networking and friendly exchange between private voluntary organizations implementing child survival projects with A.I.D. funding. Since 1986, PVO child survival regional workshops have been held in Sierra Leone, Zimbabwe, Rwanda, Kenya, Guatemala, Nigeria, Mali, Honduras and India.

Originally scheduled to take place in Kathmandu, Nepal in April, 1989, the workshop, which was to be hosted by Save the Children Federation, was first postponed and in the end cancelled due to intractable logistical problems resulting from border disputes between India and Nepal.

On May 1, 1989, Dr. Storms inquired into PCI's capacity and willingness to host the workshop in Kendari, Indonesia where PCI has operated a large-scale Child Survival project under CSI and CSIV. Inquiry was made of the PCI Country Director in Indonesia who responded affirmatively. Approval for PCI to host the workshop was given by USAID/FHA/PVC and funding would be accomplished through a subcontract with SCF/Westport, CT.

The theme of the eight day workshop, held December 5 - 12, 1989 was "Building on Lessons Learned". The participants represented six Asian countries and thirteen PVO Child Survival projects. The goals of the workshop were:

- 1) to share current information and materials among Asia region PVO Child Survival projects in order to provide possible solutions to specific problems encountered during project implementation
- 2) to present educational approaches to training and support of semi-literate village health workers and traditional birth attendants in order to strengthen efforts toward improving maternal care, prenatal care and child spacing
- 3) to increase awareness of the different means to improve project sustainability in Child Survival projects.

## **I. PLANNING AND PREPARATION**

PCI headquarters and field staff, staff members from the Johns Hopkins University Child Survival Support Program, a consultant facilitator, and a technical consultant from Management Sciences for Health met in San Diego to coordinate workshop inputs and activities that would contribute to the theme, "Building on Lessons Learned."

The major concerns of the organizers of the workshop were to provide: a hospitable atmosphere conducive to sharing successes and challenges among child survival project national staff members, an opportunity for Child Survival project managers to experience another field project, a forum for developing action plans, planning for on-going interaction and local and international resource persons to provide advice.

### A. PCI Indonesia and the Workshop Setting

Once PCI Indonesia accepted the offer to host the workshop and AID/FHA/PVC agreed to provide funding, the actual workshop planning began in October 1989 at Project Concern Headquarters in San Diego. Persons involved in the planning process included: Moises Nagiel, M.D., M.P.H., and De Millslagle from PCI headquarters staff; Robert Cunnane, M.P.H., Doris Storms, ScD, of Johns Hopkins University; Natali Ikawidjaya from PCI Indonesia, Dr. Steven Solter from Management Sciences Health, and Dr. Stuart Gilbreath, San Diego State University.

The workshop was held in Kendari, in the province of Southeast Sulawesi at the suggestion of Dr. Storr. The site was selected because of the size and impressive success rate of this PCI Child Survival project. The remoteness of Kendari provided a number of logistical challenges. Fortunately, the provincial government was very enthusiastic about this workshop and assisted in locating the workshop site, providing local transportation and subsidized some lodging facilities. There were many difficult, yet not insurmountable problems with the international transportation and the delivery via couriers of air travel tickets to the participants. Obtaining visas also presented some difficulties for the participants. However, the location also provided the characteristics of a remote program and the all-important ready access to "posyandus" - integrated clinics.

### B. PVO Participants

Early in November, PCI notified the ten PVOs and invited twenty-two participants originally identified in the Johns Hopkins Child Survival Support Program. It was recommended that the PVO representatives be those field-based, national staff personnel most directly involved in implementing child survival activities and who would be most likely to continue working in the project area in the future. Twenty participants responded affirmatively and attended the workshop. They came from Adventist Development and Relief Agency in Indonesia and Pakistan; the Aga Khan Foundation in Pakistan; CARE in India and Indonesia; Freedom from Hunger in Nepal; Helen Keller International in Indonesia; the Rotary Club's Polio Plus Program in India; Save the Children Federation/USA in Bangladesh, Nepal and Indonesia; World Vision in Bangladesh and a representative of their Asia Regional Office; and Project Concern International in Indonesia. (See Participant List, Appendix 1)

The Johns Hopkins University Child Survival Support Program requested "areas of interest" information from the PVOs invited to identify priority concerns; this information was incorporated into workshop plans. Areas of interest identified in this needs assessment are listed below:

- Defining Objectives, Targets and Strategy
- Community Involvement
- Baseline Survey
- Training
- Supervision and Management
- Communication and Behavior Change
- Health Information System
- Collaboration with Government and Sustainability

## 1. Consultants

Mr. Steven Solter, M.D., Ph.D. served as a technical consultant. Dr. Solter brought to the workshop an extremely strong background through his experience with maternal/child health project design and management in Indonesia.

Mr. John Quinley, M.D., MPH served as the second technical consultant. Aside from Dr. Quinley's very extensive experience in design and management of MCH programs, he also is a recognized expert in the application of force field analysis as used in design and evaluation of MCH projects.

Ms. Barbara Greig, Ph.D. served as the workshop facilitator. Originally, Mr. Dale Flowers had been identified as the facilitator, however, he was unable to continue with the consultancy due to the major earthquake damage to his home in the Santa Cruz area of northern California which occurred shortly before the October workshop planning session in San Diego. After an intensive search for a replacement for Mr. Flowers, Dr. Barbara Greig was identified and selected.

## 2. Workshop Design

On October the workshop staff gathered in San Diego at PCI headquarters to design the workshop around the goals and desired outcomes. They planned the sequence of the topics to be covered and assigned the responsible parties and objectives for each workshop session. The information gathered from the PVOs' annual reports and DIPS, responses to PVO home office questionnaires, responses to field project needs assessment questionnaires and the goals of the workshop were incorporated into the agenda.

The planners focussed the workshop on improving the quality of services, sustainability, collaboration, increasing coverage and use of prenatal care and family planning services, training and strengthening health information systems (HIS); realizing these topics must be considered within the broader context of community development.

Then the planners developed the workshop framework, deciding which activities should be integrated into the format of the technical presentations. These activities included a visit to a "posyandu", field site interviews, panels and group discussions. The planners created opportunities for participant interchange, one-on-one discussions and a resource room. The plans included use of local resources whenever appropriate and a "no technology" approach to workshop design. The rationale for this approach was to ensure that the workshop could be replicated anywhere in the world and not be crippled by lack of Xerox machines, VCRs, and computers. Freeing up the last day of the workshop would give the participants time to finish their 90 - day action plans.

Other planning involved the accommodations and physical environment required for the workshop site. Contingency plans and specific steps necessary to conduct each session were noted. Recognizing the physical demands of the workshop setting, organizers wanted to provide the most comfort possible within the physical constraints and to allow adequate time for rest and social exchange--considerations which are important for the maintenance of morale and a good learning environment.

Daily schedules outlining the objectives, methods, preparations, materials needed and resource persons for each activity were prepared. (See Appendix 3) The planners discussed overall workshop methodology to insure a balance between lectures, large and small group discussions, field visits and specific assignments. The "process" portions of the workshop were designed to include: get acquainted : participant expectations exercises, evaluation procedures and reflection exercises.

The planners agreed the workshop facilitator would review lesson plans with the presenter before each session. Thus, the facilitator would be able to better assist each presenter and give continuity to sessions. Regular evening staff meetings were scheduled to review final preparations for the next day's sessions. Each day wrapped up with a "Where are we at?" session for input from the participants.

The workshop objectives and a proposed schedule were discussed with Dr. J.S. Robinson, Country Director of PCI/Indonesia. He began coordinating the physical needs of the workshop with government officials and associates in Indonesia. Mr. Ikawidjaja located three "posyandus" in the area and coordinated a visit for the participants.

### E. Community Visits

PCI Indonesia in Kendari, arranged a visit to "posyandus" in the villages of Sadoka, Tobuka and Sampang for the second day of the workshop. The village sites were less than forty-five minutes travel and accessible by bus. The doctors in each area agreed to the visit as did the village heads.

The "posyandu" is a basic primary health care unit operated by MOH personnel and is available to villagers on a routinely scheduled basis. The goal was for the participants to develop a first-hand understanding of how PVOs in Indonesia are strengthening the "posyandu".

First, they were introduced to the concept of the "posyandu" by Dr. Takahasi from the Ministry of Health in Kendari. This was followed by a panel presentation on the posyandu which was coordinated by Ms. Jennifer Brinch, USAID Indonesia. The PVOs from Indonesia participated in the panel, they were CARE, PCI, SCF and ADRA.

Then they visited a "posyandu". The participants were divided into three groups. The Indonesian participants acted as translators. Each group had prepared a set of questions in advance. Other assistance was provided by the MOH staff.

The visit was followed by a group discussion conducted by Dr. Barbara Greig, the workshop facilitator. During this discussion, the participants related the experience to their own experience in their own programs and listed what they learned that related to their projects.

A second community visit for discussions and interviews with TBAs and pregnant and non-pregnant women occurred the fifth day of the workshop in four villages near Kendari. This was pre-arranged with village leaders.

This activity was designed for integration with the sessions preceding and following it, "Maternal Health:

and " Training Methods for TBAs, VHWs" respectively. The focus of this activity was on the role of the TBA and factors that influence pregnant women and lactating mothers.

The participants were separated into four groups and at each of the four villages, the group of participants was divided in half; one group interviewing the TBAs and the other interviewing the pregnant and non-pregnant women. These smaller groups of five or fewer was much less intimidating. Each group had a list of appropriate questions.

Following the visit, again the participants discussed and listed the "lessons learned" from each village. This discussion was also conducted by Dr. Greig.

Deve Solter closed this workshop session with a summary and conclusions. (See Appendix 4)

## Support Activities

### 1. Resource Materials

Workshop planners recognized the importance of providing current information. All PVOs attending were asked to provide the following resource materials: 1) map of their country with the project area indicated, 2) project files, 3) list of major "lessons learned", 4) examples of incentives used to motivate CHWs or volunteers, such as badges and certificates, 5) ORS packets, formula for home mix, recommended mixing supplies: spoon and container, 6) education materials used for semi-literate mothers or health volunteers, such as posters, 7) training materials and supervisory checklists, and 8) monitoring and data collection forms. Specific PVOs were asked to supply materials considered to be of unusual quality. Other resource materials included: 1) information about projects of the PVOs attending, 2) reference materials for the sessions, and 3) materials provided by the Johns Hopkins University and Project Concern International.

Participants were introduced to the resource room and its contents the first evening. It was available to them Tuesday - Friday and Sunday evenings.

Each participant received a "batik" bag in which to carry their resource materials, notes and workshop activity schedules, participant lists and resource materials list. All written materials were donated. For a list of the Johns Hopkins supplied materials, (See Appendix 5).

In conjunction with resource material preparation, organizers designed and printed a certificate of completion to be awarded to each participant upon completion of the workshop.

Certificates of appreciation were presented to the government officials.

Supplies such as pens, folders, markers, masking tape and staplers were provided by PCI headquarters. The video was furnished by PCI Indonesia.

All transportation to and from Kendari, Indonesia was arranged by PCI headquarters staff through a travel agency. Given the time constraints, the tickets were forwarded to the participants via courier services.

The participants were met in Jakarta by Drs. Solter and Quinley on Sunday, December 3rd. That evening they were welcomed to Indonesia at the hotel. The next day they were accompanied to Kendari via Ujung Pandang by Drs. Solter and Quinley.

Ground transportation in Indonesia was arranged by Mr. Ikawidjaja and provided, in part, by Governor's office and the Ministry of Health. The participants were transported in two, thirty passenger buses, provided by the MOH, to the events and site visits in and around Kendari.

### 3. Training and Housing Facilities

The participants, staff and technical support staff were housed at the Kendari Beach Hotel, the site of the workshop. The participants shared rooms.

Meals were served buffet style at the hotel, in the dining room, which was also used for the workshop meetings. Because the Indonesian diet consists largely of rice and fish, the participants were asked to note any food allergies in their registration materials.

The smaller group discussions and one-on-one interviews were also held in the meeting/dining room. Presentation support equipment, such as, easels and large paper pads were brought in.

A resource room with supplementary materials was set up during the workshop for the participants between sessions and evenings. This room was also equipped with a video so participants could view videos from the other PVO's projects.

## G. FINAL PLANS

Dr. Storms and Mr. Cunnane arrived in Jakarta on Monday, November 27th. Tuesday they met with officials at UNICEF, WHO, AID and the Child Survival Institute at the University of Indonesia. Wednesday Mr. Ikawidjaja and the facilitator, Dr. Greig met with Dr. Storms and Mr. Cunnane to ensure all details were being addressed and that plans were complete. Dr. Greig and Mr. Ikawidjaja also met with Dr. Takahasi, from the Ministry of Health to complete details for the "posyandu" visit. Drs. Quinley and Solter met with Mr. Ikawidjaja to review arrival and departure of participants to and from Jakarta.

Thursday, November 30, the planners met to review the workshop programs with individual consultants. The focus was to evaluate the flow of the individual sessions.

Friday, the workshop planning team, except Dr. Solter, Dr. Quinley and Mr. Ikawidjaja, flew to Kendari to the workshop site. The following day Dr. Nagiel met with the facilitator to review her sessions. Mr. Robinson met with Governor Alala to review plans for the opening ceremony, the cultural night and

protocol issues. The PCI headquarters staff met to discuss budget, resources, PCI vehicles, the secretary and any unresolved issues.

Monday the participants began arriving. Last minute preparations were complete in the morning. During these final meetings, the facilitator assisted team members in clarifying their roles. This process unified the team and created a clear definition of individual tasks.

## **II. THE WORKSHOP**

### **A. The Workshop Team**

The workshop team was comprised of Johns Hopkins University Child Survival Support Unit representatives, technical resource consultants in Child Survival, a consultant facilitator, and headquarters and field staff of the host PVO Project Concern International. All organizational levels and technical aspects of Child Survival programs were represented in the team except for a representative of the AID Child Survival in Washington, D.C. The membership of the team also included four members with extensive experience in Indonesia including one Indonesian child survival project level manager. The balance on the team of experience, expertise in training and technical aspects of child survival, and in ability to work as a team was excellent.

The majority of the workshop participants were managers of their projects or programs. Typically they were from positions in which they were directly involved in implementing child survival activities and who were likely to continue in those project areas in the future. They were also field based nationals.

PCI staff members helped organize and implement the site visits and also participated in the sessions. They addressed the needs of the participants, played crucial roles as translators and in preparing for the site visits.

### **B. The Workshop Approach and Format**

The workshop approach incorporated discussion, lecture and hands-on experience. Staff aimed to reinforce technical information as well as to maximize participation of all individuals so they could benefit from each others knowledge and experience.

Organizers aimed to create an environment where each individual, staff and participant was considered a resource person with equally valuable information to share. The facilitator provided adequate time and structured activities at the beginning of the workshop to provide an atmosphere in which the participants could learn about one another's background and experience. They were also provided with a sketch of each others programs.

The workshop participants also discussed their expectations and how the planned workshop presentations would meet their collective needs. This clear understanding in the beginning of the workshop established a mutually supportive environment enabling all to work together toward common goals.

Workshop leaders provided a technical framework and participants interacted with staff, villagers and another to question and observe how ideas translated into real world situations. As a result of combination of technical sessions, observations and analysis of community activities and discussions participants designed 90 day action plans to be implemented in their program. The objective of the plans was to achieve a measurable target in a three month period.

The workshop organizers used a variety of activities to share technical information. These emphasized identification of practical ways to incorporate this knowledge into participants' programs. The participants realized that by building on existing structures they could integrate child survival interventions into other community development activities.

Workshop sessions followed in logical sequence as indicated by the workshop agenda on the following page. The leaders and resource persons presented the technical information. Participants prepared for the site visits and then visited a "posyandu" and also interviewed TBAs and pregnant and non-pregnant women. The sessions were carried out in small and large group discussions and presentation of their day action plans.

Throughout the workshop, the facilitator requested feedback from participants to ensure that sessions were responsive to their needs. Each day ended with a 30 minute "Where are we at?" session. The staff met each evening to review the day's events and to make final preparations for the next day.

No evening sessions were scheduled in advance to allow adequate time for the participants to engage in social exchange and for rest. This flexible schedule provided for the addition of one extra session "Social Marketing". No technical conveniences such as typewriters, computers or copying machines were made available in order to model a workshop which could be conducted in the most remote location.

### C. Opening Sessions

Two afternoons prior to the opening session the participants met to get acquainted. They interviewed one another in pairs obtaining the following information:

- 1) Name you want to be called
- 2) Full name, title, organization
- 3) Family
- 4) Two things you are proud of
- 5) One core value you hold
- 6) A dream you have

This information, along with a Polaroid photo of each participant, which was taken earlier, was put on a large piece of paper and these biographical sketches were hung around the meeting room. The participants were divided into pairs and each pair met with two other pairs and each person introduced her/his partner to the group of six.

This "Gallery of Experts" exercise was facilitated by Dr. Greig. Then, the participants met in four small

groups to share individual expectations, record them on paper and select a spokesperson to report to the entire group.

The following morning the official opening ceremonies began with speeches by the provincial governor and Dr. Robinson, Country Director of PCI/Indonesia. Governor Alala described the demographics of the province of Southeast Sulawesi and his integrated rural development strategy and its' five basic targets:

- 1) Increasing the productivity of all aspects of the agricultural sector
- 2) Supplying and increasing the physical and socio-economic infrastructure
- 3) Developing and applying rural technology
- 4) Improving the quality of the environment
- 5) Increasing the quality of life of the rural society

It is his hope to motivate rural society to take part in their development effort. He expressed his joy for the opportunity to host the workshop and his gratitude to USAID and the workshop coordinators for their support and cooperation. He also expressed thanks to PCI for participation in his development efforts from 1986 onward.

Dr. Robinson welcomed the participants and expressed gratitude for the assistance of international health authorities from USAID, the Johns Hopkins University Institute for International Programs and Project Concern International's headquarters staff. He read a telex from Mr. John McEnaney, Chief of the Child Survival and Health Unit of FHA/PVC USAID in Washington, DC who was not able to attend the workshop. Dr. Robinson explained that Kendari was selected as the site for the workshop because of the project's early accomplishments in improving Tetanus Toxoid coverage among pregnant women and more recently its' success with intersectoral cooperation in health development. Dr. Robinson also noted the exceptional support from the Ministry of Health in tandem with the Governor's development program. In conclusion, Dr. Robinson welcomed the participants and stated he looked forward to learning from them.

#### **D. Technical Presentations**

##### **1. Improving the Quality of Services**

The training and discussions leading up to submission of 90 day action plans began the afternoon of the second day. Participants were introduced to the objectives of the session and the central issues involved in improving the quality of Child Survival services. They watched a video, "Improving the Odds" by PRICOR, which focused on the problems of implementing Child Survival programs and how well-planned systems analysis or operations research can identify obstacles to implementation and suggest ways for improving the situation.

Dr. Kabir Ahmed and Ms. Rose Raranta from World Vision/Bangladesh and Adventist Development and Relief Agency/Indonesia, respectively, were then interviewed to demonstrate their approach to improve program quality through better supervision. In preparation, each interviewee was handed written questions before hand. Following both interviews, a general discussion took place to get participation from everyone who was interested in the issues raised. Once again, both during the interviews and during the general discussion, certain points made by interviewees and/or participants were restated/summarized to make certain that the main messages-- the main teaching points-- were understood.

Dr. Quinley then introduced the 90-day action plan as one of the expected outcomes of the workshop. This plan is to be used as a management tool for projects; three months being enough time to accomplish specific tasks and short enough to establish a schedule of work. They were to be carried out by individuals in the Child Survival project to achieve a measurable objective or target. Two participants discussed their projects the night before with Dr. Quinley and picked suitable topics in about 20 minutes. They presented these objectives to the other participants. Following the established guidelines for selecting topics, others then decided on their 90-day action plans. After choosing topics for their plan, they were asked to develop them using guidelines with suggestions for Making the Action Plan and integrating them in the workshop schedule.

One hour was set aside on days 4, 5 and 6 to work on the action plans. Most participants discussed their ideas for objectives and drafted action plans in detail with one of the resource people. Participants reported that it was very useful to have the sessions separated because it gave them time to think over their ideas and their projects without the presence of an immediate deadline. The action plans were completed by noon of day 7 and were presented at the "Next Steps" session on day 8. (Copies of the action plans can be found in Appendix 6)

## 2. Sustainability

### a. Concept, Elements, Financial Aspects

The workshop devoted a whole day to sustainability, an indication of the importance of this concept to the PVO Child Survival Program. Dr. Storms, resource person for the session, reviewed the participants' expectations. The session began with the question of "What is my concept of sustainability?" The previous night, participants had been asked to draw pictures of their own ideas of sustainability. In the morning they hung them around the porch wall and the group listened to each member present her/his ideas.

Small group discussions then responded to the next question, "What are the elements you want to sustain in your project?" The elements identified had to be within the control of the project and the cost of the elements had to be able to be tracked. (A list of key project elements to be sustained is in Appendix

In the next phase of the sustainability session, the group engaged in a "one-on-one" exercise regarding personal experience with sustainability. Each person chose a person she/he did not know well and shared with that person something seen or heard or experienced that made her/him feel that she/he had made some difference in sustainability. This exercise increased the bonding between the participants and help

emphasize that participants could be (and had been) effective in achieving sustainability.

Dr. Storms reminded participants that the strategies being followed by PVO Child Survival projects were summarized in two documents given to the workshop participants: "Sustainability Paper" and "Project Profiles". She also stressed that PVOs take many approaches to sustainability. They discussed in greater depth how a few projects were approaching sustainability.

To gain an in-depth understanding, two PVO representatives responded to challenging questions regarding their work in Child Survival and issues of sustainability. Steve Rasmussen and Sri Chander gave thoughtful answers to Dr. Storms questions.

Specific formulas and theories regarding the AID approach to cost analysis and financial aspects of Child Survival programs were presented by Dr. Storms. Her information included, what to cost when costing programs and indicators of sustainability once cost accounting is complete.

#### **b. Intersectoral Collaboration**

The objective of this session was first to demonstrate intersectoral collaboration in the PCI Child Survival Project. Dr. Robinson conducted this session. The second objective of this session was to increase the awareness of how to strengthen monitoring of the "posyandu" in a manner that is sustainable. Dr. Ferry from the Indonesian Ministry of Health and Dr. Robinson, PCI Indonesia conducted a panel of Indonesian District intersectoral teams for the second segment of this workshop session. Objective three was to discuss the role of the private sector in making Child Survival more sustainable. Usha Goel, Program Officer for Rotary's Polio Plus Program led this section of the sustainability session. She described the structure of the Rotary program in India, explaining the division of the country into districts, the areas and population targeted for immunization and the training which informs the Rotarians of the program and enlists their participation in the government's immunization campaigns.

### **3. Social Marketing**

This session, led by Ms. Brinch, was introduced with a fifteen minute lecture on the basic principles of social marketing. Two participants, one from SCF/Nepal and one from HKI/Indonesia explained how their programs were implementing social marketing.

### **4. Increasing Coverage and Use**

The objectives for this session were to be able to:

- 1) Target high-risk children and women in order to achieve greater impact
- 2) identify ways to increase population coverage of key CS interventions without reducing program quality
- 3) use the "force-field analysis" approach to problem-solving

There were five main parts in this session:

1) Introduction

- a. Major issues covered were targeting high-risk children and women and how coverage can be expanded during "scaling up" of a project without a significant loss in project quality/impact.
- b. Basic Assumptions Behind High-risk Approach
- c. What High-risk is Not
- d. Example of High-risk Targeting
- e. Group Presentations: High-risk Approach

2) Interview with SCF/Bangladesh

- a. Their Experience with High-risk Targeting
- b. Discussion in four groups on specific project-related experiences with high-risk targeting
- c. Presentation of findings from small group to all participants
  1. High-risk Targets for Different Interventions for:
    - a) Growth promotion
    - b) Immunization
    - c) Pregnancy Monitoring and antenatal care
    - d) Permanent Method of Birth-spacing
    - e) Curative Service

3) Interview with ADRA/Pakistan regarding their experience with expanding coverage while maintaining service quality.

4) Dr. Storms explained "Force-field Analysis" a technique for problem solving. The groups then used FFA to identify supporting and constraining factors in "scaling-up" from small, pilot projects to large-scale implementation.

5) Summary and Conclusion

Expansion of services (by "scaling-up") is very difficult to achieve without sacrificing quality of services. The key is through the high-risk approach. With larger populations and geographical areas, the level of intensity of services cannot be maintained. Either few services (the more important ones) are offered or a smaller percentage of the population (i.e. those at highest risk) receive the services.

5. Maternal Health, Pre-natal Care, and Family Planning

The objectives of this session, led by Dr. Solter, were to identify effective and sustainable approaches to maternal, prenatal care and family planning, to share experiences regarding ways of achieving great impact through MCH programs, to understand the Indonesian family planning program at the village level in Southeast Sulawesi and to prepare for the next day's field visit. This was accomplished through a lecture by Dr. Solter, interview of the participant from SCF/Indonesia, a lecture by Pak Anderus (head of BKKBI for SE Sulawesi), and planning in small groups for the site visit.

## 6. Training Non-literates

Dr. Nagiel with the assistance of Dr. Robinson, and participants from CARE/India, PCI/Indonesia, KF/Pakistan, and SCF/Indonesia conducted this session. Subjects presented were: communicating with the illiterate, training through non-formal methods, training illiterate villagers, training non-literate TBAs through role playing, criteria for selecting TBA/CHW training techniques, training need analysis, curriculum steps and methods, and next steps. The introduction was followed by sharing of training experiences by the participants listed above. The session concluded with a question and answer period.

## 7. Health Information System

The objectives of this session led by Dr. Quinley and Mr. Cunnane were: 1) to hear about the strengths, constraints and requirements of family registration monitoring versus non-registration approaches to HIS in Child Survival projects, 2) produce a collection of lessons learned and recommendations regarding routine data collection by VHWs, quality of data collection, analysis of data, and use of computerization and 3) discuss the use of data in Child Survival projects by PVO managers and participation with feedback to communities of data collected. After Dr. Quinley's presentation, discussion ensued focusing on a poster describing "Family Registration and Monitoring vs Non-individual Monitoring". The first being a method of registering and tracking all members of the community, the interventions they received (immunizations, family planning and growth monitoring) and demographic changes (pregnancies, births, deaths and migrations) and the second a method of tracking using sample surveys. The participants discussed the advantages and disadvantages of both.

The participants then formed four groups, based as much as possible on having similar project structures. They listed lessons learned from "Four Topics in Data Gathering": 1) Data collection by village level workers (volunteers), 2) Quality of data collection in CS projects, 3) Analysis of data collected and 4) computerization of HIS. Discussion by the reassembled group emphasized the importance not only of re-testing, but also of periodic refinement of data systems and procedures. Practices suitable for various projects depended heavily on the educational level of the populace, the use of paid or unpaid primary health care workers, and the intensity of supervision and training available.

A group discussion led by Mr. Cunnane encouraged participants to examine their use of data for feedback to the community and project management to improve program quality. The discussion disclosed that methods of using and understanding data varied from project to project. In summary, Mr. Cunnane said HIS systems should allow project managers to have, "Their finger on the pulse of the project." The information should respond to the impact of each intervention and be used to determine what worked, what did not work and why?

Then Mr. Millslagle, Dr. Nagiel and Dr. Quinley led an exercise to gather specific feedback for AID on its annual Health and Child Survival project survey/questionnaire. This questionnaire is used to compile information which is reported to congress annually on the status of Child Survival programs. Because of this, the questionnaire must be standardized, although the projects are sufficiently dissimilar to make reporting via a standardized form quite difficult.

The participants were divided into three groups and each participant was given a questionnaire to evaluate. They were asked to note the good points and offer specific suggestions for improvement.

Dr. Quinley introduced the objective of the session on "Mid-term and Final Evaluations for CS Project". Dr. Storms briefly indicated key points about mid-term and final CS project evaluations as follows:

**Mid-term:** The project is responsible for this evaluation, using AID guidelines. Cost producing the report is paid by the PVO. It should be based on the project objectives; it may result in project mid-course corrections. Focus should be on sustainability and PVOs are requested to include someone key to project sustainability on the evaluation team.

**Final:** This is based on a detailed set of questions and on the project's stated objectives. At least one team member should be someone not directly connected with the project. This report is used by the PVO to obtain lessons learned from the project and to request AID to evaluate how the CS-PVO program is doing in general.

Three participants joined in a panel discussion and described their experiences with evaluations. They addressed questions such as:

- 1) Who was important to have on the team?
- 2) How far ahead did you have to plan?
- 3) Did the evaluation team do data collection? Were evaluation results shared with the community?
- 4) Did the project change due to the mid-term evaluation?
- 5) If you had it to do over, what would you do differently?

Dr. Storms explained the timing of mid-term and final evaluations in relation to the project cycle and request for extensions or continuation of funding. Copies of the current USAID guidelines for mid-term and final evaluations of Child Survival projects were distributed.

This day concluded with a presentation by Dr. Storms on "Communications Between Field Programs, PVO/HQ, JHU-IIP, and USAID". She reported that the JHU-IIP contract had been extended to 1993. Therefore, JHU plans to continue workshops and increase monitoring and evaluation assistance. The contract with AID is to support the PVO Child Survival projects. PVOs are able to request technical assistance via JHU-IIP.

#### 8. Completion of Expected Outcomes

Dr. Storms and Dr. Quinley introduced this workshop session with four objectives: to review knowledge, behavioral change, and coverage objectives in Child Survival projects and the proper use and refinement of these; each project was to review and to refine its objectives; each project was to complete its 90-day action plan; and finally, the refined objectives checked, the action plans were to be submitted before leaving.

Dr. Quinley explained that objectives are valuable because they keep the project oriented toward its goals. Since they are the project's own statement of what it intends to accomplish, they are used as the basis of the project's final evaluation. It is also important for Child Survival projects to periodically review and refine their objectives because baseline rates may be different than expected, activities planned may have been adjusted, or information systems may find different information than expected. In refining objectives it is important that the objectives be measurable, specific and quantitative, and technically sound and feasible.

Examples of objectives were selected from the participants' project profiles and demographic and cost data book for each area: immunization, oral rehydration therapy, nutrition, vitamin A and birth spacing. Dr. Storms provided technical comments on these objectives while the merits of these well-written objectives were discussed and questions were asked.

A listing of Child Survival project objectives relating to knowledge, behavior change, and coverage had been prepared prior to the conference at Johns Hopkins for each project, based on the most recently available Child Survival reports. Copies were distributed to the participants. For the next three hours, the participants refined these objectives as needed and completed their 90-day action plans. Dr. Storms, Dr. Solter and Dr. Quinley were available resources to the participants.

#### 9. Growth Monitoring, ORT, Social Marketing and Vitamin A, ARI, Infant/Child Feeding

The session topic area was introduced by Dr. Amin. Each participant was asked to explain why they had chosen this concurrent session and their project's experience. Dr. Amin identified four topics for discussion: what is the original justification for growth monitoring projects?, how should growth monitoring be done?, how to increase community awareness and acceptance/willingness to have their children monitored, what interventions and follow-up can projects offer and what has been successful.

The basics of social marketing are product (idea, image-positioning), place (distribution time, point-of-sale), price (monetary, non-monetary) and promotion (interpersonal, mass media, give-aways). Four PVOs presented their social marketing programs, describing the demographics, the problems, implementation of social marketing techniques and monitoring.

Dr. Quinley reviewed recent developments in Vitamin A therapy. Discussion revealed that projects active in Vitamin A therapy distribute high dose capsules to children only, at this time. All projects insist on including nutrition education with capsule distribution hoping to solve the problem without depending on supplements forever. Projects active in Vitamin A therapy plan to continue and are interested in ongoing studies supporting Vitamin A in a much larger role than solely in blindness prevention.

#### 10. Lessons Learned Revisited

The participants amended the "Prioritization of Lessons Learned" which they listed the first day. Then

they discussed the "Next Steps", how the experience of the workshop will be shared, with whom and when.

## 11. Comments on AID Annual Report

The participants commented on the AID Health and Child Survival Annual Report. They felt the report should be revised early to provide time to accumulate the new data required. Further, they commented there are too many categories dealing with nutritional activities; it is confusing and difficult to separate the costs for various nutrition activities.

### E. Community Activities

#### 1. Village Visit to Interview TBAs and Pregnant and Non-pregnant Women

The focus of this field site visit was to be, the roles of the TBA (can she do more than she is presently doing, could she be supervised, supplied, or supported better, etc.), as well as factors that influence the behavior of pregnant women and lactating mothers. The intent was that these kinds of questions could stimulate the participants to return to their own projects/countries and begin innovative approaches to maternal care. For example, factors which promote or inhibit pregnant women from getting Tetanus Toxoid, from taking iron tablets or contraceptive pills are critical to the success of any maternal health project in any country.

Having designed their questions the preceding day, and considering the lectures and orientation received in previous sessions, the participants were prepared to visit the three villages selected by PCI/Indonesia. This session was conducted by Mr. Ikawidjaja, Mr. Cunnane and Mr. Solter. The participants were divided into three groups and at each village, they were divided again into two groups, one group interviewed the TBAs and the other the pregnant and non-pregnant women. This strategy was employed to reduce the intimidation factor of many strangers interviewing only one person. Of course, the disadvantage was that the participants were not able to hear, first hand, all of the information shared in each village.

Upon returning to the workshop site, the participants processed the visits answering the following four questions:

- 1) What interested/impressed you most?
- 2) Any surprises?
- 3) What did you learn that could be helpful to your program?
- 4) What does your program have that could be helpful to them?

#### 2. Strengthening the Posyandu

The objectives of this field site visit were: for the participants to understand how Indonesian PVOs are strengthening the "Posyandu", for the participants to understand the "Posyandu" (the primary health care unit in Indonesia), and for the participants to relate the experience to their own programs. This session was conducted by Ms. Brinch and Dr. Greig.

The workshop began with a panel of Indonesian PVOs, CARE, ADRA, SCF and PCI, who presented papers on how they work to strengthen the "Posyandu". Dr. Takahasi from the MOH/Kendari (PCI's counterpart) was a guest speaker.

A group discussion scheduled to follow this first workshop occurred on the preceding evening allowing more time for visiting the "Posyandu" after the panel presentations.

The Indonesian representatives translated for the three groups of participants visiting the three "posyandus". Each group was equipped with questions. They visited the villages of Sadoha, Tobuha and Ampara.

Dr. Greig, the facilitator processed the visit with the participants and encouraged them to relate what they saw to their own projects. The participants were then asked to list lessons learned by answering the following questions:

- 1) What did you see?
- 2) What didn't you see that you expected to see?
- 3) Generalize/relate to your own experience, listing what you learned that would be useful to you in the future.

Outlines, notes and summaries of workshop activities can be found in Appendix 8)

#### F. Outcomes

On the seventh day the twenty-one participants presented 90-day action plans which outlined specific steps for implementing a measurable operational objective which would improve the quality of services. (See Appendix 6 for 90-day action plans).

Their plans addressed: improving family/community involvement, improving information systems, project expansion with continued quality, problem solving through force-field analysis, using HIS to discover causes of development problems, enhancing awareness of ORT, increasing communication and supervision within programs, developing unity and team work, increasing immunization coverage, integrating child survival programs into government health systems, training village health workers to manage health services in their area, creating a supervisory manual for field staff evaluating cost effectiveness of immunization programs through effective cost analysis, conducting a survey to evaluate effectiveness of programs, improving systems for project reporting from the field, improving program quality through use of financial information for decision making and designing refresher courses for health workers. (See Appendix 9)

#### IV. BUDGET

The budget for the workshop consisted of the remaining balance of funds which had originally been granted to Save the Children for the development of the planned Child Survival Workshop in Nepal. When the Nepal workshop had to be cancelled, the balance of the funds remaining in the Save the Children workshop grant was put into a subgrant to PCI to carry out the rescheduled and resituated workshop. The result was that PCI undertook a workshop for which the costs were significantly greater than those

originally projected for the SCF Nepal CS Workshop. After the final accounting was complete, PCI ended up having to expend \$8,200 of its own funds to cover the cost overage. In addition, PCI costs would have been much greater had the Johns Hopkins Institute for International Programs not covered a number of major cost items which would normally have come under the workshop budget: specifically, the cost of travel and honorarium of the workshop facilitator.

## V. PARTICIPANT EVALUATION

The participants were asked to evaluate the workshop according to the following questions:

- 1) What sessions/elements of the workshop were particularly useful to you?
- 2) Do you think you will use what you learned here in your work?
- 3) Process of workshop:
  - a. Did you feel free to express your opinions?
  - b. Did you feel a part of the group?
- 4)
  - a. Was the pre-workshop information useful?
  - b. Do you have any suggestions for improving it?
- 5)
  - a. Was the resource room useful?
  - b. Do you have any suggestions for improving it?
- 6) Comments to staff members.

### Participant Evaluation Summary

## VI. COMMENTS AND RECOMMENDATIONS

### A. PCI comments:

1. The experience gained by PCI in the planning and implementation of this workshop was invaluable. It was a rewarding experience for the PCI staff in headquarters and in the field program for those staff involved both directly and indirectly. Perhaps the greatest benefit was to the PCI/Indonesia field program due to the enhanced visibility and credibility that the international workshop provided to the project. This was also the first time that Southeast Sulawesi had been the host venue for an international conference of any type which was beneficial to the morale of local ministry of health officials and to the PCI staff. This has also helped in the development of an Indonesian NGO made up of ex-PCI employees which is now carrying forward the Child Survival work initiated by PCI under AID grants.

### B. PCI Recommendations:

1. The final financial accounting for such a workshop can be a logistical nightmare. A:

arrangement should be made so that all transactions to pay for the participants' enroute and return expenses are completed while the participants are all in one location. This would best be done during the workshop. Return travel expenditures should be paid for in advance by those responsible for the workshop funds based upon the enroute costs. The signature of the participant for return travel cost advances should be sufficient to meet accounting requirements of the grant. It may appear to be a minor issue to those not involved in workshop management but it is a major issue entailing a great deal of time and communication costs to finalize all the reimbursements after workshop participants have returned to their countries of origin.

NAME AND MAILING ADDRESS OF PVO REPRESENTATIVES AND OTHER INDIVIDUALS  
ATTENDING THE FIRST ASIA REGIONAL CHILD SURVIVAL WORKSHOP:

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**APPENDIX 2:**  
**DAILY TRAINING PLAN**

8		Indonesia panel; Posyandu visit	Sustainability income generation, cost recovery, Indicators Training	Strategies to increase coverage & use ORT, immunization; target high-risk	Mother interview TBAs bring in pregnant women for interview	HIS Indicators Computerization Recordkeeping Use of data	Complete 90-day plans and revision of indicators	Next steps
9								
10								
11	Introduction and expectations	Process visit until 12:30						
12								
3	Lessons learned	Management skills & action plan	Sustainability Linkages Interview with District Level Team from Unahec at the workshop site	Maternal Health	Training methods for TBAs, VHWs	Feedback MIS AID reporting	Special topics such as ARI, nutrition, Vit. A, social marketing	
4								
5	LL							

Sun. 12/3	Mon. 12/4	Tue. 12/5 Day 1	Wed. 12/6 Day 2	Thurs. 12/7 Day 3	Fri. 12/8 Day 4	Sat. 12/9 Day 5	Sun. 12/10 Day 6	Mon. 12/11 Day 7	Tue. 12/12 Day 8	Wed. 12/13 Day 9
Participants arrive in Jakarta - met by Wiwit & Steve Solter	13 participants to Kendari; arrive 11 a.m. or 4 p.m.	Opening: 9 a.m. to 11 a.m. 12 noon to 3 p.m. — Lunch	7 - 8 a.m. — Breakfast		11 a.m. — Religious Breaks			11 a.m. — Networking	10 a.m. "Next Steps"	Departure 8:30 a.m. — leave for airport
Welcome at hotel in evening in Jakarta	Dinner at 7 p.m. Name tags	5 - 5:30 — WAWA 7 - 8 p.m. — Dinner							12:15 — Group Photograph 12:30 — Lunch	
Transport to hotel and back to airport	Wiwit & Moises orientation to PCI; R. Cunnane prepare written material on PCI/I	5:30 - 6:30 — Organizing Team meets 8 - 10 p.m. — Resource Room							2 p.m. — Closing Ceremony (certificates for participants; thank you to hosts 3 - 3:30 — Evaluation paper	Organizing Team wrap-up Review of lessons learned during afternoon
Back-up person in Jakarta								Lulo party Cultural night		
John Qainley Welcomes in Wjung Padang	Galary of Experts								Shopping (Wiwit)	

SC

Mon., 11/27	Tue., 11/28	Wed., 11/29	Thurs., 11/30	Fri., 12/1	Sat., 12/2	Sun., 12/3	Mon., 12/4
<p>Rob &amp; Dori arrive Jakarta</p> <p>Visit AID Visit WHO Visit UNICEF (Ask Steve to arrange to occur before Thursday - visit Child Health Institute) (Meetings to be Tues - Wed &amp; AID person to accompany)</p> <p>MOH visit</p>		<p>Dori, Rob, Steve R., Wiwit &amp; Facilitator meet in Jakarta to discuss all Wiwit's responsibilities &amp; other planning needs</p> <p>Update on what's happened since we last saw Moises -- and Wiwit</p> <p>Everything we need to go over with Wiwit needs to be done this day</p> <p>Dr. Takahasi, Rob, &amp; Wiwit meet on posyandu</p> <p>John &amp; Steve S. &amp; Wiwit go over the arrival &amp; departure of participants</p>	<p>Workshop Planning meeting</p> <p>To go through with individual consultants -- their programs (Rob, Dori, etc.)</p> <p>ALL DAY: The flow of individual sessions is focus</p>	<p>Fly to Kendari; arrive by noon</p> <p>Dr. Takahasi guest house</p> <p>4 p.m. -- Begin agenda for next day's role clarify</p> <p>Objectives clarify</p>	<p>Moises meet with other staff and Facilitator to review his sessions</p> <p>Dr. Takahasi, Rob, &amp; Wiwit meet on posyandu visit</p> <p>Meet with Facilitator</p> <p>Dori &amp; Dr. Fery meet</p> <p>Protocol meetings? Governor Steve R. responsibility</p> <p>PCI HQs people meet on budget, resources, PCI vehicles, secretaries, etc.</p>	<p>See training facilities, Resource Room, etc.</p> <p>Participants arrive on 2nd or 3rd; in Kendari on 4th</p> <p>Leave Steve Solter in Jakarta; John to Ajp.</p> <p>Steve R. &amp; Moises in Kendari</p> <p>Be finished by noon</p> <p>Rest before Workshop</p>	

be

**APPENDIX 3:**  
**RESOURCE MATERIALS**

## MATERIALS FOR ASIA WORKSHOP

1. Management skills
  - A. "Training for Mid-Level Managers"  
Coverage Survey  
(WHO-EPI) 86 pages 23 copies
  - B. "Operations Research Findings..."  
JHU Occasional Paper #3 (Labbok & Shah) 2 copies
  - C. "A Review of Methodological Approaches  
to Evaluating Health Programs"  
JHU Occasional Paper #1 (workshop) 2 copies
2. Sustainability
  - A. "Sustainability: Reality check for PVO  
Child Survival" (Smith, Storms)  
JHU-PVO/CS 1 copy
3. Maternal Health (family planning)
  - A. "Men - New Focus for Family Planning Programs"  
Population Reports-Family Planning Programs 25 copies
  - B. "Mothers' Lives Matter: Maternal Health  
in the Community"  
Population Reports-Family Planning Programs 25 copies
  - C. "Family Planning Saves Lives" (Asian Version)  
IMPACT 29 copies
4. Training Methods for TBAs, VHWS
  - A. "Traditional Midwives and Family Planning"  
Population Reports-Family Planning Program 25 copies
  - B. "Working with Villagers-Prototype Lessons"  
(topics: infant & toddler nutrition, decision  
making, family food supply, family relations,  
family planning)  
The American Home Economics Association 1 copy
5. Health Information Systems
  - A. "Public Health Practice/Gathering  
Information for Health"  
World Health Forum, Vol 7, 1986 23 copies
  - B. "User Needs Study, PVO Component"  
Center of International Health Information 23 copies
  - C. "Health Interview Surveys for CS Programs"  
JHU Occasional Paper #6 (Huntington, Berman,  
Kendall) 2 copies

- D. "Child Survival Report  
-Results from Systems Analysis"  
PRIOR (Data Analysis) 2 copies
- E. "Review of Baseline Studies Carried out  
in PVO Child Survival Projects 1987-1988"  
IIP-JHU-AID (Bani, Storms) 1 copy
- 6. Management Information Systems
  - A. "Industrial Sampling Plans: Prospects for  
Public Health Application" (Reinke)  
JHU Occasional Paper #2 2 copies
  - B. "Checklist for Supervisors-EPI" 23 copies
- 7. Special Topics
  - A. ARI
    - 1. "Acute Respiratory Infections  
Control Program"  
Case Management- WHO 23 copies
    - 2. "Respiratory Infections in Children:  
Management in Small Hospitals"  
WHO booklet 23 copies
  - B. Vitamin A
    - 1. "Vitamin A Deficiency and Childhood  
Morbidity and Mortality"  
JHU Occasional Paper #4  
(Gadomski & Kjolhede) 2 copies
    - 2. "Information pamphlet Vitamin A"  
WHO/HKI 1989 10 copies
  - C. Growth Monitoring
    - 1. "Growth Monitoring and Nutrition Education"  
(program in the Dominican Republic)  
US-AID, Bureau for Science and Technology 21copies
    - 2. "A Critique of 4 Hanging Spring Dial Scales  
Suitable for Field Use" 23 copies

D. Social Marketing

## 1. Newsletters

a.	"Social Marketing Update" 1983	23 copies
b.	"Social Marketing Update" 1987	23 copies
c.	"Social Marketing Update"	
d.	"Technology Aids Vaccination Effort" Medical Science April 1988	23 copies
e.	"Feedback" ICOMP Jan/Feb 1987	23 copies
f.	"Population Headliners" ESCAP Jan 1986	23 copies
g.	"WIF" Nov 1987	23 copies
h.	"AIDCOM" (Asain Institute for Development Communication & Management)	23 copies
i.	"Polio Eradication" Rotary International	23 copies
j.	"Social Marketing Update" 1982	2 copies
k.	"Social Marketing Update" 1986	2 copies
l.	"WIF" March 1987	2 copies
m.	"WIF" June 1987	2 copies
n.	"SOMARC" 1986	2 copies

## 2. PCS Information Packets

a.	"Print Materials for Non-Readers"#1	1 copy
b.	"Male Responsibility" (#2)	2 copies
c.	"Basic Processes & Principles for Population/Family Planning Communication (#3)	28 copies
d.	"Social Marketing & Packages for Contraceptive Products" (#4)	2 copies
e.	"Reaching Young People" (#5)	3 copies
f.	"Working with the Media" (#6)	27 copies
g.	"Wallcharts about Contraceptive Methods (#7)	1 copy
h.	"Pamphlets about the Condom" (#8)	2 copies
i.	"Pamphlets about the Pill" (#9)	2 copies
j.	social marketing bookmarks @ 45	bookmarks

3.	"Media Asia" an Asian Mass Communication Quarterly	2 copies
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8. Miscellaneous TopicsA. Child Survival

1. "Towards More Effective Child Survival Strategies", Workshop Report  
JHU/Ford Foundation May 1988 1 copy

B. Health Intervention

1. "Health Intervention Strategies in Asia and the Near East" (Hill, Mosley)  
JHU-Occasional Paper #7 2 copies

C. Diarrhea/Nutrition

1. "Treatment and Prevention of Acute Diarrhea" WHO booklet (lt blue cover) 20 copies
2. "Improving Infant Feeding Practices to Prevent Diarrhea and Reduce its Severity" (Schroeder, Piwoz, Black, Kirkwood)  
JHU Occasional Paper #8 2 copies
3. "Case-Control Study of Childhood Diarrhea II Sample Size" WHO 12 copies
4. "Report of the Ninth Meeting of the Technical Advisory Group"  
WHO-Diarrheal Disease Control Program  
(obtained from PAHO) 2 copies

D. ORT

1. "Manual for Conducting Lot Quality Assessment in Oral Rehydration Therapy Clinics" (Wolff, Black)  
JHU Occasional Paper #9 2 copies

E. Country Profiles (From REACH)

1. Indonesia 1 copy
2. Bangladesh 1 copy
3. Nepal 1 copy
4. India 1 copy
5. Pakistan 1 copy

Resource List for Asia Workshop Materials

AIDCOM

Asian Institute for Development Communication and Management  
P.O. Box 312  
Jalan Sultan Telephone: (603) 756-7269  
46730 Selangor Darul Ehsan Telex: MA 31533  
Malaysia Cable: AIDCOM PETALINGJAYA

American Home Economics Association  
International Family Planning Project  
2010 Massachusetts Avenue, NW  
Washington DC 20036  
USA

Child Survival Report

PRICOR Telephone: (301) 654-2550  
Center for Human Services for AID Telex: 64693  
7200 Wisconsin Avenue Cable: URCINTER  
Suite 500  
Bethesda, MD 20814

Facts for Life Video

UNICEF, DIPA Telephone: (202) 326-7000  
Facts for Life Unit Telex: 175989 TRT  
3 UN Plaza  
New York, NY 10017  
USA

Feedback

ICOMP Newsletter of Management of Population Programmes  
158 Jalan Dahlia  
Taman Uda Jaya Cable: ICOMP Luala Lumpur  
68000 Ampang Telephone: 457-3234  
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IMPACT

Population Reference Bureau  
777 14th Street, NW  
Washington DC 20005  
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Media Asia

An Asian Mass Communication Quarterly  
39 Newton Road  
Singapore 1130  
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Population Headliners

ESCAP-Economic and Social Commission for Asia and the Pacific  
United Nations Building

Bangkok 10200, Thailand

PVO/Child Survival  
Institute for International Programs  
103 East Mount Royal Avenue  
Baltimore, MD 21202  
USA

REACH Project  
John Snow, Inc. Telephone: (703) 528-7474  
Ninth Floor Telex: 272896  
1100 Wilson Blvd  
Arlington, VA 22209  
USA

Social Marketing Update (Newsletter)  
An International Newsletter on Contraceptive Marketing  
UPDATE: The Futures Group  
1029 Vermont Avenue NW  
Washington DC 20005  
USA

SOMARC/The Futures Group  
Social Marketing for Change  
1111 14th Street, NW Suite 400  
Washington DC 20005  
USA

US-AID  
Bureau for Science and Technology  
Office of Nutrition  
Washington DC 20523  
USA

WHO Regional Office for South East Asia  
World Health House  
Indraprastha Estate  
Mahatma Gandhi Road  
New Delhi, India 110002

WIF Newsletter  
World International Foundation  
10, Kinross Avenue  
Colombo 4, Sri Lanka

Women's International Public Health Network  
7100 Oak Forest Lane  
Bethesda MD 20187 USA

**APPENDIX 4:**  
**WORKSHOP ACTIVITIES**

**LESSONS LEARNED**  
**FREEDOM FROM HUNGER, NEPAL**

5th December, 1989

- Training sales agent (Volunteer), and set incentives (Literate, semiliterate = illiterate)
- Past deficiencies:
  - Not interactive
  - Trainers talked too much
- Current method: Participatory approach
  - Many group discussions
  - Individual presentations
  - Role play provides greater involvement
  - Story telling is a practical communication method
  - Demonstrations
- Specific objective/specific outcomes
- Repeat shows using linear methodology

**Communication**

Messages                      Messages

Staff -----> Sales Agents -----> Community

- How sales agent teaches the client
- We found communication gap
- eg: (6) glasses of water  
clean water/fresh water
- Train them how to communicate with people
- Communicator qualities
- Show practically to consumer
- Repeat many times
- Take feedback from consumer

**Management**

- Used to have weak management system
- Ran a management workshop in Kathmandu.
- Accurate reporting system
- Regularity
- Record keeping

All staff should know about product sales. How many sales agents are in the block? How many consumers?

- How many T.J. have been sold
- Movie graphs for sales going up/down
- Why? What happened?
- Regular user/new users/support

4. Promotion of spacing ORT sales (Dhaal, pills & ORT)  
Video Programs
  - Video is too small for crowds (technical)
  - Jahari Window to do in small groups only.
  - Cassette recorder, talk program, drama, song, group discuss
5. Promotional approaches by S.M. staffs and sales agent are not enough to give messages in community.
  - Worker together with non-formal education (Adult education classes).
  - NFE teacher training.

### **LESSONS LEARNED**

#### **SAVE THE CHILDREN (USA), BANGLADESH, DURING CS PROJECT**

1. Objectives and targets should be well-defined & target fine-tuned appropriate to the intervention with periodic reviews of objectives and targets. If necessary, correction must be made.
2. All staff and volunteers should be well acquainted with the objectives of the project. Local government administrative and health structure and the community leaders should be well-informed about the objectives and targets before and during implementation of the project.
3. A CS project well-integrated into a community involved development program enhances the adoption of child protection behaviors and sustainability of these behaviors.
4. The following 7 components are necessary for adoption of a new behavior:
  - a. There is a clear, simple, concise message, appropriate for the target group.
  - b. Repeated two way practical demonstration of the expected skill.
  - c. A well known educator of good personality, capable of gaining target group's confidence
  - d. Mechanism of experience sharing within the target group.
  - e. Reinforcement of the message & skill in time of felt need.
  - f. Availability of support services within geographic & financial reach of target population.
  - g. Long term, multi-media propaganda on the expected behavior
5. In rural Bangladesh, mothers are the health caretakers of their children; however, the fathers are the ultimate decision-makers. For this reason, the fathers also should be targeted for health education.
6. In a male-dominated, conservative society like ours, female health workers alone are not sufficient to educate the male population and a team of health workers from both sexes is essential to cover the whole family.
7. Growth monitoring is the most difficult program element to implement in rural Bangladesh, as without at least 3 promotional components, namely a) curative health care facility, b) practical nutrition counselling and c) nutritional rehabilitation (food supplementation and/or income generation support), it is less acceptable to the people.

8. A food which is energy rich & protein-dense, cookable at home from staple foods available in the family, precooked, storable and palatable as weaning/supplemental food is necessary for successful growth promotion in rural Bangladesh. Most mothers (about 80%) do not have enough resources to buy "baby-foods" and/or enough time, patience, firewood, small cooking oven etc. for 2-3 additional meals for only the child.
9. Although experience has shown that a health information system is painstaking and time consuming, it is vital for identification of future program direction and strategic planning. Target rosters in the hands of village health workers are essential for good coverage.
10. Supervision and formative training should be a key element of management of CS project.
11. The women, who belong to savings groups have significantly lower TFR & their children have better nutritional status and better chance of survival.

Presented by Dr. SK.Md, Aminul Islam MD.  
(Dr. Amin)  
Save the Children (USA)  
Bangladesh Field Office

### GETTING TO KNOW YOU

This session took place the afternoon before the opening session, due to early arrival of many participants.

1. Participants met in pairs with the following task for each person
  - Interview your partner on the following topics:
    - \* Name you want to be called
    - \* Full name, title, organization
    - \* Family
    - \* 2 things you are proud of
    - \* One core value you hold
    - \* A dream you have
  - Write the info on flip chart paper with the interviewee's photo attached. (All participants had polaroid photos taken earlier)
2. Each pair met with 2 other pairs and each person introduced his or her partner to the group of 6.
3. Participants hung the flip chart sheets on the walls of the meeting room.

## OPENING SESSION

1. **Presentation**
  - Background information on the workshop
  - Workshop goals, methodology, expected outputs and agenda.
2. Participants were presented with briefcases containing some workshop materials.
3. Participants met in small groups with the following tasks:
  - Share individual expectations
  - Record those expectations on newsprint
  - Select a spokesperson to report to the large group
4. The small groups presented their lists.

Below are summaries of each group's presentation:

### Group 1

1. What is history, philosophy, objectives & future of USAID "CS" emphasis, & how it fits into overa development of health care system.
2. How to plan for and monitor financial aspects of sustainability of CSP.
3. Managerial aspects of sustainability
4. Future trends of CS strategy of USAID (CS & beyond)
5. How to achieve active community participation through CS for sustainability.
6. How to use current data more effectively in a CSP.
7. How to change attitude/behavior at all levels.
8. How to achieve revival of traditional MCH programs through CSP.
9. To share experiences of how PVO's are working with Gvt./MOH.
10. How to link up with private sector through CSP.

### Group 2

1. **Management & Supervision**
  - Time management scheduling of health workers
  - Follow up 'at risk'
  - Supervision in remote populations with transport limitations
  - Process of implementation, sharing with other PVO's
2. **Sustainability**
  - Integrating CS program with:
    - \* Govt. health program
    - \* Local govt & CD program
  - Incentives to VHS's for voluntary workers
  - Problem of dropouts
  - Phaseover from CS staff to non project staff
3. **Health Info System**
  - Refining objectives

- How much & what info VHW should collect
- What is useful to computerize

### Group 3

1. Implementation of the CS project in all countries where CS is being run.
2. What are the constraints which are being faced in implementation of CS projects.  
- Solutions?
3. Learn how different CS projects use routinely collected data for planning & decision making.
4. How to reduce drop-out rate of CHW's (volunteers)
5. How different countries train volunteers
6. More info on social marketing (selling contraception) in other countries)  
(contraceptive health implementation problems, solutions)
7. How to motivate people (mothers & children) to come to Posyandu without supplementary feeding  
(Nutrition program)
8. To make new friends whom we can visit in future
9. How to overcome cultural barriers for implementation.

### Group 4

#### Special Interest

- \* Growth monitoring
- \* ARI
- \* Prenatal death
- \* Financial reporting mechanism (esp. to USAID) (1)
- \* CSP objectives
- \* Building up sustainability
- \* Community participation
- \* VHW training module
- \* Volunteers drop out
- \* Clearing house for PVO-CS groups
- \* Motivation for volunteers, mothers, families
- \* Uniformity of educational materials
- \* Method of simple monitoring & evaluation
  - Design
  - Data collection
  - Process & analysis
  - Presentation
  - Dissemination

CS through women's empowerment

## **GROUP A TAJ MAHAL GROUP**

### LESSONS LEARNED

1. Proper type of vehicles which can give good service on very rough roads.
2. Male domination over women does not allow women to participate in program in a desired manner.

(Dominating male members motivation project)

3. Development of teaching aids and curriculum.
4. Transfer of counterpart officials
5. HBHR (Home Based Health Record)
6. Training venue
7. Income generation projects to be linked with CS project.

#### **GROUP 4**

##### **LESSONS LEARNED**

1. Target all socio-economic classes in a given project area, as the health education levels of mother of even the middle & upper middle class in urban areas have been found to be low.
2. Adjusting/integrating our CSP with district public health office (DPHO).
3. For first 2 years of a CSP, have realistic achievable targets before scaling up in following years.
4. Get tech. assistance in baseline design, methodology & analysis & reporting.
5. Simple, scientifically sound & quick surveys are always useful to assess program status.
6. Use only those audio-visual materials which are locally available & acceptable & which are consistent with govt/MOH. materials & messages.
7. Include income generation and social welfare (development) inputs in a CSP.
8. It is important to use effectively the data being collected routinely in a CSP for operational mgt
9. Start involving village people and pol. leaders in designing programs.
10. Population shift/mobilization rate is quite high in urban areas
11. Importance of visiting other PVO projects to learn & to avoid reinventing the wheel.

#### **GROUP 5**

##### **LESSONS LEARNED**

1. Difficult to train the sales agents/workers with different levels of literacy.
  - Teaching materials especially for illiterates are required
  - Participatory training more effective
2. In groups where shy people are present, it is necessary for trainers to have the skills and patience to ensure that these people are brought into the experience. This shyness can be the result of social isolation and/or religious beliefs.
3. Community involvement in surveys makes the surveys more useful
4. In communicating messages it is very important to get feedback about what has been understood
5. Long term regular follow up system should be in place to maintain and improve the program.
6. Learning to use information is more important than learning to collect information "Info for action"
7. P.V.O. and Gov. must have close collaboration in planning, implementation etc. Keeping in mind sustainability.
8. P.V.O. may be spread too thinly without quality services
9. Baseline surveys are absolutely essential to assess future progress. Adequate funds should be provided.
10. Only useful data should be collected.
11. Maps & proper information on project area are necessary

12. Community involvement should exist from the beginning (planning baseline surveys, etc.)
13. Transportation for H.Q. Staff is essential for supervision purposes especially in rural areas.

**CARE - IND  
ADRA - PAK  
POLIO+ INDIA  
GROUP ?**

- \* Objective & Target should be:
  - Well defined
  - reviewed periodically
  - revised if necessary
- \* Since the beginning of the project a close collaboration with government (national - regional - local)
- \* Since the beginning the project should be highly community based/oriented & the community leaders should be involved.
- \* Training is needed in every aspect of the project :
  - Orientation at the beginning
  - Continuing on need
- \* Mother -----> primary caretaker  
Fathers -----> should be included  
Others
- \* VHW -----> recruited based on culture  
(Bangladesh : team of CS)
- \* The importance of growth monitoring
- \* The importance of behavioral change strategy
- \* The essence of
  - Supervision
  - Monitoring
  - Evaluation

**Workshop Session : Lessons Learned**

Goal : Composite "Lessons Learned Asia" list for all PVO projects  
Responsibility : Robert Cunnane

This session had 3 steps. For each step there was a brief introduction about the process that would occur and the reasons for it.

- Step 1:** One-on-one discussion between two participants who don't know each other well.  
The questions answered will be:
1. What has working in Child Survival meant to you?
  2. What personal Lessons Learned have you gained from your work?

Time : 30 minutes

**Step 2:** Group discussion among projects to develop a list of Lessons Learned. Two or three projects to a group - 5 groups. The groups will use their list of Lessons Learned.

Time : 30 minutes

**Step 3:** Group Presentation - List of Lessons Learned.  
5 groups present lessons learned. Discussion follows at the end of the session.

Time : 1 hour

**SCF, INDONESIA**

**Ms. Ermalena**

**LESSONS LEARNED**

1. Community Leader (formal or non-formal) is the key of the success of the CS project. Hence, an intensive approach to the local community leader is critical at the beginning of the project.
2. Project strategy should be well designed at the beginning of the project. However, it should be sufficiently flexible to adjust to local conditions.
3. Training is a critical component of the CS project, as a means to transfer ideas, skills & technologies of the project. Therefore, training should be designed (either formal or non formal method) in accordance with the local needs and conditions.
4. Phasing out often "boomerangs." Hence, phasing out should be prepared from the beginning of the project to facilitate development of sustainability within the community.

**World Vision Asia Region**

**Sri Chandra**

**LESSONS LEARNED**

1. Get Technical Assistance in baseline survey design, methodology & analysis & reporting
2. Need to research all reporting/data needs before creating an HIS. PVO should get the MOF involved in the medical methodology and to refine a consistent, mutually acceptable reporting format.
3. Visit Asia PVO projects to learn from them to avoid re-inventing the wheel.
4. Importance of linking a CSP with income generating development program.
5. Need 6-12 months for community assessment planning before a PVO enters a new area. PVO staff

involved in this initial stage should come from proposed project areas.

6. Training all VHWs in their local areas.
7. The person who trains a health service provider(CHW/VHW) should be the same person who supervises that provider.
8. Importance of developing an interdisciplinary conference to facilitate community ownership of project goal.
9. Importance of learning how to use available data more effectively.

#### ADRA, INDO

##### **LESSONS LEARNED**

1. The father must be educated also, to join the family to work on the farm as well as in the house, and to encourage mother and under five children to come to Posyandu (Integrated Health Post).
2. Income Generation Projects should be Linked with Child Survival Project because the poor need more money not only to buy nutritious food, but to buy proper clothing, decent house, etc.

#### FFH, NEPAL

##### **LESSONS LEARNED**

1. Small, achievable targets in the beginning of project to create nucleus for transformation.
2. Income generation and development activities should be included in CSP.
3. Women's participation should be given high priority for successful implementation of CS interventions.
4. List the same educational materials which are in use with necessary changes and improvement, if necessary, to avoid confusion.
5. Involvement of local people (leaders - political/native/religious) in activities planning ensures more community participation and continuity of the activities.
6. Fitting of CSP into government health system effective and sustainable.

## CARE INDONESIA

### LESSONS LEARNED

- \* Respected individuals in the community, such as teachers, traditional birth attendants and religious leaders, should be encouraged to support the program.
- \* Task-oriented training sessions should be organized for village leaders and kader coordinators. Training should focus on enhancing practical skills, problem solving abilities and planning and management capacities.
- \* There is potential for improving the effectiveness of staff time at the Posyandu and strengthening the support that government staff give to the kader.
- \* A better system of supervision and incentives for kader needs to be developed which can be sustained by government and village leaders.
- \* Every effort should be made to involve government staff in all stages of the planning and implementation of the program. However, strong support by community leaders is required to supplement the limited resources of government and to ensure sustainable local management of Posyandu services.

### QUESTIONS FOR THE POSYANDU SESSION

#### GROUP A

1. What services are being provided?
2. Who is providing the services?
3. Does the community appear to be involved? How?
4. Who is being reached :
  - Many under-fives
  - Most children over 2 years
  - Are there any pregnant women
5. What is the health center's role?

#### GROUP B

1. What services are being provided?
2. Is health education occurring?
  - Do you see health workers talking to mothers?
  - Are visual aids used for education?
3. How is the Posyandu organized?
  - Do people wait long?
  - Is there sufficient space?
  - Are there places to sit?

4. Are needles re-used for immunizations?  
Are needles properly sterilized?  
How are the vaccines kept cold?

### GROUP C

1. What services are being provided?
2. How do the Posyandu staff know children and pregnant women who need follow-up?
3. Are prenatal examinations being given?
4. Are the Posyandu staff experiencing problems with growth monitoring?
  - a. Weighing children correctly
  - b. Filling in the road to health card properly.
  - c. Following up health education.

### STRENGTHENING THE POSYANDU SESSION, DAY 2

**Goal :** To develop a basic level of understanding of how Indonesian PVOs are strengthening the Posyandu basic primary health care unit in Indonesia.

#### Step 1 :

Indonesia panel: 4 Indonesian PVOs, CARE, ADRA, SCF and PCI, present papers on how they work to strengthen the Posyandu.

The Indonesian PVO participants were asked to prepare a paper for a ten minute presentation prior to the workshop.

The coordinator for the panel is Jennifer Brinch and the guest speaker is Dr. Takahasi from the Kendari, MOH, PCI's counterpart.

#### Step 2 :

Group discussion - Questions

Time: 1 1/2 hours

This part of the session was done in the evening to allow more time for the Posyandu visit

#### Step 3 :

Field visit to 3 Posyandu

The participants are broken up into 3 groups to see a Posyandu. The Indonesian representatives act as translators at the Posyandu. A list of questions is given to each group to answer. (attached)

Time : 2 hours

#### **Step 4 : Process the visit**

The facilitator processes the visit and tries to get participants to relate what they saw to their own project (see attachment)

Three groups visited Posyandus in the villages of Sadoha, Tobuha and Sampara. The group for Sampa did not get a chance to process the visit because they came back too late.

### **IMPROVING QUALITY OF SERVICES**

#### **SESSION OBJECTIVES :**

1. To share experiences regarding management and supervision as ways of improving program quality
2. To be better able to identify management and supervision problems and to develop strategies solve them.
3. To be able to develop a 90-day workplan which participants can implement after the workshop

#### **GROUP I**

##### **FIELD VISIT TO POSYANDU VILLAGE SADOHA**

#### **LESSONS LEARNED**

1. Necessary to get active volunteers.
2. Community sharing cost (cash)/in-kind.
3. Advantage of well organized
4. Counseling
5. Require community motivation
6. Pre and post Posyandu meeting
7. Inter-sectoral cooperation coordination

#### **GROUP II**

##### **FIELD VISIT TO POSYANDU - TOBUHA**

#### **LESSONS LEARNED**

- A multi-faceted program needs multiple kaders for better implementation.
- Due to excellent community participation program/activities were successful.
- Community feeling ownership from the very beginning
- Involvement of children
- Coordination between community Govt/NGOs/Social organization etc.
- Social meeting place for mothers

## 90 DAY ACTION PLANS

### I. Choosing a Topic/Objective

- Should be focused on attaining a measurable operational objective.
- Related to "Improving Quality of Services" (management, supervision)
- WS participant personally responsible for or active in this area (+ interested in)
- Just one activity
- Needs to be able to show measurable program within 90 days.
- May be something already planned for in general, but specific 90-day plan not yet done.
- Should be "doable" given the constraints and other ongoing project activities.

### II. Making the Action Plan

1. What do I want to achieve?
2. What will I do?
  - Identify activities
  - Steps
  - Schedule
  - Constraints - Contingencies
3. How am I doing?
  - Need milestones

### III. Workshop Action Plan Schedule

- Think of a suitable topic/objective
- PVOs with 2 participants can make just one AP if participants generally work together.
- Will work on AP Fri-Sat-Sun 11-12. (2 of 3)
- May use resource persons, other PVOs, etc. to help
- Will present AP on Monday AM.
- 6 month AID follow-up to see if AP useful and completed

## How ADRA (Adventist Development and Relief Agency) Strengthened Posyandu (Integrated Primary Health Care Service) in Minahasa Region, North Sulawesi Province Indonesia.

### Introduction

ADRA staff is working at 17 Puskesmas (Local Health Center) in the project area. We work together with the government health personnel to conduct Posyandu activities, in 225 villages, and 226 Posyandus, with the distance ranging from 9 to 112 km between Posyandu and ADRA office. There were 963 Kaders (Community health workers) trained by ADRA and Government Health Personnel.

The following are the activities which ADRA is doing to strengthen Posyandu:

1. **Training**

We trained kaders, vaccinator and nurses in order to improve the knowledge in areas of nutrition, health sanitation, and the possibility of putting into practice in daily life for individual/family/community, to expand the understanding of the importance of Family Nutrition Improvement Program Integrated, village based health post (Posyandu) along with its benefit for the family welfare, and to supply the training participant with practical knowledge so that he/she can be ensured to be a motivator in the community.

2. **EPI**

We maintain cold chain by distributing thermos, ...sterilizer, br... and control of how they do it. We do one needle to one child in the program, and every child under five as well as each pregnant woman has a complete immunization card.

3. **Prevention of Diarrhea**

We introduce the home-made ORS, lead and ask them mother demonstration at home to make ORS, we provide Oralit (ready made ORS) which we just put in a glass of water and let the child drink. We educate as to how to prevent diarrhea strengthened person terminated sanitation, and have a solution drink when the people in the community together of ADRA staff and gov health worker working system to clean the community.

4. **Nutrition**

To know the nutritional status of the under five children, the weighing program has been implemented. We monitor the scale so that it will properly calibrated, and teach the kader how to weigh and record, and monitor whether the kader is doing it correctly.

We educate the women in the importance of home gardening, and how to do it. Also we eat capsule and have a cooking demonstration on a locally available vegetable. The importance of...feeding also has been emphasized, and for the high risk children, we do constant monitoring visit the house, and give supplementary feeding.

5. **Family Planning**

We work together with the government health personnel to educate the mothers as to the importance of family planning, and teach them the different method of contraception, as well as have display on different kinds of continency.

6. **Health Education**

Health education has been given every Posyandu activities with emphasis on environmental and personnel sanitation, the prevention of malaria, nutrition, prevention, maternal and child health prevention of diarrhea, the importance of immunization, family planning are distribute handbooks chart. We use pattern, flip chart period aids.

7. **Prenatal Care**

For the pregnant women we collaborate of the government health personnel to give promotion, in terms of counseling, and physical check up, giving from tablet if necessary, and educate the mother on how to be healthy and have a healthy baby.

8. **Reporting Cader**  
Every month, there is a senior which called "Reporting Cadets", in which they were trained again on what the things they want to know, and a dimension in how they were doing the Posyandu activities, to cook constrains and solution. They also have games. They were given...in terms of uniform and body.
9. **Transportation**  
ADRA has provided most of the transportation to bring the health personnel for Posyandu activities, and follow up by using ADRA four-wheel drive vehicle for the distances ranging from 9 to 112 km. The vehicle is very helpful.
10. **Monitor**  
ADRA has constant monitoring of the Posyandu activity, so that the kader, will the training job properly. For follow up. we visit the leave specially for the high risk children, and to child whether...home as clean and descent.
11. **Extra C...**  
ADRA it give health personnel formers the women's, club , and healthy baby competition, have running group, and sports activity among the people in the community.

**HOW IS THE PROGRAM ORGANIZED  
AS PARTNERS WITH GOVT.**

1. Collaborate with Dist./city heath structure
2. Identify geographical area for polio plus
3. Invite rotarians and other volunteers to an orientation workshop
4. Conduct enumeration
5. Set up Immunization Post and six days
6. Public awareness activities through procession, visits, cinema slides
7. Asst. Govt. Immunization team

**5 major activities for volunteers**

- Public awareness/social mobilization
- Enumeration
- Registration, recording, talk to mothers
- Follow-up on drop-outs
- Cold chain maintenance

**SESSION LINKS WITH THE PRIVATE SECTOR**

**ROTARY POLIO PLUS IN INDIA**

STRUCTURE

National Task Force  
Technical Support

Dist. Polio Plus Committee (24)

Club Polio Plus Committee (1450)

TARGET AREA

Urban/Slums

ORIENTATION/TRAINING  
REVIEW

One workshop every year at all the three levels.

INFORMATION  
ORIENTATION  
MATERIAL

- Dist. Polio Plus Manual
- Club Polio Plus Manual
- Volunteer Hand Book
- Video Cassette
- Quarterly newsletter

Besides, clubs print charts, posters handouts and pamphlets for distribution

**INTERSECTORAL COLLABORATION: POSYANDU SUPERVISING TEAM**

STRUCTURE

PROVINCE PST

DISTRICT PST 4

SUB DISTRICT PST 30

VILLAGE PMT 150

SUSTAINABILITY ... SESSION

**DONOR AGENCY  
VIEW**

USAID/DONOR

1 2 3 4 5 6

**S.O VIEW**

S.O. USAID/DONOR S.O/DONOR S.O/DONOR

0 1 2 3 4 5 6 7 8 9 10

**F.O.  
VIEW**

0 1 2 3 4 5 6 7 8 9 10

**COMMITMENT TO FUNDING FOR THE LIFETIME OF A  
CS/DEVELOPMENT PROJECT**

**INDICATORS TO MONITOR**

1. ATTENDANCE
2. % POSYANDU
3. % KADERS ACTIVE

**AKF/PAKISTAN**

- \* CORE SUPPORT GROUP  
Before/After
- + SUPPORT TO COMMUNITIES  
(e.g. FOLLOW-UP, MOTIVATION)
- + TRAINING OUTSIDE FUNDING
- + NEW IDEAS / FLEXIBILITY / CHANGE
- + "QUALITY CHECKS"
- + SUPPORT FOR  
MONITORING, EVALUATION, RESEARCH

**ADRA PAKISTAN**

1. AWARENESS BY COMMUNITY AND CONTINUED PARTICIPATION
2. PERMANENT FLOW OF RESOURCES FROM AGENCIES

**SCF/INDONESIA**

**KEY ELEMENTS:**

1. KADER'S TRAINING
2. TRAINING OF TRAINERS
3. MANAGEMENT INFORMATION SYSTEM
4. HOME VISIT ACTIVITY
5. INTEGRATED PROGRAM
6. STRENGTHENING PUSKESMAS (TRU: TRANSFER SKILL)
7. CLEAR GOAL AND CLEAR STRATEGY

**HKI INDONESIA**

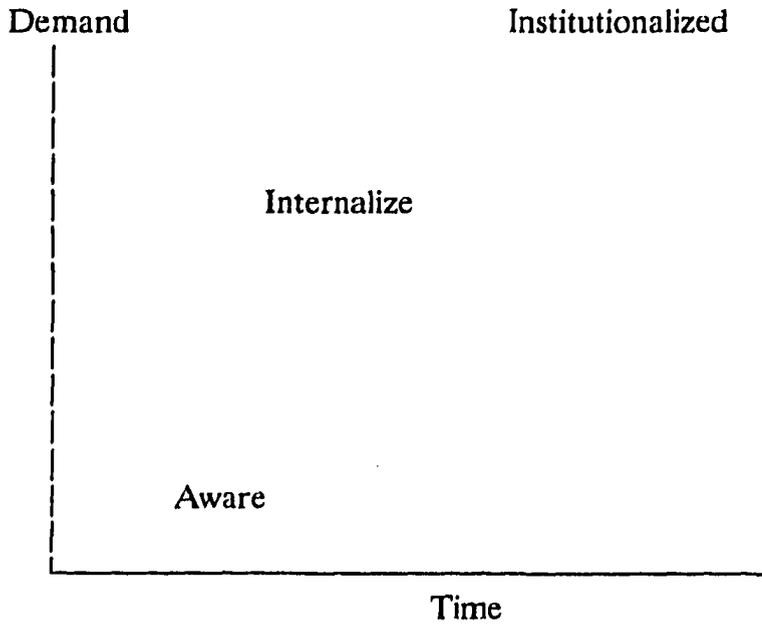
**ROVITA PROJECT**

\* **KEY ELEMENT :**

Consistent		DEMANDS (on CS means)
Institutionalized		

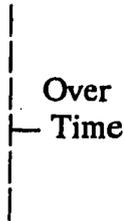
(related to their behavior)

\* TRACKS :



Measures / "Interventions"

- Training System
- Delivery System
- Social Marketing
- Community Institutional Devel.



PCI INDONESIA

PST (POSYANDU SUPERVISORY TEAM)

GIVE WORKPLAN THE SUPPORT POSYANDU:

- MONITORING & SUPERVISION
- FUNDRAISING

06

## MOH INDONESIA

### STRATEGY FOR SUSTAINING POSYANDU

1. Strengthening intersectoral collaboration
2. Income generating
3. At the very beginning, we should involve the community, formally/informal leader
4. Posyandu monitoring team
5. To improve the methodology of the training
6. The involvement of the local government

## ADRA INDONESIA

### KEY ELEMENTS TO SUSTAINABILITY

1. Income generating program
2. Kader's training
3. Build the ownership health program in community
4. Health staff training
5. Government support

## FFH/FPAN

- Mothers' groups training:
- a) kitchen gardening
  - b) immunization

## SCF/NEPAL

1. Awareness generation in community (educational program)
2. Skills transfer (through training (for sales agents/workers)
3. Delivery of services (regular)

## SAVE BANGLADESH

- \* **CHILD PROTECTIVE BEHAVIORS:**
  - a) Safe delivery practices through TBA. training
  - b) Knowledge & practice by pregnant women & lactating mothers of "eat for two"
  - c) Initiation of weaning/support food at the appropriate age and feeding at sufficient quantity
  - d) Urge and skill for ORT & EPI
- \* Community structure to help sustain the above mentioned behavior change

## WV BANGLADESH

1. Training of DMC staff
2. Training of committee volunteers  
(through nh committee formation = 70% active)
3. Utilization of EPI & VAC (delivery cost)

## CARE INDIA

### KEY ELEMENTS:

- we leave legacy of trainers/monitors in project area
- linkage of csp in care food program areas
- involvement of community at all level
- self-reliance

## CARE INDONESIA

### KEY ELEMENTS:

1. Knowledgeable/skilled gate keepers (leaders)
2. Goi consensus
3. Com. & Information from the grassroots to the top management
4. Trainer at each level

## ROTARY INDIA

### ELEMENTS TO BE SUSTAINED:

1. Immunization locations where children can be brought
2. Immunization teams
3. People's confidence in usefulness of immunization
4. Regular supply of vaccine
5. Local community (rotarian) support to govt.

## DAY 3 - A G E N D A

### Sustainability

#### 8 AM CONCEPT

What is it? Elements to Sustain?

#### 9 AM UNEXAMINED ASSUMPTIONS

Where are we on concept?

10 AM PVO APPROACHES TO TRAINING

11 AM FINANCIAL ASPECTS

A.I.D/FUA/PVC Monitoring Cost Accounting

3 PM COORDINATION / COLLABORATION

Inter-Sectoral Team

4:30 LINKS TO THE PRIVATE SECTOR

### EXPECTATIONS RELATED TO SUSTAINABILITY

- o Process : Building up sustainability
- o How to plan or monitor financial aspects of sustainability of CSP
- o Managerial aspects of sustainability
- o How to achieve active community participation through CS for sustainability
- o Integrating CS program with
  - \* Gov't Health Program
  - \* Local Govt Program
- o Phase over from CS staff to non-project staff

### SUSTAINABILITY SESSION - DAY 3

#### OBJECTIVES

1. To increase awareness of different approaches to establishing sustainability in CS projects.
2. To examine some of our unstated assumptions about sustainability that prevent our being more effective.
3. To increase awareness of financial aspects of sustainability (cost accounting)
4. To review where PVA/PVC is going in sustainability, and expectations of projects
5. To increase awareness of different approved monitoring sustainability in CS projects.

#### CONCEPT OF SUSTAINABILITY

What is it?

What are the elements you want to sustain?

**TASK :** Each PVO CS project should identify the few key elements you wish to sustain. The elements should be within the control of the project, and you should be able to trash the cost of the elements. (10 min)

## ONE - ON - ONE

Pick a person you do not know well and share with that person something you saw, or heard, or experienced that made you feel you had made some difference in sustainability.

## DIVERSITY OF PVO APPROACHES TO SUSTAINABILITY

### RESOURCES

1. Sustainability Paper
2. Project Profiles

### FISH BOWL

AKHS/Pakistan  
World Vision Region Asia

### PROCESS POSYANDU VISIT

1. - What did you see?  
- What didn't you see that you expected to see?
2. Generalize to your own experience.  
Make list of what you learned that will be useful to you in the future.

### COSTING PROGRAMS

- What to cost?
  - Outputs
  - Program activity
  - Cost Finding
1. Direct Costs  
Identify activities directly related to or supporting output.
    - Who does them
    - How much time attributable to output
    - Costs to Government/PVO/etc. (Salary, bonus, honor, in-kind etc.)
  - Identify Materials
    - Materials used up with output
    - Materials used over a long time
  2. Indirect Costs
    - Administrative overhead
    - Material (capital) overhead

Once Cost Accounting is done:

Uses Include

- o Direct vs Indirect - If mostly indirect there may be too much overhead.
- o Fixed vs Variable - If mostly fixed then output should cost/output.
- o PVO vs Government - If any item is high % PVO then this is place to check if sustainable.
- o Start-up vs Recurrent - Recurrent is most important for sustainability.
- o Knowledge of output/program costs ability to do good program budgeting.

Final Points

- o Some outputs/programs more difficult to cost
  - This doesn't reflect one value of that output.
- o Costing is not very hard but may need TA or an accountant at first.

FINANCIAL ASPECTS

FVA/PVC TRENDS:

AID. cost per potential beneficiary per year

Total [AID \$ - (#0-5 + LB yr2 + LB yr3 + LB yr4 + q 15.49) -  
# Project years

Intervention  $\left[ \frac{\text{EPI}}{\text{EPI}} \left( (\text{AID } \$ \times \% \text{ intervention}) - (\text{Beneficiary } \# \text{ 0-1} + \right. \right.$   
 $\left. \left. \#q \text{ 15-49} + \text{LB yr2} + \text{LB yr3} + \text{LB yr4} \right) \right] - \text{Project years}$

ORT/GMP 0-3

How long? - 5 years

Initial start-up costs version recurrent costs

On guidelines  
Knowledge of how much survey, training, education, etc cost.

Function + Activity

Indicators - how monitor program

**SOCIAL MARKETING**  
**Dr. Satoto**

**ROVITA - HKI**

- Low distrib - coverage vit. A
- Low usage of ORS
- Govt reporting system
- Scattered studies
- Preliminary rapid assessment feasible
- Meetings
- Ethnographic inquiries "KAP"
- Focus group discussions recourses-P4
- Audience research
- Market segmentation : I, II, III, etc.
- Product positioning (brand)
- Promotion : material           pretesting  
                  media/channel       formative  
                  time, etc.           evaluation
- Broadcasting
- Display
- Face to face
- Meeting
  
- ✓ - Spot check
- Broadcast monitor
- Rapid survey
  
- ✓ - Periodic recording/reporting (MIS)
- KAP study  
  (pre-post)  
  (case control)

**C - INDONESIA**

- Jakarta)
- CS Program quality (integrated)
  - Management papers
  - Baseline

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- Community self survey
- Meeting

Face to face Kader  
Mother  
Leader

- Materials : (Thru pretesting)  
Posters, etc.

Meetings  
Integrated  
MIS

**CARE - INDONESIA**  
NTB

Program quality  
low intensity of  
kader - community  
communication

Integrated (Management rationale)

Face to face/group communication (kader-community)

- additional media - cassette  
Pretested
- poster

Integrated

**SM : PROJECT - PLACE - PRICE - PROMOTION**

"Create-meet the demand"

PROBLEM  
STATEMENT

PRODUCT  
PLACE  
PRICE

OPPORTUNITY

PROMOTION

## ANALYSIS

Ising-isingen  
ngenteng-entengi

## MARKETING RESEARCH

bulan ganjil  
ndawani  
murus  
mumpruk

## STRATEGY DEVELOPMENT

nggebros  
kontap  
mangsur  
mancut  
mencret

## IMPLEMENTATION

muntaber  
muntah ngising  
ngisih geting  
ngising umbel  
disentri

## MONITORING EVALUATION

Expensive?

? tor

## BASICS OF SOCIAL MARKETING

Definition + Focus (target)  
(perception, attitudes, beliefs, fears)

### 4 Ps :

1. Right Product (idea) (image positioning)
2. Right Place (distribution time point-of-sale)
3. Right Price (monetary, non-monetary)
4. Right Promotion (interpersonal, mass media, give aways)

### MARKETING PROCESS: interrelated

1. Opportunity Analysis
2. Consumer Research

2. Consumer Research
  - Quantitative (Sample Surveys)
  - Qualitative (Focus Group Discussions)
  - Ethnographic Studies, Interviews observations)
  
3. Communications Strategy - What  
to whom  
by which means
  - Interpersonal (face-to-face)
  - Mass media (Print: newspapers, magazines, electronic, Pre-Test ! ) radio, TV, Video, Slide/tape)
  
4. Monitoring (tracking implementation)  
Evaluation (based on specific objectives)

**SOCIAL MARKETING SESSION**  
Jennifer Brinch Presentation

**CONCEPT OF SUSTAINABILITY PICTURE THEMES**

- \* Agencies Talk Community confused
- \* Training Legacy
- \* Entire Community Support
- \* Community Feels its their program
- \* Cycle
- \* Unbroken intersectoral chain strong browng tree of community
- \* Entire community working together
- \* House must be built on strong foundation
- \* Realistic support
- \* Ocean
- \* Vending, Flexible
- \* Teach people to stand on their own
- \* Kadir - Educated Motivated Inter Sectoral Support Strong Tree - New Tree
- \* Teach community to work on it's own
- \* Programs support strong community must be taught from beginning

**SOCIAL MARKETING PROJECT, SCF/USA**

NEPAL (Gorkha District)

Background:      Pop    = 265,000  
                             Arca    = 2,505 Sq-Km

- Most Gorkha is accessible by foot-trails
- Attitudes ranging from 1,000 ft to 16,000 ft
- Gorkha District (68) Panchayats
- (9) Ilakas
- SCF/USA has been working since 1981

**SCF IS WORKING COMMUNITY DEVELOPMENT PROGRAM IN**

**(9) Panchayats (C-Bird)**

**Regular Program (Program Director)**

Agriculture	Adult Ed.	Drinking water	Infra-structure	Resource Conservation	Health
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Vertical Project

Social Marketing (Child Survival)

**THE PROJECT SELECTED TO SERVE (7) ILAKAS**

About (53), Panchayats

Pop about = 220,000 or 84  
of total = about 50,000 women

\* Two this 40,000 - 45,000 (5 years)  
Diarrhea related in child bearing age.

\* Every year delivery  
More than = 35,000 one children under (5) years  
Over = 16,000 one children under (2) years of age  
Over = 8,000 children under (1) year

- Ethnic groups: Brahmin, chettene Gurung, Muslim Newar, Magar  
Northerm - Tibeto - Burmese  
Lower Post Indo-Aryan

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## The Beginning of the Project

### (A) Baseline Survey

(quantitation Research) Average family size (6.31)

- Women (15 - 49)  
1050 respondents
- Knowledge % (pills, condoms, ORS)
- Practicing % pills = 0.96 %  
condoms = 1.0 %

### (B) Focus Group Research

- (10-12) men/women
- Knowledge, A, P
- Marketing strategy 4 P's, Product, Price, Place, promotion
- Tradition, belief, religion
- Human behavioral, Anthropological/sociology

## Team Work Activities

1. Social Marketing presentation in village Panchayats.
  - Head of village
  - Local leaders, school teachers
  - Influential people, village people

2. Men/women "F.G" in village

3. Selection of sales agents

4. (3) days intensive training

1st started in I. No. I

2nd " " IV

3rd " " VII

- \* Majority of S.A. Women, get incentives
- \* Women want to buy from women
- \* It is easier to mature woman by woman
- \* Criteria : Above 25, married, literate, active
  - (2) months
  - Every two months (Refresher)
  - Problems/salary
  - Products supply
  - New information
  - Pay incentives

Incentives Plan

"CYP" = 100 condom  
or  
13 cycles

<0:5.CYP	0:5-<1CYP	1-2CYP	2-3CYP	3-4CYP	4-5CYP	5-6CYP	ABOVE 6CYP
180 - 20	200 - 20	240 - 30	290 - 40	350 - 50	400 - 50	450 - 50	450 - 50
160	180	210	250	300	350	400	400

**SOCIAL MARKETING ORGANIZATIONAL CHART:**

Director (NFO)

Program  
Director

KTH  
Level

Health Consultant

Marketing  
Consultant

Project Coordination

Office  
Manager

GRK

Ass. Project Coordination  
Ass. Project Coordination CRS  
Company

I.No(1)

I.No.(4)

I.No.(7)

Supervision

(2) Supervisions

Supervisions

Sales Agents

Sales Agents

Sales Agents

26

42

32

Community

Sell  
CRS ----- SCF

Phase over

Company After (3) years Hand on  
(10) years to  
CRS Company

Where we are?  
In 23 Panchayats

I.No.(1) : Implements for one years  
I.No.(4) : " (4) months  
I.No.(7) : " (6) "

### Regular Users

I.No.(1) : Pills ( 7) women  
Condoms (25) men

I.No.(4) : Pills (39) women Drop-out 80%  
Condoms (x ) men (Pills)

I.No.(7) : Pills (34) women  
Condoms ( 9) men

### Total Sales :

(3) Ilakas = Dhaal = 13176 Condoms  
(Condoms) = (2195) PKTs  
Pills = 856 cycles  
T.T = 7103 PKTS  
(ORS) up to supt:

### Problems

Free List Vs Selling  
HMG Vs SCF  
Reduction Vs ...

People buy:

1. Due to carry accessible

2. Good service/follow up
3. Distance from health post/workers (HMG) 80%

\* Pills :

Heavy bleeding, Nurses, weakness, milk become len.

\* Condoms: - bursting (open-out)

- left Vision Region/to be operated out
- such the blood of women

To overcome Rumors

- Promotion program
- District level (Manager)
- Village level
  - a. Talk program
  - b. Group discussion (cassette recorder)
  - c. School health education program (ORT)
  - d. Video program
  - e. Poster competition

**AGENDA FRIDAY**

8.10            Increasing coverage and use  
                          Targeting  
                          Expanding

11.00           Action Plans  
                  Religious Break

LUNCH

3.00            Pre-Natal Care  
                  Family Planning

5.00            WAWA

6.00            Squash Prelims

**PROBLEM SOLVING TECHNIQUE  
 "FORCE FIELD ANALYSIS"**

Observation:

- \* There are conditions and forces that strongly support a high level of effectiveness.
- \* Also, there are conditions or pressures that strongly discourage effectiveness and act as powerful obstacles to change.

**HIGH LEVEL OF  
COVERAGE & QUALITY**

**RESTRAINING FORCES**

--	--	--	--	--

**EXISTING  
LEVEL**

--	--	--	--	--

**DRIVING FORCES**

**TASKS (Each Group)**

1. Identify some factors or pressures that strongly support changes in the direction of more coverage and quality.
2. Identify some pressures that act as powerful obstacles to achieving more coverage and quality.

**HOW CAN I IMPROVE THE COVERAGE & QUALITY IN MY CHILD SURVIVAL PROJECT?  
CHANGE  
HOW?**

1. **DEFINE THE PROBLEM**
2. **IMPLEMENT CHANGE**

## THE IMPLEMENTATION OF CHANGE

Change in the direction of more coverage & quality by:

1. Strengthen or add driving forces
2. Reduce or remove some of the restraining forces

Which ones?

### OBJECTIVES - Increasing coverage and use

1. To be able to target high risk children and women in order to achieve greater impact.
2. To be able to identify ways to increase population coverage of key CS interventions without reducing program quality
3. To be able to use the "force-field analysis" approach to problem solving.

## SCHEDULE

8:15 - 8:25	Introduction
8:25 - 8:45	Interview with SCF/Bangladesh
8:45 - 9:05	Small Groups
9:05 - 9:25	Small group presentations
9:25 - 9:35	Break
9:35 - 9:55	Interview with ADRA/Pakistan
9:55 - 10:15	Introduction to force-field analysis + Demonstration
10:15 - 10:35	Exercise
10:35 - 10:55	Presentations
10:55 - 11:00	Conclusion

## HIGH-RISK APPROACH

What high-risk is not:

- All infants or all < 5
- All pregnant women 15 - 45

Example of high-risk targeting:

- Think in terms of numbers (rule of halves)
- If no GM, you can target all sick children, and all children who look very thin.
- 2 simple rules:
  - a. All sick children must eat more, especially breastmilk.
  - b. All very thin children should eat more.

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## **BASIC ASSUMPTIONS BEHIND HIGH-RISK APPROACH**

1. Available resources are not sufficient to do all that should be done for mothers & children.
2. By choosing certain "high risk" women + children, we can use limited resources to have maximum impact.
3. For example, a CHW has 150 households with <5 children to cover. She can go to every home every 3 months or to 30 high-risk homes more frequently and low risk homes every 6 months.

## **TASKS OF SMALL GROUPS**

1. Choose one project in each group which is not using high-risk groups (or is not satisfied with their definitions) and choose 3 high-risk groups; define each one.
2. What will you do differently with the high-risk child or woman once she or he has been identified?
3. Give a 5 minutes presentation of your conclusions.

## **OBJECTIVES**

### **MATERNAL HEALTH, ANTE-NATAL CARE, + FP**

1. To identify effective and sustainable approaches to maternal and ante-natal care + FP
2. To share experiences regarding ways of achieving greater impact through MCH programs.
3. To prepare for tomorrow's field visit, incl. developing questions for pregnant women and TBAs.

## **SCHEDULE**

3:00 - 3 :30	Introduction to maternal health, ante-natal care & prevention of neonatal tetanus.
3:30 - 3.50	Interview with SCF/Indonesia
3:50 - 3:55	Break
3:55 - 4:30	Pak Andarus discusses village-level FP in Southeast Sulawesi.
4:30 - 4:55	Preparing questions for tomorrow's field visit
4:55 - 5:00	Conclusion + instructions for tomorrow's field visit.

CAUSES OF MATERNAL DEATHS

Country	MMR	Hemorrhage	Sepsis	Eclampsia	Abortion	Obstructed Labor	Other & Unknown
Bangladesh (Matlab, 1976-1985)	550	20	7	12	18	7	36
India (Anantpur, 1984-1985)	837	20	14	16	14	NR	35
Indonesia (Bali, 1980-1982)	718	46	11	5	7	NR	32

COST - BENEFIT COMPARISON

Cost per death prevented  
 (Assume pop. = 1,000,000 CBR = 46  
 MMR = 800/100,000)

1. 5 HC with transport + 5 small hospitals	\$ 2,516
2. 10 HC without transport	\$ 2,536
3. 20% pregnancies averted by FP	\$ 2,667
4. 10 HC with transport + 5% women treated in urban hospitals	\$ 8,203
5. 100% of deliveries by trained, supervised TBAs	\$ 17,250
6. 100% coverage by prenatal care	\$ 41,818

TT COVERAGE COMPARED WITH CHILDHOOD EPI COVERAGE

Country	TT-2	BCG	DPT-3	Polio-3	Measles
Bangladesh (1987)	7	14	9	8	6
India (1988)	58	72	73	64	44
Pakistan (1987)	27	72	62	62	53
Indonesia (1988)	29	74	61	61	55

SCF/INDONESIA (URBAN JAKARTA)

= PRENATAL CARE =

KADER'S  
TRAINING

TBA  
TRAINING

HOME VISIT/MIS  
(PREGNANT MOTHER  
CARD + MIS CARD)

MOTIVATION  
P.M.

PPKIA

1.m 1 IX 2 3 PREGNANT

HEALTH CENTER	POSYANDU	MOTHER GROUP
------------------	----------	-----------------

- Examination by: MW + TBA
- TT Immunization
- Counseling
- Iron tablets
- Weight-for height monitoring
- Other service

IF HIGH RISK -----> PUSKESMAS HEALTH CENTER -----> HOSPITAL

### QUESTIONS FOR TOMORROW'S FIELD VISIT

1. Use "reverse fishbowl" with resource persons in the center, interviewed by the circle.
2. 3 groups
  - a. One group decides on questions to ask pregnant women.
  - b. 2nd group decides on questions to ask TBAs.
  - c. 3rd group decides on questions about FP for either pregnant women or TBAs.
3. Each group prepares its questions for tomorrow.

### GROUP PRESENTATIONS "HIGH-RISK APPROACH"

#### PROJECT - AKF-P

1. III Deg. malnourished children 0 - 3 years
2. Pregnant women (below 20 years)
3. Pregnant (above 35 years)

### ROVITA - HKI : SOCIAL MARKETING FOR VIT. A DISTRIBUTION

- \* Target (original) :
  - All 12 - 60 month-old children
- \* Problem : The project treats all children in different - Ecological/social economy the result in some areas is not so high area the same way.
- \* Retargeting (high risk approach !!!!!)
  - Children 1 - 5 years old, who live :
    - Poor availability of Vit. A rich food (e.g.: dryness to social economy, where fish is expensive)  
(Source of information: Project, agric., Govt.)
- \* Intervention :
  - High risk groups : Mass promotion (radio, banner)  
Prioritizing (more intensive, more pregnant) under training/supervision materials.  
Individual (face-to-face health education).
  - Non high risk group: Mass promotion

## HIGH RISKS

- How we do differently
- Community volunteers and health workers will visit/pay special attention to the HR groups more frequently (depends on types of high risk)
- Counseling
- Referral to the health center
- Community in neighborhood encouraging to make the supplementary food for the malnourished child.

### HIGH-RISK TARGETS FOR DIFFERENT INTERVENTIONS SAVE, BANGLADESH

1. For Growth Promotion:
  - a. A child under 12 months of age, who fails to gain weight within 30 days.
  - b. A child from 12-36 month age group, who fails to gain weight within 60 days.
  - c. A child from 0-36 months age group, whose weight is less than the weight equal to three standard deviation below the NCHS median for both sexes.
2. For Immunization:
  - a. A pregnant woman without complete TT immunization.
  - b. A child from 9-12 months age group without complete immunization.
3. For Pregnancy Monitoring and ANC:
  - a. A pregnant woman <19 or >35 years old
  - b. A pregnant woman who previously delivered > 4 times
  - c. A pregnant woman with history of miscarriage and or any serious\* complication during previous pregnancies and child-births.
  - d. A woman, who got pregnant within one year from last child-birth.
  - e. A woman having twin pregnancies
  - f. A pregnant woman with a serious\* illness.
4. For Permanent Method of Birth-Spacing:
  - a. A woman, who has only 2 children and the youngest one is < 2 years old.
5. For Curative service:
  - a. A child under 5 years old with serious\* illness.
  - b. A pregnant woman with serious\* illness

-----  
\* Whether the illness is serious or not is decided by the field staff team which includes a medical assistant and a nurse-midwife, who use a guideline as well as their own judgment

### GROUP IV. HIGH RISK APPROACH

ADRA/INDONESIA

ROTARY POPULATION INDIA

PCI/INDONESIA

MOH/INDONESIA

## SCF/BANGLADESH

- \* Project chosen : Polio plus, India
- \* High-risk groups :
  - a. Children 9 - 12 months who have not received complete immunization.
  - b. Pregnant women with incomplete immunization
  - c. Children & pregnant women with post-vaccinal complication
- \* Things to be done :
  - a. Mop-up approach for a & b groups.
  - b. Training for volunteers on
    - 1. Post vaccinal vaccination
    - 2. Referral services

### POSSIBLE QUESTIONS FOR TBA

1. What is your name please?
2. Since how long you are working as TBA?
3. Have you been trained? by whom? how long? on what subjects?
4. Did you like that training?
5. Are you happy that we have come to see you?
6. Do you like to be trained again?
7. How many children do you have?
8. Who attended you in delivering children?
9. Do you give F.P. advice to couples?
10. When you have done the last delivery? what were the complications?
11. After the alcohol/yodium is exhausted, what do you do? Do you get any replacement? after How many days?
12. What do you get as incentive for attending a delivery?
13. What do you think about high risk (mother/child)?
14. What do you do when mother does not want TT?
15. When do you contact the mother first?
16. Have you ever heard that a child dies just after birth what are the symptoms.
17. What do you advise the mother about her child?
18. Do you report the birth to anybody? to whom? when?

### THE ROLE OF EACH SECTOR IN INTERSECTORAL TEAMS SPEECH BY DR. FERRY

#### 14 SECTORS

1. Directorate rural development:
  - Coordinate related sector to implement program in the village.
  - Increase the community participation in the village through LKMD including Posyandu (Community village resilience body)

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2. BKKBN (National Family Planning Coordination Board)
  - Motivate the people through communication, information and education in family planning.
  - RR in Posyandu
3. PKK (Family Welfare Movement)
  - Motivate the target group in Posyandu
  - RR
  - Implement the 10 program PKK in village including Health & Family Planning, Nutrition etc.
  - Motivate the target group in Posyandu through Dasa Wisma (ten family groups) in village.
4. Health Dept.
  - Motivate the people through communication, information and education in 5 program Posyandu by medical reason.
  - Professional services in table 5. (Immunization, pregnant mother exam, mother and under 5 children exam, IUD, injection).
  - Distribution the organizing to Posyandu needed (Vit A, Oralit, contraceptive).
  - Monitoring the 5 program
5. Public Welfare Division :
  - Coordinate related sector to supervise Posyandu
  - Monitor operational related sector.
6. (BAPPEDA Development Planning, District Board)
  - Coordinate related sector in planning the activities for the next year.
  - Coordinate related sector to plan the operational
  - Kantor operational related sector
  - Budgeting for the program each sector in Posyandu.

#### DISTRICT ROLE :

- Analyze and give information to subdistrict level.
- Intersectoral meeting
- Supervised subdistrict level
- Evaluate the result in Posyandu
- Travelling seminar
- Integrated the activities related to Posyandu actives
- Completion: P2WRSS, Dasa, HKN (Posyandu, PKK. LKMD), PPLK,
- Consensus meeting to implement program in Posyandu.
- Reporting to Province level.

#### QUESTIONS FOR MOTHERS

##### Antenatal

1. What special food do you eat during pregnancy?
2. Any food avoidance or restriction?
3. Do you eat the same amount of food during pregnancy?

4. Any activity avoided during pregnancy?
5. Have you ever checked your pregnancy - if yes, where & when?
6. What special activity you do?
7. Where do you expect to have your baby and what preparation do you need?
8. Past observation problem

### QUESTIONS FOR TBA's AND MOTHERS

#### FAMILY PLANNING

1. Why are you using FP services?
2. Who decides if contraceptives should be used? Do men support use of FP services?
3. Where do you receive services and how do you come to know about services?
4. If FP services are not used, why not?
5. What is the most popular method & why? What are the side effects?
6. Are there religious or social barriers to using FP services?
7. How many children do you have & how many do you want to have?
8. Do you want to have male or female children & why?

#### NAME AND MAILING ADDRESS OF PVO REPRESENTATIVES ATTENDING THE FIRST ASIA REGIONAL CS WORKSHOP.

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Name

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ADRA/PAKISTAN

(USAID)  
ADRA INTERNATIONAL (USA)

LOCAL GOVERNMENT

CHAIRMAN D/C

ADRA TRANS. EUROPEAN DW. ENG.

CHIEF OFFICER

ADRA PAKISTAN - ANDRA ADVISORY COMM.

D/C H.C. CHAIRPERSON

ADRA/KAH

D/C COORDINATOR ADRA CS PROJECT DIRECTOR - CSP ADVISORY COMM.  
M/O

ACC/SEC.

(DISPENSARIES)

TECH. ADVISOR

VACCINATORS

ASSIST. DIRECTOR - GAVE BIG HEAD  
"TALK TALK TALK"

PROVINCIAL

(3 FIELD TEAMS)

AREA SUPERVISOR

- 1 CH.WS (HOBASED PAID)  
(TBAS)
- 3 VACCINATORS  
DRIVERS

LOCATION RURAL KARACHI (60 - 130 KMS FOR CITY)

GEOG. AREA APPROX. 800 SQ MILES

TOTAL POP. 132.000

TARGET POP. CHILDREN 0 - 24 RL - 3.66% + 3.0%  
WOMEN OF CBA - 22%

INTERVENTIONS

1. MASS IMMUNIZATION
2. ORT
3. GM. (INC. NUTRITION ADVICE)
4. A.N.C.
5. BIRTH SPACING

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## OTHER ACTIVITIES

1. TRAINING CHWs & ASSISTING IN UPGRADING TBA's
  2. EST. 1 STATIC CENTER IN EA. U/C (WITH COLD CHAIN)
  3. EST. WELLS FOR POTABLE WATER
  4. MIN. CURATIVE (WHERE THESE SERVICES NOT AVAILABLE FROM OTHER SOURCES)
- 

1. Expectations of ADRA/I and USAID confused. eg. fixed centers no fixed centers (issue vital to sustainability) commitments made in D.I.P. but no budget.
2. No ADRA country level person USAID home office "talk talk" no active interest. csp. staff not advised re NGo. Dept. at home office.
3. In experienced management staff at base + unable to attend start up workshop due to political reasons.
4. Due to late start target area (too much "talk talk")  
Changed other agencies working change from urban to undeveloped rural. But on same small budget (app. 800 sq miles)
5. No maps available
6. No budget for baseline
7. Financial constraints.- No vehicle (suitable) for HQ "Spot" check supervision - poor field work (reasons given for poor performance "villages difficult to find + Suzuki van needed to be pushed most of the way.
8. General lack of dedication. (Too much romancing + not much work)
9. ADRA/I and USAID working closer together from proposal writing. We all know sustainability is key issue.
10. ADRA person at home office and AID Ngo keeping in close touch from proposal writing some funds way become available for Ngo.
11. Managers learned by experience + through workshops such as this (more efficient planning other staff from HQ already trained)
12. Budget proposed according to target area.
13. Only new area to be mapped. This will be done along with village family registration at beginning of project.
14. Budget for baseline also a person in place for community development who will select V.H.W from each community to assist.
15. A vehicle for HQ supervision budgeted (no car, no project)
16. Major emphasis will be on training master trainers from community who will train VHW's from each village.  
V.H.C. will be formed at beginning of project and guided in managing resources, record keeping and basically solving their own problems.
17. Networking with DHO's, PWP. UNICEF and other organizations for integrated program.
18. TBA'2 working teams - reporting problems.

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## ADRA/PAKISTAN

### VILLAGE FAMILY REG.

1. Names & ages parents
2. Names & ages of all children
3. Names & ages of all women of CBA.
4. Total number in each family
5. Pregnant women in house hold & ages
6. New borns
7. Deaths & cause if known
8. Fetal loss (M/C)
9. Vaccination status

- Easy identification of those due for vacc.
- Easy to trace drop-outs
- Correct acc. of births, deaths, preg + M/C
- Correct total census
- Involves community from beginning
- Costs very little
- Serves as part of on going evaluation
- Easy identification of at risk families

### TRAINING NON-LITERATE VHW's & TBA's

- I. INTRODUCTION (15')
- II. CARE/INDIA (15')
- III. AFRICAN EXPERIENCE (15')
- IV. PCI/INDO (15')
- V. AKF/PAKISTAN (15')
- VI. SCF/INDO (15')
- VII. QUESTIONS & ANSWERS (30')

### GROUP PROCESS TECH.

#### BRAINSTORMING

- Technique for generating new ideas by using group resources.
- Convince participants of the value of the whole group.
- The more diverse the group the more wide ranging the ideas for problem solving.

#### BASIC RULES

1. All members are encouraged to contribute ideas.
2. All ideas are accepted without criticism.
3. Contributions are recorded for all to see.
4. Large number of contributions is encouraged in the shortest possible time.

5. Criticism on judgement is deferred until the group has exhausted ideas.
6. Participation is rewarded by recognizing that the fine solution is the result of their contributions.

## CARE - INDIA

### TRAINING THROUGH NON FORMAL METHODS

- No hierarchical barrier
- All participant share their view
- No lecturing but facilitation
- Learners are adults with extended life history of experience & knowledge - no under estimation.
- Every participant is a facilitator
- Emphasis on process/contents
- Facilitator to have patience - attitudinal change
- Mutual respect amongst participants.

### METHODS/PROCESS ADOPTED

- Ice breaking
- Group formation
- Group discussions
- Sub group discussions
- Story telling
- Role play
- Brain storming
- Field visits
- Self critique/guided observations
- Illiteracy day
- Use of teaching aid.

### TRAINING OF ILLITERATE WOMEN

#### CRITERIA FOR SELECTION

- Who selects
- Age, experience, acceptability, family position
- Residential status, motivation
- Pick & drop from
- Training center in their own area
- Set on floor

## TRAINING TECHNIQUES

- Use local language (as medium of instructions)
- Create a friendly atmosphere and help them mix up with each other
- Use dummy
- Use posters and pictures
- Demonstrations and practical
- Role playing - let them get involved
- Try to involve in discussion and demonstrations
- Repeat again and again the lessons taught  
(Repeated exercise and role playing)
- Don't take 2nd topic unless the 1st topic is fully understood
- Pay additional attention to weak ones
- Trainer must be female, well experienced and cool minded

## COMMUNICATING WITH THE ILLITERATE

- Communication = Transportation of information from one individual to other.
- Illiterate are very sensitive to differences between exclamation (spontaneous movements, screams) and articulation (actions or verbal expressions)
- Concept of quality and mass.
- Concept of perspective
- Zambia Experiment
  - A simple line drawing
  - A silhouette
  - A "block-out" of the subject
  - A photograph

## TRAINING

1. TRAINING NEED ANALYSIS
  - Who participant
  - Level of education
  - Other
2. Develop training curriculum

### Implementation

- A. Pre Tes
- B. Pre condition
- C. Curriculum (methods/media)
- D. Evaluation
- E. Posters

Follow up  
R T

## CURRICULUM STEPS

1. Warming up
2. Process (methods?, media?)
3. Congelation
4. P.O.L.

## E. METHODS

1. Open Question
  - A. What do you see
  - B. Why does that happen
  - C. If that happens in your area, what should you do?
2. Role Play
3. Group Discuss
4. Practice

## HEALTH INFORMATION SYSTEM: USING DATA

### **Goal:**

Get participants to exam if they are really using data for feed-back to the community and project management to improve program quality.

### **Method:**

Group discussion lead by Robert Cunnane.

### **Leading Question:**

PVO Headquarters for many projects identified utilization of data and feed-back of information to the community as a problem of PVO field projects. What do they mean by this? Are people using data to make improvements in project implementation?

### **Discussion:**

SCF/Bangladesh is experiencing difficulty analyzing data in a central location and providing timely feed-back to the community. The central office makes graphs documenting things like immunization coverage for the health workers to explain to the community

SCF /Indonesia has trained there health workers to make information boards with pictures and data on immunization coverage, and under 5 attendance at the Posyandu. In some areas SCF has had success with this CARE/Indonesia, CARE India and SCF/Bangladesh have trial information boards with little success.

Worldvision regional officer mentioned the importance for managers to have information for project management, and supervision SCF/Bangladesh, ADRA/Indonesia WV/Bangladesh and ADRA/Pakistan say they are using information on a monthly basis for project management. It appears that the other projects are not analyzing and using data for management on a regular basis.

Dory Storms put emphasis on tracking quality and impact of programs. She used an example of monitoring your CDD program by ORS distribution. This information doesn't tell you if mothers we using ORS and if not, why they aren't using it?

AKF/Pakistan is trying to track causes of mortality for under's to track program quality and make charges in the program to impact on mortality.  
AKF/Pakistan is using verbal atopies to do this.

Rob Cunnane summarized by saying that your HIS systems should allow project managers to have "Their Finger on the pulse of the project". The information tells you how each intervention is doing and can be used to determine what worked and why and what didn't work and why. The information is received and analyzed in a timely manner so it can be used to improve the quality of the project.

### SATURDAY

7:30 Visit with TBA's & pregnant woman  
10:00 Process visit  
11:00 Religious break/action plants

### LUNCH

1:00 Training of VHW's & TBA's  
3:00 WAWA  
3:30 Hash; Boat Trip  
Dinner - Vendors, Kendari Beach - on Boat

### OUTPUTS - LESSONS LEARNED FOR ASIA PVO's

#### PROCESS

1. What interested/Impressed you most?
2. Any surprises?
3. What did you learn that could be helpful to your program?
4. What does your program have that could be helpful to them?

#### GROUP 1

1. - Interesting thing was that there were no pregnant woman while the population was more 1200.
  - Team work/integrated efforts
2. - No maternal & neo-natal deaths during last 2 years
  - No referrals necessary, to health center
3. - Involvement of village chief & his wife makes the program more effective.
  - Smaller target units makes the programs more manageable & effective
4. Sharing experience.

## GROUP 2

### PROCESS

1.
  - a. TBAs are happy to see healthy mothers & children.
  - b. TBAs generosity
  - c. Great faith in TBAs
2.
  - a. No preference for boy/girl
  - b. Husband's participation in wife's delivery.
  - c. Untrained TBAs don't put anything than oil on the umbilical stump.
3.
  - a. TBAs dedication and commitment
  - b. TBAs can become instrumental in CS activities.
4.
  - a. Training methods - Dummies
  - b. Promotion of permanent FP methods after certain number of children.

## GROUP 4

- A.
  1. Participation of PKK
  2. Very well organized
  3. Very good feeling of responsibilities of govt admm. officer.
  4. Good link between TBAs & govt.
- B.
  1. Health Services - Pregnant mothers not taking additional food besides their usual diet.
  2. Weaning body for babies starts as early as three months.
  3. Pregnant mothers not having choice of boys & girls.
  4. Weight of the child taken immediately after birth but not mentioned in Health Chart.
- C. Use of cigarette to estimate time for boiling & knife.
- D.
  1. Good incentives provided to the couple who has healthy child.
  2. Contribution to TBAs by the service users.
- E.
  1. In order to keep track of growth of the babies the weight record should be immediately recorded in Health Chart.

**GROUP 3**

(From session on increasing coverage & use force field analysis)

**RESTRAINING FORCES**

**HIGH LEVEL OF  
COVERAGE & QUALITY**

Inreach (passive) approach  
Low Socio-economic level  
Low educational level  
Large geographic Area  
Socio-Political Conflicts  
CHW dropouts  
Cultural Taboos, Beliefs, etc.  
Lack of Support from Govt/Community Leaders  
Insufficient Community Mobilization  
Time Constraints  
Communication Gap  
Low Community Initiative

**EXISTING LEVEL**

Dedicated, knowledgeable field manager  
Realistic design of Intervention  
Positive Approach  
Trained Manpower  
Adequate Funds  
Adequate Transportation  
Good Team Work  
Close Collaboration, Understanding With Community  
Collaboration with Government and Other Organizations  
Strong Supervising System  
Flexible Approach

**LOW LEVEL**

**DRIVING FORCES**

**GROUP 1**

From session on increasing coverage & use (Force field analysis)

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## RESTRAINING FORCES

### HIGH LEVEL OF COVERAGE & QUALITY

Lack of Government Support  
Lack of Skilled Manpower  
Dissatisfied Staff  
Not Planning Properly  
Poor Planning  
Too Many Bases  
Poor Linkage to the Community  
Mismanagement of Resources

### EXISTING LEVEL

Coordination with District-Level Government  
Well Defined, Achievable Objectives  
Availability of Resources  
Track Record of Success  
High Level of Community Motivation  
Motivated and Dedicated Staff  
Un-met Needs

### LOW LEVEL

Group 2 (From session on increasing coverage & use)

## RESTRAINING FORCES

### HIGH LEVEL OF COVERAGE & QUALITY

Trying to do too much  
Cultural Barriers/Taboos  
Ecological Barriers  
Lack of Government Support  
Compliance with the Donor's requirements  
Poor Communication

### EXISTING LEVEL

Team Spirit: Motivation, Commitment  
Skilled Manpower  
Proper Planning and Prioritizing  
Inter-Sectoral Collaboration  
Community Involvement (active)  
Funds for Logistic Support  
Building on Lessons Learned  
Good Supervision and Monitoring

## LOW LEVEL

### DRIVING FORCES

#### Day 8 - Morning

Lessons Learned 1/2 hr morning session

Participants' prioritizations of lessons learned were collected for subsequent analysis by the staff.

Participants were given a chance to correct or add to lessons learned.  
Consensus was reached on a list of lessons learned for Asia.

#### Next Steps 2 1/2 hr morning session

##### Presentations

Country Follow-up Plans  
Follow-up to WS by JHU, AID, PC  
PVO Action Plans  
Logistic, travel  
Roster distribution & correction  
Evaluation Form

#### Workshop Evaluation

1. What sessions/elements of WS were particularly useful for you?
2. Do you think you will use what you learned here in your work?
3. Process of WS :
  - a. Did you feel free to express your opinions?
  - b. Did you feel a part of the group?
4.
  - a. Was pre WS info useful?
  - b. Do you have any suggestions for improving it?
5.
  - a. Was the resource room useful?
  - b. Do you have any suggestions for improving it?
6. Comments to staff members.

#### Comments on AID Health and Child Survival Annual Report

1. AID should revise the forms early around June so there is time to learn about the new data required.
2. Question 9: Many categories dealing with nutrition activities, it's confusing and difficult to separate the costs for various nutrition activities.
3. Question 18 is good.
4. Don't change the form. It takes time to get used to a new form.

## Country Next Steps

### Bangladesh

1. Share about WS with people in the organization.
2. Try to adopt some of the processes at the WS to activities in their projects.
3. PVO staff make periodic visits to each project. Especially for evaluations.
4. Organize meetings of PVOs to discuss Lessons Learned. PVOs working in health.

### Pakistan

1. Keep in touch with each other to share successes and lessons learned.
2. Share projects visit periodically.

### USA

1. Report of lessons learned
2. Incorporate specific information learned in the workshop in the Technical update.
3. Complete 6 months evaluation with PVOs who attended.

### India

1. Rotary India will assist with care India to organize meetings with Rotary groups in CARE's project area so they can begin working together to promote CS activities.

### Indonesia

1. Midterm evaluation results will be shared among projects.
2. In each PVO project area informally meet with projects working in CS.
3. Attempt to organize meetings between the PVO projects working on CS every 3 months.
4. Share materials developed for project activities with each other.

### Nepal

1. Share information of project successes with each other.
2. PVOs make periodic visits to each other projects to learn from one another.
3. Will try to organize a country workshop among PVO's involved in CS.
4. Organize sports event among PVO's involved in CS.
5. PVOs will jointly bring issues to the MOH they feel need attention.

**APPENDIX 5:**  
**90-DAY ACTION PLANS**

**ACTION PLAN FOR 90 DAYS**  
**CARE INDIA**

**1. What do I want to achieve?**

- a. To collect logistic information for starting new (approved) project. Expansion of Oral Rehydration threa... project in Mandla district of Madhya Pradash from ICDS/Tribal blocks.
- b. Formation of Baseline Survey strategy in consultation with H.Qs/State Administrator/Field functionaries.

**2. What Will I do?**

- a. Design final formats for logistic information collection.
- b. Collect logistic information from Block/Village level in consultation with functionaries etc.
- c. Process the logistic information for its use in preparation of survey tools.
- d. To make logistic arrangements.
- e. To here surveyor's for data collection.

**Steps to be taken**

- Design formats in consultation with field officers.
- Visit project area with field officers and collect logistic information in consultation with District/Block/Sector/Village level functionaries.
- Process the logistic information for its use appropriate use in preparation of survey tools.
- Surveyor's lined.

**Schedule**

S.No.	Activity	Jan 90	Feb 90	March 90
1.	Development of Formats			
2.	Information Collection			
3.	Logistic Arrangements			
4.	Process Logistic Information			
5.	Hiring of Surveyors			

**Milestones:**

1. Formats developed
2. Meetings held with District/Block/Village level functionaries and logistic information collected/logistic arrangements made.
3. Logistic information processed
4. Surveyors hired

**POSSIBLE CONSTRAINTS**

- Non-availability of some of field functionaries
- Non-availability of some logistic info/data
- Home office may not agree to above plan.

**POSSIBLE SOLUTIONS**

- Will send info. to concerned functionaries in advance about visit.
- Advance information to functionaries to keep required data ready
- Flexibility/No solution

Submitted by

(S.K. Kapoor)  
CARE-India

**90-DAY ACTION PLANS  
PCI/INDONESIA**

**GOAL:** Strengthening PSTs ability recognize and solve problem at the Posyandu.

**OBJECTIVES:**

1. Using quarterly report to know Posyandu problems.
2. Find out of problem solving by force field analysis.
3. Make the action plan.
4. PST districts get practice at sub-district (transfer knowledge in how the problem solves).

**STEPS**

<b>OBJECTIVES</b>	<b>TIME TABLES</b>	<b>CONSTRAINTS</b>
1. Using quarterly report to know Posyandu problems: - Collecting data of fourth quarterly (Oct-Dec)1989 - Compare between fourth quarterly	PST District Jan 1990	Health Centers usually rate to send LB5/LB3 (Monthly Report)

data with last  
quarterly report.

- Analyze problems  
the fourth quarterly  
report especially  
percentage of active  
Posyandu community  
participate and  
active cadre.

2. Find out of problem  
solving by force field  
analysis. Jan 1990

- Discuss using the  
force field analysis
- Choice which one  
specific solve problem
- Choice one subdistrict  
for practicing

3. Make the action plan  
- Compile action plan  
using by PST district Jan 1990

4. PST district get  
practice at subdistrict  
(transport knowledge in  
how the problems solves) Feb 1990

- Training for PST sub-  
district with some  
method

5. Evaluation :  
- Action plan  
- Indicator percentage  
of active Posyandu,  
community participate  
and active cadre.

**PARTICIPANTS** - Participants at district level: PST = Posyandu Supervision Team.

1. Head of PST district (Women Welfare Association)
2. Health Office
3. Family Planning Board
4. Planning and Development Board
5. Rural Development Board

Total Participants : 5 persons

This 90 days action plans will try of all district (Kendari, Kolaka, Muna and Buton) and will be organize by each Project Manager.

CARE INDIA (ORISSA) 90 DAY ACTION PLAN BY L.R. PANDA

**GOAL :** To enhance awareness of village mothers (age group 15-45 years and having children less than 36 months) on growth promotion/home management of diarrhea/immunization in CS project areas.

**SPECIFIC:** 1. To start village level training in 50% of anganwadi centers by the end of third month.  
2. To increase awareness of mothers having children < 36 months in 50% villages of CSP area on growth monitoring/home management of diarrhea/immunization.

ACTIVITIES	TIME	RESPONSIBLE	CONSTRAINTS
1. Meet ICDS field staff and finalize training session plans in 50 AW centers.	January 20-31, 1990 February 1-10, 1990	Care F.0-5-2 ICDS CDPOs-4 ICDS supervisors- 20 AWWs-50	1. ICDS field staff may not be available
2. Training/ monitoring in 25 AW centers for 250 mothers.	February 12-28, 1990	AWWs Supervisors CDPOs CARE FOs	1. Dropouts of AWWs & mothers 2. Non-availability of suitable training venue
3. Move to another 25 AW centers for training in those 25 centers.	March 5-10, 1990	CARE FO ICDs supervisors concerned AWWs/CDPOs	ICDs supervisors may not be available. Same is applicable to AWWs.
4. Training/ monitoring in 50 centers (25 of Feb. and 25 of March) total 500 mothers, 10 per center	March 15-31, 1990	AWWs ICDs supervisors CARE FOs CDPOs	-Drop-outs of mothers -Some AWWs/supervisors may avail-leave -Unsuitable training venue

## 90 DAY ACTION PLAN SCF NEPAL

### COMMUNICATION AND SUPERVISION

#### Objectives :

- \* Continue communication system between Gookha and Kathmandu efficiently in the absence of health consultant/health program officer.
- \* Continue supervision system in the absence of health consultant/health program officer.

#### Activities:

- \* Selection of person(s) in Kathmandu level who can spare time to look after CS/health program.
  - See time schedule of each program officers in Kathmandu and of coordinator and assistant coordinator.  
(Program Director Dec. 2).
  - If all are packed prioritize some of the urgent activities and keep aside less urgent activities for 90 days.  
(Program Director + Program Officer Dec. 2)
  - Prepare a list of activities which health p.o. is supposed to do (general list follows)
    - = Go thru progress reports, training reports, sales agents report, sales reports etc.  
(Program officer on going Dec.3 on ward)
    - = Provide feed back on the reports to Gookha  
(Program officer on going Dec.3 on ward)
    - = Make sure data has been entered and analysis and feed back is sent to Gookha.  
(Program officer on going Dec.3 on ward)
    - = Make sure the supplies are being sent regularly as per the demand.  
(Program officer on going Dec.3 on ward)
    - = Hold monthly meetings to know the progress and problems and find solution.  
(Program officer Jan. 1, Feb. 1)
    - = Do liaison needed with other related agencies.  
(Program officer as per need)
    - = Visit field, at least twice in 90 days to get firsthand information.  
(Program Director + Program Officer Jan. 3, Feb. 3)
    - = Conduct one sector/program meeting  
(Program Director + Program Officer Dec. 3 or Jan.1)
  - With clear stops give the responsibility to the program officer selected.  
(Program Director Dec. 2)
  - For technical problem contract a doctor for two hours time every week and help solve problems.  
(Program Officer Dec. 3)
  - Program Officer and doctor will solve technical problems and send to field.  
(Program Officer + Doctor every Friday)
  - A review meeting with Director, Deputy Director, Program Director, CS coordinator, CS assistant coordinator and Program Officer.

Conditioned to directors approval: Jan 4

- \* Advertise in local newspaper for program officer  
(Admin. Jan. 1)
- \* Interview  
(Director, Program Director Feb. 1)
- \* Recruit  
(Director Feb. 2)
- \* Handover responsibilities to new program officer.  
(Program Director Feb. 3 or 4)

90 DAY ACTION PLAN  
AKF PAKISTAN

CREATE & USE SELF CHECKLISTS

Objectives :

1. Improve quality through clearer thinking on what we do & why we do it.
2. Promote teamwork by involving all staff.
3. Examine growth monitoring in more depth.

Gul + Steve to work together in Punial

Meeting 1 : 6 Feb. 1990

Meet all staff to explain idea.

Sep up groups to make checklists

- a. Growth monitoring in health center
- b. Supervisory/support visit to health center
- c. Follow up meeting with volunteers
- d. VO/WO meeting

Meeting 2 : 28 Feb. 1990

Meet all staff to review & finalize list

Spend 2 months using lists with Gul & Steve helping out in field.

Meeting 3 : 15 May 1990

Meet all staff to review results & prepare report for sharing with other field modules.

Meeting 4 : Beginning June 1990

Share in larger workshop & decide if wider use would be helpful or not.

Constraints & Contingency Plans

Staff unable to meet at designated times in which case meetings will be adjusted by one to two weeks.

Checklists not short enough, in which case additional meetings can be held to discuss with staff.

NEPAL ANP/CS III  
90 DAY ACTION PLAN

**Problem:** Irregular attendance of vaccinators

**Topic:** Strengthening Coordination and cooperation with District Public Health, Office (DPHO), Regional Health Posts (RHP) and Mothers Groups.

**Objective:**

1. To minimize absence of vaccinators to boost up coverage in immunization and other mobile comp activities.
2. To fit program activities into government's system.

<u>ACTIVITIES/ TASKS</u>	<u>PERSON(S) RESPONSIBLE</u>	<u>1ST QTR 1990</u>	<u>POSSIBLE CONSTRAINTS</u>
1. Meet w/DPHO (to discuss problems general consensus on actions to be taken) (Public Health Directorate)	(CR), FPM/PC  CR/FPM/PC	Jan (ii)  Jan (II+)	  If PHO not able to respond, appeal to PHD at local level.
2. Meet w/DPHO and RHPs to prepare together and agree upon: a. Prepare joint-action plan/ schedule of health activities. b. Reach agreement on deployment & 2 vaccinators to stay regu- larly in project area. c. Reach agreement on payment of salaries to vaccinators from project budget and reimburse- ment of it from DPHO monthly.		Jan (IV)	
3. Meet with Mother's Group and female health volunteers (FHV): a. To discuss mobile camp schedules. b. Their role in tracking pregnant women and new-borns.	EPI-coord/ Nutrition/ CD	Feb. (1-IV) March (1-IV)	

4. Follow-up meet with:

DPHO

RHPs

FPH/PC Feb.(I-II)

EPI-Coord Feb.(I-II)

March(I)

Evidence of success:

1. No disruption in immunization schedule
2. Increased Mother's Groups Participation in Mobile Camps
3. FHVs working more actively

ADRA PAKISTAN  
90 DAY ACTION PLAN

Objective: to train V.H.Ws from remote areas to manage services in there own areas.

Specific objective: to train 30 VHWS 90 days especially to provide promotion for vaccinations give ORT training to mothers and give ORS and assist with village family registration.

DATE	ACTIVITY	BY WHOM	CONSTRAINTS
Jan 1990 15 - 30	Meet & communities form VHC Select VHW trainers & assistance from VHC Select Centers for Training	Dr. Dur Moh Baloch Dr. Ayub Walayat Naomi	No Transportation community factors
Feb 1 - 14	Obtain/Make Teaching ADS Identify Trainers	Dr. Dur Moh Dr. Ayub	
Feb 15 - 28	Teaching by Aids & posters; role play; discussions; one illiteracy day	As per selection; supervised by Dr. Dur. Moh.	
March 1 - 31	Field Exp. under Close Supervision	Field Supervisor Dr. Ayub Area Supervisor	
April 1 - 15	Evaluation-retraining in weak areas	Naomi/Dr. Dur. Moh. + trainers	

SCF BANGLADESH  
90 DAYS ACTION PLAN

Objectives

By March 30, 1990 a draft supervisory manual for field staff will be prepared and ready for field testing.

<u>Activities</u>	<u>Person to be involved</u>	<u>Time Frame</u>	<u>Constraints</u>
1. Find out the things to be considered for preparation of the manual.	Director, Dy. Director Program Officers	Jan.1-10	
2. Supervisory need assessment through task analysis method using job-assignment of the field staff.	Dy. Director, PO Public Health Officer	Jan.20-30	
3. Supervisory need assessment through discussion with field staff and find out how much is really needed and doable by the field staff.	2 field team PO Public Health Officer	Feb.10-20	
4. Prepare a draft supervisory manual	Public Health Officer	March 1-10	
5. Reviews the draft manual with field staff and finalize it.	The above mentioned field-staffs teams and Public Health Officer.	March 20-30	

OUTPUT

A draft supervisory manual for field-staff.

is ready for field-testing

Prepared by: Dr.SK.Md.Aminul Islam (Dr. Amin), Public Health Officer  
Save the Children (USA)- Bangladesh Field Officer

DR. KABIR U. AHMED  
WV-BANGLADESH

90 DAYS ACTION PLAN

Goal:

The Project Manager of Kamalapur CS project will be able to use costing program of immunization component for decision making as well as improving quality.

Specific Objective:

The PM will start costing the immunization component of kesp by April 30, 1990.

<u>Activities</u>	<u>Time Table</u>	<u>Persons Responsible</u>	<u>Constraints/Contingencies</u>
A. Self Orientation on Cost Effectiveness Analysis: 1. Literature/books reviewing (e.g. Cost Effectiveness Analysis - Prigor) 2. Consultation 3. Initial paper work & planning exercise	2/28/90	-Self -Dr. Chander -WVRD -Prgrm Mgr. -Local resource people	If Appropriate materials are not available on time, contact Regional Office/WVRD and other alternative resources for assistance.
B. Sharing/orientation with the PM, care-team members & finance and Admm.	3/15/90	-Self -PM -Care Staffs -Finance	If schedule changed, and time constraints for project/FO
C. Go Through the Exercise: 1. Review the existing accounting system/procedure of project - Interview project mgr & finance/admm people - Go through past & current financial reports/records. - Identify direct & indirect costs for EPI component.	3/30/90	-Self -PM -Finance -Local Resource (EPS, UNICEF, WHO, etc.)	If preoccupied with certain additional unexpected assignments, these will be delegated to PM, finance/admm. people & other relevant FO people after appropriate orientations.

- |  |                |   |   |
|--|----------------|---|---|
| <p>2. Analysis of different staffs time involvement on EPI component</p> <ul style="list-style-type: none"> <li>- List of major activities of each staff</li> <li>- Approx. % of time involvement analysis (quick method)</li> <li>- Identify the activities of imm. for both promotion &amp; service delivery</li> </ul>                                  | <p>3/15/90</p> | <ul style="list-style-type: none"> <li>-Self</li> <li>-PM</li> <li>-Other core team staffs</li> <li>-Finance</li> </ul>   | <p>If occupied with other assignments/out of country, these will be delegated to the PM, operations coordinator and finance and admn. people.</p> |
| <p>3. Analysed the information/ data collected</p> <ul style="list-style-type: none"> <li>- Costing the EPI component both in terms of promotion and service delivery.</li> <li>- Cost per beneficiary</li> <li>- Determine usefulness of analysis &amp; make recommendations to explore whether it will be possible to go through this process</li> </ul> | <p>4/25/90</p> | <ul style="list-style-type: none"> <li>-Self</li> <li>-Dr. Chander</li> <li>-PM</li> <li>-Finance/FO</li> <li>-Local Resources (EPI, UNICEF, MOH, WHO, etc.)</li> </ul> | <p>If somebody is not available, look for alternative resource.</p>   |
| <p>4. Develop a 3-month plan for getting report from the PM.</p>   | <p>4/30/90</p> | <ul style="list-style-type: none"> <li>-Self</li> <li>-Dr. Chander</li> </ul>   | <p>If project manager has any problem, provide him assistance (in obtaining report from PM).</p>  |
| <p>5. Submit report &amp; recommendations to regional office WVRD &amp; PVD CS support (JHU) program.</p>  | <p>4/30/90</p> | <ul style="list-style-type: none"> <li>-Self</li> <li>-FO Staff</li> <li>-(field Dir., Fin Directs)</li> </ul>  |   |
| <p>6. Follow-up review of report &amp; recommendations at MT evaluation.</p>   |                | <ul style="list-style-type: none"> <li>-Self</li> <li>-Dr. Chander</li> <li>-PM</li> <li>-Care Staffs</li> <li>-MTE team</li> </ul>                                     |   |

DOLI SITUMEANG  
ADRA - INDONESIA

90 DAY WORK PLAN

Goal

Develop and improve system of project reporting from three field project managers to ADRA country office that will allow completion of ADRA reporting requirements to USAID, ADRA International, and the government of Indonesia without unnecessarily disrupting field activities.

Specific Objective

Within 90 days, we will be able to have an appropriate reporting system.

No.	Activities	Time Table	Persons Responsible	Constraints/Contingencies
1.	Go through project description to see what objective and indicators the project has agreed to follow.	Jan. 1990	Doli/Program Assistant Anas/Program Assistant	
2.	Go through USAID reporting form and list what is needed for reports.	Jan. 1990	Doli/Program Assistant; Iim/Country Director; Jennifer Brinch/USAID Health Coordinator; Raja/Treasurer/ Anas/Program Assistant	
3.	Go through currently rec'd project reports (this is routine Psyandu service report from the Ministry of Health).	Jan. 1990	Doli/Program Assistant; Anas/Program Assistant; Iim/Country Director; Govt Health Personnel; Raja/Treasure	
4.	Make a list of all data still needed: how frequently for each piece of information; what priority	Jan. 1990	Doli/Program Assistant; Anas/Program Assistant	
5.	Send the list to all project directors: find out what they can and can't report; find out whether there is more information needed, or maybe we need to eliminate unnecessary information.	Feb. 1990	Doli/Program Assistant; Anas/Program Assistant	Because of distances betw. country office & the project, it will take time.

6.	If there is still more information needed, discuss with field officer, ADRA country office personnel, govt health personnel & USAID personnel.	Feb. 1990	Doli/Program Assistant; Anas/Program Assistant	
7.	Develop the reporting form and pre-test the acceptability of the form with the field office	Mar. 1990	Doli/Program Assistant; Anas/Program Assistant; Field Officer Project Director	Maybe there are certain things to be clarified when pre-testing, which can't be done since only the field officer can do this.
8.	Modify as necessary.	Mar. 1990	Doli/Program Assistant; Anas/Program Assistant	
9.	The reporting form ready	End of Mar 1990	Doli/Program Assistant	

I will know that the task is accomplished if reporting system from field office to country office fits with field Health Information System and is adequate for reporting requirements, the field officer able to complete forms and send in on time, and I am able to compile the reports.

**ROTARY POLIO PLUS INDIA**  
**90 DAY ACTION PLAN**

**GOAL:** To estimate the effectiveness of Polio Plus Program in India

**OBJECTIVE:** To design a questionnaire and prepare a plan for conducting cluster survey and collecting info. on morbidity pattern due to vaccine prevention table diseases in four areas.

S.N.	ACTIVITY	TIME PLAN	PERSON RESPONSIBLE	CONSTRAINTS
1.	To discuss the action plan with colleagues in Rotary to have a commonly agreed plan.	Jan. 20	Self	Some changes may be required.

S.N.	ACTIVITY	TIME PLAN	PERSON RESPONSIBLE	CONSTRAINTS
2.	To identify Jenr Rotary Clubs where polio plus activities have been for over a year.	Jan. 30	Self	
3.	To contact the clubs to discuss objectives, time schedule, no. of volunteers required, their training, etc., for conducting cluster survey.	Feb. 15	Self and Colleague	It is possible that other person is not available and may have to visit all Jan. clubs, which means longer time.
4.	To prepare enough copies of cluster survey Jermis for conducting survey in Jenr club areas.	Feb. end	Secretarial staff in the office	
5.	To prepare a questionnaire for collecting information from local hospitals and medical experts on morbidity pattern due to vaccine preventable discharges.	Feb. end	Self and colleague	
6.	To discuss with experts in ministry of health and UNICEF the questionnaire design.	March 15	Self	The questionnaire may require revision to include inputs.
7.	To revise design after the discussion according to suggestions.	March end	Self	
8.	To fix dates for conducting training for volunteers who will collect data for cluster survey.	April 1st	Self	
9.	To set up time pattern for conducting cluster survey and collect information on morbidity pattern.		Self	
10.	To prepare action plan for conducting survey.	April	Self	

The criteria for completion of this plan and its implementation will be that the questionnaire will be ready and next action plan will be ready to conduct training and collect data.

SRI CHANDER  
WV THAILAND  
90 DAY ACTION PLAN

**Goal:** The project manager of 2 WV Bangladesh CS Project will be able to obtain, analyze and use financial information for decision making to improve program quality.

**Objective:** The 2 project managers will start calculating annual recurrent costs of council program elements as well as cost per beneficiary of immunization intervention from May 30, 1990.

<u>ACTIVITIES</u>	<u>PERSONS RESPONSIBLE</u>	<u>CONSTRAINTS</u>
<b>A. PLANNING/PREPARATION</b>		
1. <u>Background Reading</u> on cost accounting and effective analysis:		
a. Review old JHU notes	Self	If unable to get, contact John Quinly in Beijing.
b. Get paper on cost-effective analysis	Pricor/Self	
c. Get cost-effective software analysis.		
2. <u>Technical Consultation</u>		
a. Meet with WV accountant	Self/John Key	If essence people unavailable, will talk on... If funds available for (AFK Pakistan) Steve, speak to Regional Director.
b. Meet with Dr. Reinke, JHU	Self	
c. Meet with PRICOR	Self	
d. Recruit Steve Rasmussen	Self	
3. <u>Planning with Costing Exercise</u>		
a. Determine dates, objectives, methodology & process, expected outcomes & evaluation of proposed costing exercise.	Self, Kabir John Key Jeanne D'Csab	If schedule changed, will... World Asia Regional Director SWV Bangladesh Field Director. On new dates, will also delegate responsibility to Dr. Kabir if sudden change in itinerary.
b. Short list materials & prepare visual aids for exercise.	Self, Kabir, Dr. Resnke	
4. <u>Prior Communication</u>		
a. Confirm with WV Bangladesh on dates, objectives & expected	Self, Kabir	

outcomes of exercise.  
 b. Send advance reading materials to 2 project managers, Dr. Kabir & WV Bangladesh Field Director

Kh. Vipadz  
 Kabir  
 Self

Mail is unreliable, send materials by .....

**B.PROCESS**

1. Review Exercise Objectives & Outcomes  
 with Dr. Kabir & 2 project managers & Finance/ Admin Officers

Kabir, Self  
 WVB Accountant

Civil Unrest-plan timetable & be prepared to stay longer  
 (have min 2wk visa)

2. Review with each Project Manager  
 The current accounting system of his project:

- a. Interview project mgrs Admm/ finance officers to find out whether they are using financial data for decision meeting, resource for doing so or not.
- b. Review of past & current financial reporting procedures & formats.
- c. Discussion on basic cost accounting principles and practices.
- d. Discussion on outcomes of cost accounting for decision making.
- e. Revision of financial reporting formats to reflect cost centers.

Kabir, Self  
 WVB Accountant

Kabir, Self  
 WVB Accountant

"  
 WVB Accountant

3. Interview Project Staff on 2 Projects:

- a. List current major activities of staff.
- b. Estimate rough percentages of staff involvement in various activities, including immunization (rapid assessment).
- c. List all activities for health prevention & service delivery of immunization intervention.

Dr.Baser (WHO)  
 Dr. Talukder  
 Kabir, Self

If consultants not available, talk to them on phone & request for alternative consultants.

4. Analyze and Calculate the Following:

- a. Direct & indirect costs of project.
- b. Recurrent costs of project (FY89).
- c. Direct & indirect costs of the EPI

Kabir, Dr. Baser  
 Self, WVB Accountant  
 "

- intervention
- d. % of staff field spent on both health preservation & since delivery of immunization component "
- e. Cost per beneficiary of the immunization intervention. "

### C. PRODUCT

- |   |                              |  |
|---|------------------------------|--|
| 1. Written report of outcomes of cost acctg analysis.   | Self/Kabir<br>WVB accountant |  |
| a. recurrent costs of project   |                              |  |
| b. cost per beneficiary of immunization intervention  |                              |  |
| 2. Written review of the usefulness of this approach & exercise: whether to outcomes this approach or usalify it.   | Self/Kabir                   |  |
| 3. Written recommendations to WV Bangladesh on what steps to take in the next 3 months after the execution.   | Self/Kabir                   |  |
| 4. Submit report on exercise outcomes' usefulness of approach & proposed next 3 month activities to PVO child support unit, SHU, WV Bangladesh, World Asia Regional Office & WVRD (PVO HQ). | Self/Kabir                   |  |
| 5. Debriefing with Project Staff JWV Bangladesh Field Director & Senior Management Team..   | Self/Kabir                   | If unavailable or out of town, will call from Bangkok & give phone debriefing. |

### ADRA - CS. HEALTH CADRE REFRESHING INDONESIA

I. Issues : In the program Kaders need refreshing

II. Objectives :

A. General :

1. Within 90 days & among the 17 L.H.C. will give refresher for 30 Kaders each.
2. 80 % of Kaders improve the way they trace the at Rish group and do Reporting.

**B. Specific :**

1. 80 % of Kaders have the knowledge and skills to identify the EPI, Diarrhea cases and Nutrition or Growth - monitoring drop outs.
2. 75 % children and pregnant women given follow up.

**III. Period of Refreshing : 2 days ( ..... hours)**

**IV. Refreshing Participants**

1. Maximum numbers of participants are 30 persons
2. Men/women chosen by village community be sure they can reach or write.

**V. Personnel of Faculty :**

**A. Refresher staff :**

1. Project Director
2. M.O.H. Consultant of the Region
3. L.H.C. Doctors

**B. Facilities :**

1. Classroom (village hall or at the office of the village head)
2. Supplies and materials for demonstration:
  - Weighing scale, arins conference bands
  - Road to health cards (KMS)
  - Flip charts, posters, hand-outs material
  - Glass, spoon for ORS (home made)

**VI. Methods and Procedures :**

Suitable for the refreshing participants (Kader) that can carried out through any of the methods bellow:

1. Pretest/Postest
2. Group Competition
3. Demonstration
4. Role Playing
5. Assignments

**VII. Constraints/Contingencies**

1. The weighing scales we are using is not accurate.
2. Time, Kaders move slowly.
3. Others facilitator don't really understand thoroughly the Project Objectives.

**VIII. Sustainability**

1. Involve the leaders in the community
2. The knowledge and skills of the Kaders in the community

## KADER REFRESHING SCHEDULE

January - April 1990

Day/Date	Time	Subject	Instructional Goal	Trainer	L.H.C.
I. Mon	8:00-9:30	Opening Program/Pretest	To know how for their knowledge on at-risk groups	Project Director	Pineleng Jan 22
23	9:30-9:45	Break			
	9:45-12:00	Nutrition, Growth Monitoring System	80% of Kaders increase knowledge & skills to identify EPI, TT drop out	L.H.C. Doctor	Tetali Feb 5-6
LUNCH					
	3:00-4:00	Diarrhea & Rehydration	80% of Kaders learn techniques & skills to determine diarrhea cases	L.H.C. Doctor	Talawaan Feb 19-
20	4:00-4:55	Recording, Reporting	Increase Knowledge on how to do report promptly & accurately	Project Director	Sawangan Mar 5-6
	4:55-5:00	WA WA			
II Tues	8:00-9:30	Communication & Information; Social Marketing System & Counseling	To cover 80% of Kaders have capability	Project Director	Kolongen Mar 19-
20	9:30-9:45	Break			
	9:45-12:00	Pre-Natal Care TT Immunization	80% of Kaders increase knowledge and may help 90% of pregnant women	L.H.C. Doctor	Tatelu Apr.2-3
	3:00-4:00	Family Planning	80% of Kaders increase knowledge to help couples to follow FP pregnant	L.H.C. Doctor	Kema Apr.16-
	4:00-4:10	Break			

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	4:10-5:00	Post-Test and Closing Ceremony	To know how Kader have learned and how closely goal has been reached	Project Director	Koya Apr-30-1st May
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Note : All are scheduled on Monday - 1st day  
Tuesday - 2nd day

### LIST OF LESSONS LEARNED

#### ON SUPERVISION & MANAGEMENT

1. Long term regular follow up system should exist to maintain & improve a program. - Group 5.
2. Supervision and "formative" training" should be a key element of management of CS project. - SCF, Bangladesh.
3. The person who trains the health staff/CHW/VHW should be the same person, who supervises those health workers. - WV, Asia Region.
4. Health education and continuous follow-through is essential in order to out-down the high drop out rates from intervention.
5. Adequate and proper type of vehicles is essential for supervision, especially for rural areas. - ADRA, Pakistan, Group 1 & 2.
6. Headquarter's supervision should be regular.  
- ADRA, Pakistan.
7. Suitable qualified field staff should be in key position.  
- ADRA, Pakistan.
8. It is important to visit other AID-funded CS projects to learn from them to prevent ourselves from re-inventing the wheel. - WV, Asia Region & Group 4.
9. Simple scientifically sound & quick surveys are always useful to assess program status. - Group 4 & WV, Bangladesh.

#### ON COLLABORATION WITH GOVERNMENT & SUSTAINABILITY

10. Every effort should be made to involve government staff in all stages of planning and implementation of the program. However, strong support by community leaders is required to supplement the limited resources of government and to ensure sustainable local management of Posyandu services. - CARE, Indonesia.
11. Phasing out often becomes "boomerang". Hence, phasing out should be prepared from the beginning of the project to facilitate development of sustainability among the community. - SCF, Indonesia.
12. Projects conducted in response from the community need have greater chance of success. - ADRA, Pakistan.
13. A better system of supervision and incentives for Kader needs to be developed which can be sustained by government and village leaders. - CARE, Indonesia.
14. Importance of soliciting an interdisciplinary constituency to facilitate community ownership of

- project goals. - WV, Asia Region.
15. NGOs should network with other NGOs and government organizations and local welfare organizations. -ADRA, Pakistan.
  16. Raising volunteers in real sense is quite unrealistic in poor countries where poverty and unemployment/ underemployment is a common phenomenon. So, community volunteers in a given project area may not give sufficient commitment to their tasks unless some consideration is given to monetary and non-monetary incentives for them. - WV, Bangladesh.

#### **ON EXPANSION & COVERAGE**

17. Maps and proper information about the area is necessary. - ADRA, Pakistan.
18. Need 6-12 months for community assessment and planning before a PVO enters a new area, PVO staff involved in this initial stage should come from proposed project area. - WV, Asia Region.
19. High rate of population shift, both in and out of the project area in urban context is one of the major constrains in terms of project coverage. - Group 4 & WV, Bangladesh.
20. Reliable female workers who can speak local dialogues are absolutely essential. - ADRA, Pakistan.
21. In a male dominated society, female health workers are not sufficient enough to educate the male population and a team of health workers from both sex is essential to cover the whole family.

#### **ON DEFINING OBJECTIVES, TARGETS & STRATEGY**

22. Objectives & targets should be well-defined and then target should be fine tuned appropriate to the intervention with periodic review and necessary correction. - SCF, Bangladesh & Group - 3.
23. Small, achievable target in the beginning of project to create nucleus for transformation. - FFH, Nepal, Group 4.
24. Target all socio-economic classes in a given project area, as the health education status of mothers of even the middle & upper-middle class in urban areas have been found to be low. - WV, Bangladesh & Group 4.
25. Project strategy should be well designed at the beginning of the project. However, it should be flexible to be able to adjust with local condition. - SCF, Indonesia.
26. Women's participation should be given high priority for successful implementation of CS interventions. -FFH, Nepal.
27. The male members, who are the ultimate decision-makers, should also be targeted for education and motivation. - SCF, Bangladesh, ADRA-Indonesia, Group 1 & 3.

#### **ON TRAINING**

28. Training is needed for everybody involved in the project :
  - Orientation at the beginning
  - Continuing as per need. - Group 3
29. Training is a critical component of a project as a mean to transfer idea, skill & technology. Therefore, training should be designed (either formal or non formal) in accordance with the local need and condition. - SCF, Indonesia.
30. Task-oriented training sessions should be organized for village leaders and Kader coordinators. The training should focus on enhancing practical skills, problem-solving abilities and planning & management capacities. - CARE, Indonesia.

31. In country personnel should be trained to a level where they can satisfactorily give technical assistance. They should conduct their own survey and evaluation to reduce unnecessary cost. - ADRA, Pakistan.
32. Train all VHWs locally. - WV, Asia Region.
33. Difficult to train workers with different level of literacy. Teaching materials are necessary, especially for illiterates. Participatory training more effective. - Group 5.
34. Trainer should have good skills & should not lose patience, when training shy people. - Group 5.
35. It is very important for the trainers to be well versed in the local language and in terms and phrases traditionally used. - CARE, India.
36. Unavailability of proper venue creates problem for training. - CARE, India & Group 1.
37. An important lesson learned during the process of developing education materials was the need to allow adequate time in the timeline of a project, which calls for the use of effective training aids primarily for a non-literate population. The development of education materials called for repeated changes in design and field tests to assure their effectiveness. - CARE, India.
38. List the same of education materials which are in use with necessary changes and improvement if necessary, to avoid confusion. - FFH, Nepal.
39. Transfer and/or late placement of government personnel considerably affect the training schedule and project timeline. A policy decision from the government not to transfer trained personnel from project area until completion of all tiers of training would help prevent waste of training efforts and the extra resource required to train new personnel. - CARE, India.
40. Use only those audio-visual materials which are locally available, acceptable and which are consistent with govt./MOH materials and messages.

#### **ON INTEGRATION OF CSP WITH OTHER DEVELOPMENT ACTIVITIES**

41. Along with CS interventions, efforts to be given to go beyond this and step into the greater area of total community development. That means, the need exist for involving a structure which responds to the needs and priorities of a total community. - WV, Bangladesh.
42. A CS project well integrated into a community involved development program enhance the adoption and sustainability of child protective behaviors. - SCF, Bangladesh.
3. Income generation and development activities should be included in CSP. - FFH, Nepal & Group 4.

#### **ON COMMUNITY INVOLVEMENT**

44. Like all urban areas, there is a great deal lacking in terms of community organization within the project area. - WV, Bangladesh.
45. Community leader (formal or non formal) is the key of the success of the CS project. Hence, an intensive approach to the local community leader is critical at the beginning of the project. - SCF, Indonesia.
46. Community leaders should be well-informed about the objectives and targets before and during implementation of the project. - SCF, Bangladesh.
47. Since the beginning the project should be highly community based/oriented & the community leaders should be involved. - Group 3.
48. Involvement of local people (leaders - political/native/religious) in activities planning ensure more community participation and continuity of the activities. - FFH, Nepal.

### ON BASELINE SURVEY

49. Survey should be done before activities start and adequate funds should be provided. -ADRA, Pakistan.
50. Baseline survey is absolutely essential to assess future progress. - Group 2.
51. Get technical assistance in baseline survey design, methodology and analysis & reporting. - WV, Bangladesh, WV Asia Region & Group 4.
52. Community involvement in survey is very useful. - Group 5.

### ON COMMUNICATION & BEHAVIORAL CHANGE

53. The following 7 components are necessary for adoption of a new behavior :
  - a. Clear, simple, concise message, appropriate for the target group.
  - b. Repeated two way practical demonstration of the expected skill.
  - c. Well-known educator of good personality, capable to earn to confidence of the target group.
  - d. Mechanism of experience sharing within the target group.
  - e. Reinforcement of the message & skill in time of felt need.
  - f. Availability of some support services within the reach (geographically & financially) of the target population.
  - g. Long term multi-media propaganda on the expected behavior.  
- SCF, Bangladesh.
54. In communicating messages it is very important to get feed-back about what has been understood. - Group 5.

### ON HEALTH INFORMATION SYSTEM

55. A health information system is vital for identification of future program direction and strategic planning.  
Target rosters at the hands of village health workers are essential for good coverage. - SCF, Bangladesh.
56. Scientific but simple health information system to be developed which lead to appropriate decision making for program. - WV, Bangladesh.
57. Only useful data should be collected. - Group 2.
58. Important to use effectively the data being collected routinely in a CSP for operational mgt. - Group 4.
59. The home based health records are an essential component for growth promotion/monitoring and immunization. - CARE, India.

### ON HEALTH INFORMATION SYSTEMS

60. Need to pretest data collection forms and the process of collection.
61. Continue to modify the data collection system don't collect data you can't use.
62. Volunteers should be properly trained and supervised and the quantity of data should be small and concrete.
63. To ensure good data quality and completeness spot checking should be done by the supervisor.
64. Get TA to ensure timely and quality analysis, and train project staff to do this.

65. Need communication and understanding between the computer processing people and field staff.
66. Volunteers should collect data which is useful to them.
67. Computerization of data increases centralization of data and increases turn around time.

#### **HEALTH INFORMATION SYSTEMS - LESSONS LEARNED**

68. Very little data analysis is done by workers who should use the data.
69. In most cases health workers dislike collecting data and do not take "ownership" of this task.
70. Need to develop a HIS that can be turned over to the MOH and useful to the PVC.
71. In large areas, with a large population it is not possible to collect all the data.
72. It is better to collect and process data in small groups at the village level.