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Report of the

Workshop on Community Based Integration and Implementation of National PHC-MCH-FP Nutrition Programs in Tanzania

Office of Maternal Child Health
of the Directorate for Preventive Services
of the Ministry of Health of the Government of Tanzania

in collaboration with

The Center for Population and Family Health
of Columbia University
in New York

1-15 December 1983

Danish Volunteer Training Center
Usa River near Arusha
Tanzania

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1. Executive Summary

With direction and leadership from the Office of the Director for Preventive Services of the Ministry of Health, representatives from the Center for Population and Family Health (CPFH) and the senior medical officers (SMO) of the Ministry of Health (MOH) programs for Maternal and Child Health/Nutrition and Primary Health Care developed a plan for this workshop in March 1983. The workshop was designed to impart management and training skills to regional level staff responsible for implementing the national programs. Eight objectives were written at that time and became the guidelines for the workshop which took place 1-15 December 1983. (Appendix 1):

"Participants will gain new skills or will expand skills necessary to their roles as senior level program managers. Particular emphasis will be placed on the following areas:

1. Program design, including the use of epidemiogic and demographic methods to formulate problem statements and program objectives, needs and resources assessment to formulate appropriate community based approaches, linkages between objectives and evaluation as managment tools.

2. Program management with particular emphasis on implementation planning methods, program support strategies and the management of logistics given limited resources.

3. Program evaluation and information systems, with emphasis on determination of evaluation indicators to assess both impact on health and the level of functioning of the program, the development and collection of service statistics which lead to ongoing program evaluation, the use of operations research methods to get information or evaluate programs.

4. Supervision and support of the program, with emphasis on the development and maintenance of a functioning system to assure continuous support and backup to a village level program.

5. Training and the development of training teams, to include important concepts necessary to the support and backup for a program which has a high priority for training of village level participants.

6. Community based approaches in which experiences and results of a variety of programs will be examined.

7. Strategies for the integration and implementation of PHC, MCH and FP services at the village level, including identification of specific priority interventions.

8. Implementation of selected high priority interventions of PHC to include infant diarrheal diseases and oral rehydration, malaria prevention and control, childhood nutrition surveillance and family planning."

Twenty-five participants attended, complemented by a team of seven full-time and two part-time facilitators. The course was co-directed by Susan Nalder, Assistant Clinical Professor at the CPFH and Dr. Tengio Urrio, SMO for MCH/Nutrition at the MOH. It was held at the Danish Volunteer Training Center at Usa River near Arusha. Funding for the workshop was provided through cooperative agreement no. 0662-A-00-2068-00 for training from the Africa Bureau of USAID.

The workshop was officially inaugurated by Ms. Jitto Ram of the National Executive Committee. She emphasized the national significance of this unique kind of training for regional level staff who must execute the national programs of MCH/PHC/FP and Nutrition.

The workshop was designed using the competency based training method in order to assure transfer of skill to the participants. Three modules were presented:

1. Management

2. Implementation Issues of PHC/MCH/FP and Nutrition

3. Training and Supervision

At the beginning of the workshop, participant knowledge and experience were assessed using pretests, self assessments, a written exercise and informal interviews. During the workshop, most material was treated within the context of design, implementation and evaluation of community based programs. Lectures and discussions were followed by dividing the participants into workgroups for structured exercises designed so that participants could practice using new information. This was followed by presentation of work group results. Workgroups were organized by region whenever possible so that participants performed exercises using their own regional problems and real data. Participants worked long hours, often omitting tea break and going into evening hours to complete exercises.

All participants and facilitators received some forty books, papers and monographs to complement information presented in plenary sessions (Appendix 6). Of particular interest to the group were the National Primary Health Care Program Guidelines.

Special sessions were held to hear reports from the regions represented, as well as the Maasai Health Project. The field experience of the Maasai project has been carefully documented due to the operations research activities attached to the project. Project findings were shared concerning processes of gaining community participation, the design and conduct of training and the implementation of supervision and were especially meaningful to this group. The project field experience in training was complemented by a presentation by the Arusha Region staff. Both groups strongly recommend a carefully planned, small scale approach to training of VHW's and TBA's which is based on community support and inputs.

Four approaches to evaluation of the workshop were used. The most important and comprehensive evaluation was of participant performance in work group exercises and the final work assignment which was done by regional teasms. It was apparent that all participants benefitted from the high percentage of time devoted to applying the many new management and training methods and in the structured exercises so that on final evaluation, the workshop was found to have had significant results. Participants gained management skills, especially in being able to research and formulate program objectives, to design community-based programs, based on detailed analysis of needs and resources, and to design information systems for monitoring program activities and impact. Scores in these areas changed from a pre-workshop score of 12% to an end of workshop score of 88%. In addition, participants learned how to apply competency based methods to the design of community based training of VHWs and TBAs. They also learned how to design and use training of trainers programs which is key to successful implementation of training at any level.

In addition to the workgroup exercises, three other measures were made in evaluation. Pre-testing using a multiple choice questionnaire indicated that approximately 50 percent of the material was known to participants at the beginning. This indicated to the training team that the material to be covered was geared to the right level. Post testing revealed relatively high (20%) gains in training and supervision content moderate gains (6%) in manangement content and no change in the clinical topics. The latter was due in part to inadequate time given to clinical topics on growth monitoring of children, oral rehydration, family planning and malaria.

A self-assessment inventory was done before and after training to measure the participants sense of how well they believe they can function with the fifteen topics covered in the workshop. Self-assessment rose for program management tools, competency based training and oral rehydration. Participants were asked to rate the importance of all topics to themselves, which were rated very high (87 on a scale of 100). Participant reaction to sessions was evaluated by participants as to whether sessions were worthwhile, were meeting participants individual needs and group needs as well as an assessment of the quality of the trainers delivery. These evaluations were used to identify participant needs and

concerns, and to adjust training accordingly. The most frequent observation was a desire for more time and for trainees to go more slowly. The overall scores on trainee reaction indicated a high degree of satisfaction.

In conclusion, the facilitators and participants drew up a short list of recommendations arising out of the proceedings of this workshop.

1. Because the management training skills acquired in this workshop are critical to regional level personnel, this type of workshop needs to be conducted for regional level personnel in the remaining 14 regions of the country over the next two years.

2. The levels of knowledge of family planning clinical skills and program management was found to be low for most participants, reflecting the need for continuing education to be planned for regional level personnel as soon as possible. Also, the MOH should seek to send key national and regional personnel to family planning training events in other countries as well. Recommended courses include a FP-TOT at the Center for African Family Studies in Nairobi in Spring 1984 and the 4 week course in Design, Management and Evaluation of FP/PHC/MCH and Nutrition Programs held at CPFH in New York, June 1984.

3. Participants from this workshop discovered among themselves various persons with special training or experience in TOT, training, FP and management. Therefore, the MOH should encourage the continued identification and the use of a network of consultants from the regions for the development of training programs and new activities in PHC, MCH and FP.

4. The MOH should work closely with regional staff to continuously evaluate its approach to implementation of community based programs. Participants recognized the importance of developing community commitment before training VHWs or TBAs. VHW and TBA training needs to be executed using trained trainers, competency based methods, and short-phased modules or units of skills interspersed with field practice.

5. The MOH should find means to introduce the skills and methods of <u>management</u> and <u>training</u> into the curriculum of medical and paramedical schools.

6. The MOH should seek to collaborate further with the CPFH to evaluate the impact of this workshop and to conduct future workshops.

A full description of this workshop is found attached.

2. Workshop Facilitators and Participants

The facilitators for the workshop were assembled from the Ministry of Health (MOH), the Center for Population and Family Health (CPFH) of Columbia University, and the Maasai Health Services Project. Dr. Tengio Urrio, Senior Medical Officer for MOH-Nutrition at the MOH and Susan Nalder, Assistant Clinical Professor of CPFH served as Co-Directors. In addition, facilitators from the MOH included Dr. Edward Moshi, Regional Medical Officer for the Arusha Region, Mr. I.V. Mibagga, Assistant to the Senior Medical Officer of the National PHC program, and Mr. Wamesa Wagara of the Tanzania Food and Nutrition Center. CPFH facilitators were Dr. Martin Gorosh, Dr. Joe Wray, and Therese McGinn. Dr. Eli Nangawe, Director of the Maasai Health Services Project, and Erik Rowberg, a CPFH Technical Advisor to the Maasai Project also served as facilitators. (List in Appendix 3.)

Mr. Spencer Silberstein, Population Officer of the USAID Mission to Tanzania attended one week of the seminar and served as a work group facilitator during his visit.

Participants were invited from the five pilot regions for PHC implementation, Arusha Region and selected regions having plans for community based MCH-PHC activities. Representation at the seminar was as follows:

Coast Region:	Regional Medical Officer (RMO), Regional Primary Health Care Coordinator (RPHCC), Regional Maternal and Child Health Coordinator (RMCHC)
Iringa Region:	RPHCC, RMCHC
Tanga Region:	RMCHC
Dodoma Region:	RMCHC, Assistant Matron
Monogoro Region:	RMO, RPHCC, RMCHC
Shinyanga Region:	RMO
Arusha Region:	RMO (As facilitator), RPHCC, RMCHC,
Mtwara Region:	RPHCC, RMCHC
Kilamanjaro Region:	RMCHC

Tabora: Nutritionist
Zonal MCHC: Nibeya, Nivanza, Mashi, Dar es Salaam
National Programs: MCH (as Co-Director) EPI, PHC, Nutrition
Maasai Health Services: Director and Technical Advisor (as facilitators), Trainer, Evaluation Assistant

A complete list of participants is found in Appendix 3.

Upon arrival, participants were asked to complete a biographical form (see Appendix 4) which served as one form of needs and resources assessment for the workshop planners. From the information collected, a summary of selected characteristics can be developed. In total there were 17 women and 8 men, ages 26-48 with an average age of 40.24 years. The group consisted of 3 medical doctors, 4 health officers, 10 public health nurses, 6 nursing officers, 1 nutritionist, and 1 teacher.

Seventeen participants provided information on their educational backgrounds. Of the 3 medical doctors, 2 had received their training in the USSR, supplemented by a Master's of Medicine degree in Tanzania, while 1 had been trained at the Dar es Salaam School of Medicine. All of the public health nurses and nursing officers had received their training in Tanzania which was supplemented for some study in the United Kingdom or the United States. Three of the nursing officers had entered nursing school after primary education; the others had first completed secondary school. The health officers had received diplomas from the School of Hygiene of the University of Dar es Salaam and 2 had furthered their studies in Nigeria and Kenya. One participant had attended teacher's training after secondary school.

Supervision, administration, and training were the major job responsibilities most often cited. Also mentioned, among others, were health education, environmental sanitation, MCH service coordination, and clinical service provision.

Since 1980, these participants reported attending a total of 22 different continuing education training events. Five participants had never attended any continuing education training events prior to this one. Eleven had attended 2 or 3, and 2 had attended as many as 5. These events varied in length but the great majority were 2 weeks or less. Four had taken place outside of Tanzania in Japan, Egypt, Kenya, and the United States.

The most common training event attended was the EPI Mid-level Management Course with 12 participants having taken part. Seven had attended an Essential Drug Workshop, 5 a PHC workshop, and 5 an MCH workshop. Two participants had attended a TOT workshop and 1 took part in a training of VHW seminar.

Nineteen of the participants reported having served as trainers since 1980. Seven of them had taught at MCH seminars covering topics such as immunization, clinic management, and home visiting. Other courses at which the participants served as trainers include TOT, training of VHWs, health education, drug handling and management, PHC, and rural sanitation. Two participants had served as full-time trainers for nursing assistants.

In response to the question "What do you expect to get out of this workshop?", many participants cited general knowledge and skills in PHC and MCH. Other specified that they desired skills in problem solving strategies, insight into existing PHC and MCH programs, management skills, and a chance to exchange ideas with their colleagues.

3. Description of Workshop Implementation

3.1 Workshop Opening

The workshop was opened officially by Ms. Jitto Ram, a member of the National Executive Committee of the Party (CCM) who is also a nurse. Her opening comments were especially pertinent to the main theme of this workshop, the community based implementation of the rational programs for PHC/MCH/Nutrition and family planning. She highlighted the national level awareness that management training is a priority for a successful Primary Health Care program in Tanzania. She further cited the need for continuous evaluation and re-evaluation of the implementation of services at the community level. And finally, she spoke of the need for relevant and effective training programs to achieve the community based programs.

The objectives for the workshop were determined by a team from the Ministry MCH/PHC programs, the Center for Population and Family Health and the Maasai Health Services program.

The objectives are fully described earlier in the executive summary and are found in Appendix 1.

3.2 Workshop Design and Implementation

The workshop was designed to give national, zonal and regional program managers an opportunity to gain new management and training skills within the context of integrated PHC/MCH/FP and Nutrition programs. Emphasis was placed on exploring and analyzing community based strategies. Participants and facilitators also studied some of the service delivery issues in oral rehydration, family planning, nutrition and growth monitoring and malaria prevention and control.

The competency based training approach was used in nine of the eleven training days. Training objectives were developed with exercises designed so that trainees would use the management tools or training tools presented that day.

A short presentation was made followed by structured work group exercises. Work group reported their results to the large group. Usually a facilitator was present to work with each group. This approach is considered to be essentail to the successful assimilation of new knowledge and skills for trainees at any level. An outline of the management series, the field trip

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observation and the training and supervision modules is found in appendix 7.

Lecture-discussions were conducted in the subject areas of primary health care interventions and implementation topics. These sessions served as a forum for program managers to debate the issues they have encountered on the job as well as the issues from the literature about nutrition rehabilitation, family planning and oral rehydration.

Formal presentations were made by a representative from Coast, Mtwara, Morogoro, Iringa and Arusha regions. Their presentations focused on the status of community based primary health care and MCH activities. These presentations helped everyone to better understand the settings, strengths, and constraints of the various programs.

The objectives, activities and research findings of the Maasai Health Project in Arusha Region were presented. This presentation was especially useful because the applied research methodology has made possible a good analysis of what factors are critical in gaining community support/participation as well as what factors are critical to successful training of villager health workers. Supervision networking from the program manager level, through the dispensary staff to the villager level was examined also. The essential lessons to be learned were:

1. Community commitment and participation can be gained through meetings in which the focus is on the felt needs and aspirations of the community

2. Training of VHWs is best done in their home community and this approach further promotes a sense of community participation and ownership

3. Dispensary workers need retraining and TOT in order to participate as the local level supervisor/supporter of a community based program.

3.3 Technical session on selected primary health care interventions

These aspects of community based primary health interventions were discussed:

1. Growth monitoring

2. Use of oral rehydration therapy (ORT) in the management of childhood diarrhea.

3. Malaria

Growth Monitoring:

Tanzania has introduced growth monitoring at Dispensary and Health Centre levels as a part of the MCH services. Participants reviewed the skills, knowledge and attitudes essential for the techniques of growth monitoring and the need to develop community based growth monitoring services using VHWs and the community resources in order to ensure well designed programs to be implemented at the community level.

The Tanzania Food and Nutrition Centre (TFNC) is working out plans to establish a National Nutrition Surveillance to provide planners information on food and nutrition situations in regions. The use of such data for planning nutritional programs was explained by a representative from the TFNC. Such information has been collected for Iringa region and served as a baseline for the joint WHO/UNICEF Supported Nutritional Program.

ORT: The Childhood diarrhea problem in Tanzania was described. Diarrhea is among the leading causes of death in Tanzania. Together with measles, malaria and malnutrition, it is responsible for the high (IMR of 135/1000. Studies in Iringa and Coast Regions showed a high prevalence of diarrhea of 7% and 16% respectively.

The scientific basis for the use of ORT and the management of diarrhea using home prepared solutions and the oral rehydration salt packets was described. It was emphasized to the participants that the Essential Drugs Programme will provide ORS packets to the dispensaries and health centers. There is need therefore of training the staff at these levels to develop their skills in teaching mothers the use of the salts and the use of alternate methods of preparation of oral rehydration solutions by the scoop and pinch or the spoon methods. Participants demonstrated preparation of oral rehydration solutions by the spoon method.

The importance of continuing feeding and breastfeeding during attacks of diarrhea were emphasized.

Malaria

The malaria situation in Tanzania has deteriorated and there is need to develop low cost community based strategies for the control of the disease. A community based program design for malaria control was described.

The work groups worked on developing program design, implementation and evaluation of community based growth monitoring, ORT, and malaria control programs. The training of VHWs to manage these programs was included in the program designs.

Implementation Issues in the National MCH Program

The results of the 1981/82 evaluation of the MCH services were discussed. The MCH program started in 1974/75. Since then a service delivery infrastructure has been set up and over 2,500 MCH-Aides have been trained to provide MCH/FP services in the rural areas.

In the 1981/82 evaluation of the MCH services coverage, utilization, immunization coverage, MCH training, trends in mortality and morbidity rates were evaluated. Immunisation coverage is still low and the childhood immunisable diseases, especially measles, are still common. The need to develop program design showing implementation and evaluation strategies for each region and district in the country was stressed.

Participants discussed some of the implementation problems faced by the MCH services including shortage of transport, kerosene for fridgerators and MCH cards. There was a general concensus that regions should provide themselves with kerosene and MCH cards and that the Ministry should help identify sources of transport.

Field Visits and Discussion

One complete day was given to field trips to health service delivery sites and villages in the Arumeru District of Arusha Region. Participants were allowed to choose one of six possible sites listed below. An observation guide (appendix 14) was distributed the night before as a tool to help focus and direct the visit.

What transpired during the trip varied from place to place but all groups began with discussions with health personnel. Groups then proceeded with activities determined by the site and their own interests.

The sites visited were:

1. West Meru Health Centre where the group visited the health centre, the village government leaders, and did a small survey in the village.

2. Ndurruma dispensary. This group also visited with dispensary staff, government leaders as well as visiting a TBA and interviewing men and women coming to the clinic.

3. Regional Hospital MCH Clinic and Ngaressarok Clinic in Arusha town. This group observed two town clinics offering MCH and FP services. At both sites interviews were held with health staff and people coming for services.

4. Usa River dispensary is a Catholic dispensary. The group spent time discussing with the staff and observing the MCH clinic.

5. Kissongo Lutheran dispensary. This group began by observing a MCH clinic and discussions with dispensary staff and village health workers in training. The group then accompanied a VHW to a housing unit for informal discussions.

6. Selian Lutheran dispensary. MCH clinic activities were observed and discussions were held with MHS project staff. This group met with VHWs and also one TBA who wants to attend TBA training at the dispensary

In the evening, participants came together informally to share experiences. Most groups tended to focus on MCH and FP activities during their visits. One of the main discussion points was about factors which tend to prevent women from using family planning services in their village, such as the public perception that prostitutes use contraceptives, so that married women fell shy to be going to FP clinics. In one urban clinic, there were many FP users but participant observers did not note the geographic area being served. A problem was voiced about how different types of pills are distributed by UMATI according to their stock. This means that pill users were often given changing brands or even different preparations. This changing of pills is confusing and in some cases women complain of new side effects.

Growth charts were not in supply in most areas but where women did have growth charts they did understand what they were about. Groups found that evaluation systems were not in existence and that the recording systems were not used on a local level.

The participants demonstrated an ability to look at programs analytically using principals learned in the management sessions just prior to field visiting.

This experience also impressed on participants that for effective program design, management or evaluation they must get out into the field from time to time so as not to loose touch with the realities.

4. Evaluation of Training

4.1 Evaluation of Trainee Skills

The competency based approach used in this workshop enabled participants and facilitators alike to gain new knowledge and skill in management methods, training methods and supervision. At the beginning of the seminar, participants completed a short exercise to enable the facilitators to have insight into the level of skill people had in writing objectives and their proceeding to think through the basis for program activities, as well as implications for training, supervision and evaluation. A sample of the exercise is found in appendix 9.1. Twenty five participants completed the exercise. One very critical management skill is the ability to write program objectives. Prior to training, participants skills in writing objectives in the exercise were as follows:

Ability to write objective as determined by these questions	**Yes**	**No**
Was the objectives clearly stated?	4	21
Was the objectives measurable/ observable?	3	22
Was the objective relevant?	25	0
Ws the objective feasible?	3	22
Did the objective address process indicators?	21	4
Did he objective address impact indicators?	11	14

Although in this exercise everyone wrote of relevent concerns, very few could state objectives which are clear, measurable and feasible. Fifty percent of the group wrote impact indicators while more than 95% wrote only process or activity indicators.

Therefore, generally speaking, 12% of participants were skilled in writing program objectives. At the end of the course, more than 90% of participants became skilled as evidenced in workgroup exercises post testing and the final planning exercise.

As one might expect, this improvement has significant impact on related management skills. The inability to write objectives leads to confusion in planning service delivery activities, training and supervision activities and evaluation.

In the final exercise, participants demonstrated acquisition of new planning skills. All groups made detailed tables depicting training activities for TBAs, TOT activities, coordination and supervision activities. Check lists for monitoring activities were described by two groups.

All groups were able to describe effective approaches to community development for the purpose of getting community commitment and support for health activities. However, most groups had developed VHW or TBA training schedules which were too ambitious in terms of time table. It was pointed out that the development of community commitment to VHW/TBA programs takes time, and that mass training activities may probably not achieve the desired results when newly trained VHW/TBA programs returns to begin practicing.

All groups adopted the principles of competency based training for VHW or TBA programs, as well as for TOT and various continuing education programs. This is a significant achievement for these participants, all of whom are involved in managing training programs of major significance for the country. The group has concluded that this methodology is most appropriate to the kinds of training for which they are responsible.

Evaluation skills were not well developed during this short 11 day program. Nevertheless, the group began to master important concepts on information systems which are basic to evalaution. The group did learn the close link between statement of objectives and evaluation, and came to demonstrate use of detailed analysis of needs and resources in order to do realistic program planning and implementation.

4.2 Measurements of Trainee Learning

Pre and post tests were developed and implemented to measure participant learning of workshop content. The test was written in three parts as follows.

1. Management - 20 multiple choice questions
2. Training and supervision - 20 multiple choice questions
3. Selected PHC Interventions - 15 multiple choice questions

(See copies of Appendix 9.2)

Parts 1-2 had been field tested in Kenya with a similar group of participants. Part 3 was new and was not field tested. One question was dropped as it was found to be incorrectly stated.

The pre-test was administered before any sessions and before materials were distributed. The post test was administered at the end of the course, and contained the exact same questions as the pre-test in a scrambled order.

Results were tabulated by question and by participant. Feedback about group performance on the pre-test was given just before beginning the corresponding topic in the training program. Post-test results were given at the end of the course and a discussion

was held about the instrument, group results, individual results, particular question results, the tabulations and the net result. This discussion was in effect a work group exercise for the trainees on the topic of training evaluation.

The outcome of all pre and post tests is presented in table 1.

Table 1. Results of Pre-Post Testing for 23 Participants

	Management 20 Questions		Primary Health Care 15 Questions		Training Supervision 30 Questions	
Measure	Pre	Post	Pre	Post	Pre	Post
Mean Score	11	12.35	9.3	9.26	11.4	14.86
Mean %	56%	62%	62%	62%	55%	74%
Median	12	12	9.5	9	11	15
Mode	13	15	10	9	11	15/18
Range	4-16	9-15	6-13	5-11	5-17	10-20
Net Gain (Mean)	6%		0		19%	

The wide difference between the net gain in mean scores may be due to differences in training design, time elapsed between the module and the test and trainee language abilities.

The approach to management training and to training/supervision training was, similar however, the post test for management was given 11 days after completion of the unit. The post test for training/supervision was given immediately after the unit which may account for better results in lerning the material.

The unit on PHC interventions resulted in no gain in learning, and this is very probably due to these factors: There were no training objectives developed for the unit; the presentations although relevant, were brief; there were no work group or individual exercises to use new material; and PHC interventions were squeezed into one day rather than 3-4 days. The topic of clinical family planning was not dealt with until the very end of the course; no readings were assigned before or after the unit although a lot of material was distributed about family planning methods growth monitoring and oral rehydration.

When the test results were analyzed by subject area (Table 2) and by professional category of the participant, they were as follows:

Table 2:

Professional Category	Management Mean Score		Training & Supervision Mean Score		PHC Mean Score	
	Before	After	Before	After	Before	After
Physicians	58	70	50	73	58	67
Public Health Nurses	51	59	58	74	61	57
Health Officers	64	70	65	82	62	65
Nursing Officers	50	58	43	69	61	62
Teacher (1)	60	65	75	95	73	73
Nutrition Officer (1)	40	45	25	60	53	53

Table 3:

Percent Answering Yes or Scoring "High" of "Very High" on Subject Areas, Pre and Post-Workshop

Subject Area	Expect to gain concepts		Expect to gain skills		Personal level of competence		Personal Level of importance	
	Percent answering "yes"				Percent "high" or "very high"			
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Management principles	96	100	81	96	15	48	88	90
Planning programs	100	100	88	96	31	35	92	95
Implementation	96	96	88	91	38	35	96	95
Information systems	88	87	88	91	12	48	85	86
Evaluation	96	100	92	96	42	52	96	81
Malaria	77	74	50	70	12	52	65	76
ORT	88	100	73	87	35	83	81	86
Family Planning	85	96	77	87	38	39	65	76
Nutrition Surveillance	92	96	85	91	23	43	81	86
Cit/Nutrition Implementation	96	100	92	91	35	43	88	86
Competency based ining	77	100	92	96	15	43	77	90
ing of trainers	88	100	88	96	23	48	88	95
Supervision by objectives	81	96	88	91	31	56	85	81
Progress & issues/ MCH	92	96	92	91	15	39	88	86
Community based strategies	88	91	81	96	15	39	92	90
Overall means	89.3	95.1	83.7	91.1	25.3	47.1	84.5	86.6

4.3 Pre-Post Training Self Assessment

Using a pre and post self evaluation from participants considered fifteen subject areas covered in the workshop. (See example in appendix 9.3.) They indicated with yes or no answers whether they expected to gain in general concepts and also in specific skills in each of the areas. In addition, they estimated their own level of competence in each subject area on a scale of 1 (very high) to 5 (very low) and to score the level of importance to themselves of each subject area.

The initial and final responses to this questionnaire are shown in Table 3. Expectations both for increase in concepts and skills were relatively high initially, at 89% and 84% after end of the workshop.

There as a substantial increase in participant feelings of competence. Initially 25 percent of the participants rated themselves at high or very high; 47 percent gave themselves that rating at the end. It should be noted that much of the overall increase was due to dramatic increases in several subject areas. To cite a few examples, the percentage considering themselves competent in information systems for health program management rose from 12 to 48 percent, in competency based training from 15-43 percent, in ORT from 35-83 percent. Changes in perceived level of importance of the various subject areas was slight. Eighty five percent rated the areas as high or very high initially and 87 percent did so at the end of the workshop. This indicates that the topics were perceived as important throughout the workshop.

4.4 Quick Feedback

After completion of ten of the major subject areas, participants were asked to complete amonomously a quick feedback form (appendix 9.4). These were reviewed immediately by the facilitators to provide them with a prompt response to the day's session. Participants were asked to score on a scale of 0-5 these estimates, as to whether the session (1) was worthwhile, (2) met their personal needs, (3) met the needs of others, and (4) the trainers' performance. In addition, they were invited to write out (1) what they liked best about the session, (2) what they liked least, and (3) other comments and suggestions.

The means of the scores on the ten session topics and the overall session mean scores are shown in Table 4, where it may be seen that the means were between 4 (high) and 5 (very high) in all cases except two.

Table 4:

Summary Form
Rapid Feedback Mean Scores

Session Topic	Session Was Worthwhile	Session Met Personal Needs	Session Responded to Others' Needs	Trainees Performance	Overall Mean
1. Planning	-	-	-	-	-
2. Implementation	4.38	4.41	4.04	4.42	4.31
3. Evaluation	4.39	4.50	4.25	4.32	4.37
4. Workgroup Session on Implementation Planning	4.35	4.38	3.88	4.19	4.20
5. O.R.T.	4.29	4.32	4.50	4.07	4.30
6. MCH Program Implementation Discussion and Reaction Panel	4.33	4.26	4.62	4.00	4.30
7. Community Based Discussion	4.21	3.69	4.34	4.04	4.07
8. Competency Based Training	4.56	4.24	4.48	4.54	4.44
9. Lesson Plans/TOT	4.43	4.52	4.30	4.52	4.44
10. Supervision	4.55	4.65	4.50	4.35	4.51

[1]Scores are the mean score from a scale of 0-5 where 0 represents waste of time, 1 represents poor, 2 is midpoint between poor and useful, 3 is useful, 4 is midpoint between useful and very worthwhile and 5 represe' 'worthwhile. 23 participants responded.

[2]The session on planning was not evaluated as forms were not yet available.

5. Outome and Recommendations

5.1 Outcome

Outcome of the workshop may be described as follows:

1. Participants developed program design implementation and evaluation skills. The work group exercises helped them to develop a more detailed and analytical approach to planning monitoring and evaluation. For example, in growth monitoring, they realized the importance of collecting statistics on coverage instead of concentrating mainly on the number of children that attended clinics. In immunisation services it is also very important to look at coverage in terms of the number of children that completed their immunisations instead of counting only the number of doses and children immunised for each vaccine. The importance of collecting service statistics relevant to the target was emphasized.

2. Participants gained new skills which they will use to design training programs in their regions. They appreciated the importance of competency based training that imparts on trainees the skills necessary for the fulfillment of their duties instead of the "educational" approach that is aimed at mainly imparting knowledge. Competency based training was seen as the practical approach to the training of workers involved in community based health programs because this training focuses upon the tasks the workers are going to be involved in.

3. Participants developed program designs relevant to their regions at this very time:

Shinyanga Region: Developed a program for training TBAs because only about 30% of the pregnant mothers in the region deliver in hospitals and clinics.

Kilimanjaro Region: Developed a program for training TBAs. The American College of Nurse Midwives will provide technical assistance to develop a TBA training program in Kilimanjaro, in spring 1984. The program developed at the workshop should help in the implementors prepare to start the program.

Morogoro and Mtwara Regions: These two regions in the training of VHWs developed a PHC scheme for their training.

Iringa Region: In developing their program for VHWs reviewed their training programs using analytical management tools.

Coast Region: Managed to clearly outline community based approaches. Management tools for coordination and monitoring programs were developed.

This exercise was a particularly important outcome as participants worked up plans which they can implement now. Before finishing, each group received good feedback from the entire group, as well as from individual facilitators. The feedback helped to further refine their plans. Strong messages of caution about planning too much too soon came from those now in involved in community based programs.

4. Participants identified among themselves a network of consultants. For example, Arusha region with its experience in training of TBAs could be asked by other regions to consult to their planning efforts to train TBAs. This networking of Tanzanian expertise was recognized as very important by the group.

5. Family Planning. During discussions about family planning, participants showed gaps in their knowledge of contraceptive practice. This showed that there is a need for family planning training for regional level managers.

6. Supervision. The participants learn to look at supervision as a process of motivating, educating, and helping workers learn and deliver services more effectively.

7. Evaluation. Participants learn the importance of evaluating services at the community level and the importance of rapid feedback to improve services at all levels of the health care delivery system.

8. Lessons from the Masai Health Project. The Masai Health Project is a collaborative project between the Centre for Population and Family Health and the Lutheran Synol of Arusha.

Participants appreciated the skills used in the project in development of community commitment to the project, the importance of having a supervisory schedule and a checklist for supervision, the training of VHWs and teaching mothers about ORT. Project staff impressed upon participants the need to begin with small numbers and to try to develop community support before actually beginning training.

5.2 Recommendations

These recommendations were formulated by the co-directors of the course in collaboration with participants and facilitators.

1. The need to hold other workshops of this kind:

The participants in this workshop developed skills in program design especially in formulating program objectives, needs and resources assessment and development of competency based training programs. These are skills necessary for senior level managers of MCH/FP/PHC programs. The workshop drew participation from 6

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regions. There is need to hold the same workshops to cover the other 14 regions of the country. The Ministry of Health should, if funds are available, collaborate with the Center for Population and Family Health to hold 2 more workshops with 7 regions per workshop in the next two years.

2. The need for training regional level managers in family planning.

Family planning is a felt need in this country as shown by the fact that the number of acceptors for family planning is increasing as the services expand into the periphery. Participants in this workshop showed gaps in their knowledge of family planning clinical sevices as well as family planning program management. This underlines the fact that a workshop is necessary to train senior level personnel in family planning program design, clinical services, implementation and evaluation. There is need also to send national level and regional level managers to family planning training courses in other countries to improve their skills.

3. Consultancies. .

It will be very useful to the regional MCH/FP/PHC programs if the faculty from this workshop who came from the Center for Population and Family Health as well as other consultants from the centre visit the participants to follow-up on the impact of this workshop and give advice "on the spot" about the programs these regional managers are involved in.

4. Implementation of Community Based Programs.

The question of how to proceed with training VHW/TBA deserves careful study at the national level as well as the regional level. Experience within programs now underway suggests that regions should begin small. Start-up activities are critical to success and include adequate assessment of community needs, resources and readiness to commit to the activity. Regional staff must take time with district staff to develop a training program which is realistic to the milieu. All persons to be engaged in the training/supervision of VHW or TBA must receive special training for these new skills (training of trainers). Early in the program, training implementation must be monitored closely. Regional level staff must be involved with the first round of training in order to familiarize themselves with how things go so that they may more effectively guide others as well as manage the program. Furthermore, the time-schedule of dispensary services must be revised so that dispensary staff can participate in training, supervising and community development activities inherent in community based programs.

5. Guidance to regions implementing the PHC.

The MOH needs to arrange to provide one copy of the PHC guidelines to each member of Regional staffs (RMO, RHO, RPHCC, RMCHC) and to each District Office. These people need to have this document in order to embark on planning and training activities in order to help the MOH attain the PHC goals and objectives.

In addition to these 5 major recommendations, trainees were asked to make recommendations about this workshop in terms of themselves, their regions, the Ministry of Health, and the Center for Population and Family Health. In general, all said they should discipline themselves to use new skills in planning, implementation, and evaluation. One said that he/she would try to practice management by objectives. For their regions, participants all recommend this type of training for district level staff. Regions were self-admonished to strengthen their supervisory/support systems and to develop realistic plans for training.

Participants recommended that the Ministry needs to find means to conduct this training seminar for the remainder of regional teams and if possible, for district level teams. They further recommend that these management and training skills must be added to the curriculum of medical and paramedical schools. They recommend that the MOH respond to needs for resources and materials to implement community based programs.

For the Center for Population and Family Health, all participants recommend a follow-up to evaluate use of the new skills and to collaborate with the Ministry to conduct further programs for the rest of the regions.

One of the facilitators prepared a list of recommendations for the training team. These are included because the co-directors of the program found them to be particularly relevant to future programs.

1. Evening sessions should be limited to light concentration materials like slide presentations, films, and demonstration. Most participants found little time for reading and lost concentration during late afternoon and evening sessions.

2. Facilitators should have meetings each day to review and plan the coming sessions.

3. Family planning methods should have been dealt with more, especially side effects compared with risks of pregnancies.

4. A follow-up seminar should be done in one years time. This could be held for one week and used to give the Ministry of some guidelines for helping other regions develo CB programs.

5. Two week time was too short for the topics covered.

6. Administration and Logistics

The workshop was held at the Danish Volunteer Training Center (DVTC) at Usa River, 10 miles from Arusha. This training center has a full range of training facilities and equipment. Participants are housed in cabins scattered over the campus in single, double and group accomodations. Meals are served in a common room. It is a large facility and other groups of Swahili language trainee were present. There is day care for samll children. (See DVTC description, Appendix 10) Lodging, meals, and meeting rooms were provided by the DVTC. Photocopy, duplicating, and telex facilities were available (see price list in Appendix 12). A typewriter was made available and the workshop arranged for a temporary typist to assist with administrative details and to type training materials.

For routine transport needs, the workshop provided petrol. One vehicle was made available by the MOH and a vehicle and a motorcycle was provided by one of the facilitators. For the field trip, six VHW combi vans were rented from the Tanzania State Travel Service in Arusha.

On the final day, participants received a temporary certificate recognizing their participation in the workshop. (See Appendix 13). Workshop certificates will be prepared in New York, sent for the paper signatures, and mailed to participants.

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WORKSHOP TITLE: Community Based Integration and Implementation of National Primary Health, Maternal and Child Health and Family Planning Programs of Tanzania

WORKSHOP DATES: 24 August to 7 September 1983
Alternate dates 21 November to 2 December 1983

WORKSHOP LOCATION: Danish Volunteer Training Center
14 miles from Arusha

RATIONALE:

The Ministry of Health of Tanzania has initiated a National Program to implement Primary Health Care at the village level. In the initial phase five regions have been selected to implement the program. These five regions are Coast, Dodoma, Iringa, Morogoro and Mtwara. A health team from each of the five regions has undergone a 6 week Training of Trainers (TOT) course early in 1983. Arusha Region, although not included in the national program, has spontaneously launched a primary health care program and is currently conducting TOT programs for regional personnel.

The proposed workshop which will involve senior level managers of health programs in the regions and in the Ministry, is crucial to the overall success of program implementation. Participants in this workshop are responsible for planning, management, supervision, support and evaluation of community based programs. The workshop will provide skills to this group which are essential to their roles as leaders, and is particularly important to the support of field level personnel who have recently been trained in primary health care and have received a TOT in primary health care. In addition, other key ministry of health personnel will be trained. These people will have an important role in the expansion of the national programs beyond the five pilot regions and Arusha Regions.

OBJECTIVES

Participants will gain new skills or will expand skills necessary to their roles as senior level program managers. Particular emphasis will be placed on the following areas:

1. Program design, including the use of epidemiologic and demographic methods to formulate problem statements and program objectives, needs and resourses assessment to formulate appropriate community based approaches, linkages between objectives and evaluation as management tools.

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2. Program Management with particular emphasis on implementation planning methods, program support strategies and the management of logistics given limited resources.

3. Program Evaluation and Information Systems, with emphasis on determination of evaluation indicators to assess both impact on health and the level of functioning of the program, the development and collection of service statistics which lead to ongoing program evaluation, the use of operations research methods to get information or evaluate programs.

4. Supervision and support of the program, with emphasis on the development and maintenance of a functioning system to assure continuous support and backup to a village level program.

5. Training and the development of training teams, to include important concepts necessary to the support and backup for a program which has a high priority for training of village level participants.

6. Community based approaches in which experiences and results of a variety of programs will be examined.

7. Strategies for the integration and implementation of PHC, MCH and FP services at the village level, including identification of specific priority interventions.

8. Implementation of selected high priority interventions of PHC to include infant diarrheal diseases and oral rehydration, malaria prevention and control, childhood nutrion surveillance and family planning.

CURRICULUM

The workshop is organized in two, one-week sessions. During the first week participants will examine the issues of village level health care through several types of sessions. After an introduction to the concepts of community based integration and implementation of services, the participants will visit three or four sites in the Arusha Region to observe community based program activities, to conduct needs and exercises and to gather information about community level participation. These field visits will help set the stage for the workshop by providing participants and faculty an opportunity to examine first-hand the real circumstances of rural communities. The findings of the field visits will be discussed in work groups and by the large group. This will be followed by a discussion of the essential Concepts of community based approaches and an examination of examples of programs from the literature.

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The National Programs of Primary Health Care, Maternal and Child Health and UMATI (family planning) will be discussed. Emphasis here will be placed on a close examination of objectives, implementation issues and evaluation reports. An update on selected issues in PHC, MCH and FP will be offered. The focus here will be on issues in malaria treatment and prevention, the implementation issues of oral rehydration in the reducation of childhood diarrheal morbidity and mortality, the heath impact of family planning services and childhood nutrition surveillance program issues and problems.

Three PHC projects in the Arusha Region will be examined

1. The CPFH operations research project in collaboration with the Masai Health Services project.

2. The AMREF continuing education assessment in the Arusha Region and the Arusha Region TOT program.

3. The Manang Village Health Worker project.

Issues which will be examined are the following:

1. Development and maintenance of community participation and support.

2. Training and supervision of village level workers.

3. Integration of projects into the government system.

4. Results of CEproject (a comprehensive needs resources assessment) and the implementation of TOT in the Arusha Region.

5. Cost of developing and maintaining village level programs.

Throughout the week, a presentation will be made by each of the participating regions. Each presentation will provide a description of the present status of the village level program and will include relevant information as a demographic profile, a socio-cultural and economic description, a resources inventory and description, and available epidemiological information.

After this intensive intake of information and examination of important approaches and interventions, problems and issues, the workshop participants will then continue the second week which focusses on development and practice of skills essential to program managers.

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Six work groups will be organized by region. Those not in a region will be assigned to work with one of the reginal groups. Daily sessions will be conducted in which concepts, issues, and methods will be presented. Each work group will then use the new information in an exercise relevant to their respective region. Topics in this week are to include:

1. Program Design

2. Program Management

3. Evaluation and Information Systems

4. Training of Trainers

5. Training and Supervision

A pre and post evaluation of participants will be conducted in which each one will assess their gain in general concepts, specific skills, their overall level of competence and the relative importance of training. Examples of the evalaation tools are found in the appendix.

A final session will be conducted during which conclusion of the workshop will be discussed and plans for implementation of new or improved skills will be discussed.

A day to day schedule of the workshop is presented on the following pages.

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APPENDIX 7.2

PROGRAMME FOR MORNING OF DECEMBER 2nd

8.30 Welcome to collaborative seminar of the Ministry of Health and the Center for Population and family Health of Columbia University in New York. -- Susan Malder

Presentation of the Objectives of this workshop and Introduction of Guest of Honor ---- Dr. Edward Moshi

Official opening of workshop by Miss Jitto Ram of the National Executive Committee.

9.30 Introduction of Participants ---- Susan Malder

10.00 T e a

10.30 Complete Introduction of Participants

11.00 Introduction to the Center for Population and Family Health (CPFH) ----- Susan Malder

11-15 Presentation of the collaboration between CPFH and the Ministry of Health in Tanzania and the Masai Health Service -------- Dr. Mangawe

11.30 Pre - Fest

12.30 L u n c h

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WORKSHOP PROGRAM

Day/Time	Description	Faculty
Friday 2 December		
8:00- 9:30	Welcome addresses by Ministry of Health and Columbia University Introduction of participants and faculty	Dr. Mgeni Dr. Tengio Urrio Ms. Nalder
9:30-11:30	Pre-evaluation exercises for the seminar -- Tea will be served	Ms. Nalder
11:30-12:30	Introductory session on the integration and implementation of community-based PHC-MCH-FP services	Dr. Tengio Urrio
12:30-14:30	Lunch Break	
14:30-15:00	Overview of Course	Ms. Nalder
15:00-16:00	Overview of programs with presentation of a conceptual model	Dr. Gorosh
16:00-16:30	Tea Break	
16:30-17:30	What is management?	Dr. Gorosh
Evening	Management case & discussion	

Program Note

Saturday, Monday and Tuesday will be spent on three key management topics. Each day will begin with a presentation followed by work group exercises and will terminate with presentations of the work group findings.
We will follow the usual time pattern of 8-12:30 and 14:30-17:30, two tea breaks, lunch and dinner break and evening session (hours to be determined).

Saturday 3 December		
All day	Program Planning Presentation, work group exercises and work group presentations	Dr. Gorosh
Evening	Arusha Region Presentation	Dr. Moshi

Day/Time	Description	Faculty
Monday 5 December		
All Day	Program Implementation Presentation, work group exercises and work group presentations	Dr. Gorosh
Evening	Masai Health Project presentation	Dr. Mangawe Mr. Rowberg
Tuesday 6 December		
All Day	Program Evaluation Presentation, work group exercises and work group presentations	Dr. Gorosh
Evening	Panel on Planning, Implementation and Evaluation	Moderator to be announced
Wednesday 7 December		
8:00-10:00	Technical sessions on selected primary health care interventions	
	Malaria: immunity, resistance and treatment	Dr. Magari
	Oral rehydration for infant and and childhood diarrhea	Dr. Tengio Urrio
10:00-10:30	Tea break	
10:30-12:30	Family planning: safety and effectiveness of CBD and the health impact of family planning	Dr. Mwaikambo
	Nutrition Monitoring Methods	Dr. Wray
12:30-14:30	Lunch	
14:30-16:00	Continuation of discussion groups about technical sessions Preparation for field visits	
Thursday 8 December		
All Day	Field Visiting Details to be announced on 7 December	

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Day/Time	Description	Faculty
Friday 9 December	Tanzania Independence and Republic Day	
Saturday 10 December		
8:00-10:00	Field visit debriefing Each group will present their findings	
10:00-10:30	Tea Break	
10:30-12:30	Implementation issues in the National PHC/MCH/Nutrition and UMATI Programs	Dr. Wagara
12:30-14:30	Lunch	
14:30-17:30	Continuation of the morning program Reaction panel from each region	
Evening	Regional presentations	
Sunday 11 December	Free	

Program Note

Monday, Tuesday and Wednesday will be devoted to the topics of training, training of trainers and supervision. As with the management sessions, each day will begin with a presentation followed by work group exercises and will terminate with presentations of the work group findings. We will follow the usual patter of 8-13:30 and 14:30-17:30, two tea breaks, lunch and dinner break and evening session (hours to be determined)

Monday 12 December		
All day	Training presentation with emphasis on competency-based training for village health workers	Ms. Nalder
Tuesday 13 December		
All Day	Training of trainers Presentation, work group exerci exercises and work group presentations	Dr. Teri

Day/Time	Description	Faculty	Faculty
Wednesday 14 December			
All day	Supervision presentation Presentation, work group exercises and work group presentations		Dr. Shoo
Thursday 15 December			
8:00-10:00	Post-evaluation exercises for the seminar		Ms. Nalder Dr. Tengio Urrio
10:00-12:30	Tea Break		
10:30-14:30	Work groups, by region, to prepare summary of seminar and plans for using new information/ skills in the region		
12:30- 12:30-14:40	Lunch		
14:30-16:00	Presentation of work groups		Dr. Tengio Urrio Moderator
16:30-16:30	Tea Break		
16:30	Closure of Seminar		Dr. Tengio Urrio Dr. Wray Ms. Nalder

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Center for Population and Family Health/Ministry of Health of Tanzania

Schedule for Training Seminar in Arusha, 1 - 15 December 1983

			TEA	LUNCH	TEA	DINNER
-	DATE	08H00 - 10H00	10H30 - 12H30	14H30 - 16H00	16H30 - 17H30	EVENING HOUR
JNDAY	NOV 27					
)NDAY	NOV 28	-CPFH/MOH Meetings all day				
ESDAY	NOV 29	Pre-Training Briefing and Planning, all trainers, all day				
ESDAY	NOV 30	Pre-Training Briefing and Planning continued				
RSDAY	DEC 1	Trainees Arrive,	All Day	Trainees complete Biographic Forms		Informal Reception
IDAY	DEC 2	Introductions Pre-testing	Pretesting cont. MCH/PHC Integrat	Course Overview Program Model	What is Management?	Management Discussions + 1 region
URDAY	DEC 3	Planning Presentation	Work Group Exercises	Work Group Presentations and Discussions		Arusha Regior Presentatior + 1 region
NDAY	DEC 4					
NDAY	Dec 5	Implementation Presentation	Work Group Exercises	Work Group Presentations and Discussions		Masai Health Presentatior + 1 region
ᐧᐧDAY	DEC 6	Evaluation Presentation	Work Group Exercises	Work Group Presentations and Discussions		Panel on Plan/ Implement/Eva
ESDAY	DEC 7	Malaria Oral Rehydration	Family Planning Nutrition Method	Field Visit Preparations		
RSDAY	DEC 8	Field Visits				
IDAY	DEC 9	TANZANIA INDEPENDANCE AND REPUBLIC DAY, A NATIONAL HOLIDAY				
URDAY	DEC 10	Field Visit Debriefing	Implementation Issues PHC/MCH FP and Nutrition	Panel on Issues		Regional Prese tations, TBA (2)
NDAY	DEC 11					
NDAY	DEC 12	Training Presentation	Work Group Exercises	Work Group Presentations and Discussions		
SDAY	DEC 13	Training of Trainers Present	Work Group Exercises	Work Group Presentations and Discussions		
NESDAY	DEC 14	Supervision Presentation	Work Group Exercises	Work Group Presentations and Discussions		
ᐧᐧDAY	DEC 15	Post-Evaluations	Work Groups to Prepare Summary and Plans	Work Group Presentations and Closure of Seminar		Final Party

APPENDIX 7.3

LIST OF PARTICIPANTS

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LIST OF FACILITATORS

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Ms. Therese McGinn Center for Population and Family Health Columbia University 60 Haven Avenue New York, N.Y. 10032 U.S.A.	Staff Associate CPFH
Mrs. Joyce Mahalu Ministry of Health P.O. Box 9083 Dar es Salaam TANZANIA	Senior Nursing Officer I
Dr. E. E. Moshi P.O. Box 3092 Arusha TANZANIA	Regional Medical Officer Arusha Region
Dr. Eli Nangawe Selian Lutheran Dispensary P.O. Box 3164 Arusha TANZANIA	Project Director Maasai Health Service Project Lutheran Synod in Arusha Region

Ms. Susan Nalder Center for Population and Family Health Columbia University 60 Haven Avenue New York, N.Y. 10032	Assistant Clinical Professor
Mr. Erik Rowberg Selian Lutheran Dispensary P.O. Box 3164 Arusah TANZANIA	CPFH Staff Associate Project Advisor to Maasai Health Services
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Dr. Tengio Urrio Ministry of Health P.O. Box 9083 Dar es Salaam TANZANIA	Senior Medical Officer National Coordinator of MCH Services

PARTICIPANT BIOGRAPHICAL FORM

APPENDIX 7.4

NAME _____ AGE _____ SEX _____

MAILING ADDRESS _____

_____

_____

PROFESSION _____

EDUCATION (PLEASE LIST ALL UNIVERSITY AND PROFESSIONAL EDUCATION)

JOB TITLE _____

1. PLEASE LIST MAJOR JOB RESPONSIBILITIES.

2. PLEASE LIST ALL TRAINING EVENTS YOU HAVE ATTENDED FROM 1980 - 1983.

TITLE	DURATION	LOCATION

3. HAVE YOU SERVED AS A TRAINER IN THE PERIOD 1980 - 1983?

YES _____ NO _____

IF YES, SPECIFY:

TITLE OF COURSE(S)	TOPIC(S) YOU COVERED

4. WHAT DO YOU EXPECT TO GET OUT OF THIS WORKSHOP?

Best Available Document

ADDRESS BY JITTO RAM, MEMBER OF

NATIONAL EXECUTIVE COMMITTEE OF CCM AT THE

OPENING OF WORKSHOP ON "MANAGEMENT OF COMMUNITY BASED

INTEGRATED MCH/PHC/FP PROGRAMMES IN TANZANIA"

delivered at Arusha
2nd December, 1983

Mr. Chairman

Distinguished Guests,

Ladies and Gentlemen.

I have been asked to inaugurate this workshop for participants from various walks of life which has been jointly organized by the Ministry of Health and Centre for Population and Family Health, Columbia University - New York. To me, this is a gratefying undertaking and an honour and a privilege to have been invited to open such an important workshop.

I am sure, you will agree with me that the organizers should be congratulated for having made possible for this workshop to take off as planned. The subjects chosen are of direct and immediate relevance for the improvement of quality care in Health Services. I sincerely hope that at the end of it, both the organizers and the participants will part with a feeling of satisfaction, that all were enriched by it, and that having achieved all objectives they will be able to discharge their everyday functions and responsibilities more effectively and meaningfully.

The need for efficient management which would put to optimal use, the scarce resources available especially at this time of

Allow me, Mr. Chairman, to draw you back to the originality of Primary Heath Care and the Declaration made during the conference at Alma Ata in 1978 in USSR and the sole objective of 'Health for All by Year 2000; and to remind ourselves of the definition of Primary Health Care as adopted and hitherto stated:

"Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."

The definition is therefore, underlined by five principles, namely:

(i) Health Service must be accessible to everybody, not neglecting the rural people

(ii) Active participation by the community itself as an essential component in their own health decision-making.

(iii) Preventive and promotive services should be the focus of health vis a vis the curative services

(iv) Resources - human and non-human - should be appropriate, acceptable and affordable.

(v) Health Care should be in totality, that is, encompassing nutrition, education, water supply and housing, etc. This demands multi-sectoral approach or community based integration.

The Declaration of Alma Alta therefore, called on all governments to formulate national policies, strategies and plans fo action to launch and sustain Primary Health Care. In Tanzania, we fully subscribed to its establishment and sustainance on a permanent basis and as far as possible an integral part of our national health system.

Mr. Chairman, through Primary Health Care, as you are all aware, we hope to reach as close as possible to where the largest percentage of our population live and work. Already, we have a health infrastructure for sustaining areas, through village health posts at grassroot level, dispensaries, rural health centres, district hospitals, and eventually the regional and consultant hospitals. This Health Services provides basis health care for the population at the lowest possible level for everyone and at a cost that the country can best afford. This same service, also provides a referral network system linking primary health care to higher levels of the national health service. For any health service to be objective and meaningful, it has to be near the majority of health users.

There are a number of /ealthprogrammes which you are all aware of being integrated on the basis of Primary Health Care, such as:

- Maternal and Child Health
- The Expanded Programme of Immunization
- The Mental Health Programme
- The Family Planning Programme

- The Nutrition Programme
- School Health
- TB and Leprosy

At the level of implementation, that is, at the district level, all programmes are offered as a comprehensive "health care package" in the existing health infrastructure.

However, each programme has a coordinator at district, regional and zonal level -- with the DMO or the PMO as the overall coordinators of all health programmes being conducted in their respective areas. Therefore, your role is of vital and invaluable importance in evaluating constructively the existing services and making positive recommendations where possible.

Mr. Chairman, the success of any programme depends largely on the careful collective planning between the people and the implementers. Hence, community involvement is an essential element in planning. Collective problem-solving and decision-making can be achieved through inter and intra sectoral as well as involving appropriate inputs from the public and party organs.

Following the Decentralization Act of 1972 there has been a great deal of intersectoral coordination at both the regional and district levels. Management Teams were established comprising of heads of all departments - health, education, agriculture, livestock, lands etc.

Intra-sectoral coordination was strengthened at the Ministry of Health drawing its members from all the directorates (e.e. manpower and training, hospital services and the preventive services) and the planning unit.

Distinguished participants, the main changes in health infrastructure to support Primary Health Care and all your endeavours need strengthening in order to be more effective. The following areas need special attention.

- training of village health workers and setting up of more effective village health posts.
- re-training health workers at all levels, as you are aware of the establishment of a Centre for Education Development in Health in Arusha (CEDHA), which carries out a continuing education programme to improve knowledge and skills and the quality of health workers output.
- improving the health information and education system.
- improving management capabilities of health workers at various levels through organization of workshops, such as this one, short managerial courses conducted by National Institute of Productivity or ESAMI at Njiro Hill.
- evaluation system of all national health programmes.

Mr Chairman, the benefits of good management in Health Services are numerous, although there is a recognized gap between what is known and what is to be done; between knowledge and its application. In other words, we know how to prevent measles yet

many children <u>die</u> from it. The same applies to a wide range of infections, parasitic, nutritional and environmental based diseases that still afflict millions of people as if our medical knowledge did not exist.

Questions arise about health priorities, the use of limited resources, the training of manpower and the evaluation of a service and its impact. But it is now recognized that applying the general principles of management can help in making principles of management can help in making priorities that are more relevant, in making informed judgements and in using limited resources better.

Management principles can be applied at all levels of organization in the Ministry of Health, the regions, district hospitals, health centres, dispensaries and equally to the specialist as well as village health workers. It is a common mistake to regard management as a function of those at the top hierachy only. To be more effective, a manager of health service must know the management skills and a good management must permeate the whole organizational structure. Well conceived programmes fail because of poor management both at the top and the periphery. Good management, is to an organization what health is to the body -- the smooth efficient functioning of all its parts. Good management highlights priorities, adapts the service to the needs of a changing situation, makes the most of limited resources, improves the standard and quality of service, and maintains high staff morale. Good health management means good health care.

Ladies and Gentlemen, it is my sincere hope that on your return home to your places of work you will put changes which will improve the effectiveness of management of health services and thereby provide better health services at a less cost, greater speed and enhance the Primary Health Care as spelled out in the Declaration of Alma Alta.

With these remarks, Mr. Chairman, I declare this workshop open and wish you a great success.

THANK YOU

APPENDIX 7.6

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ject: Overview of Program Model

:: Development of a model representing the key elements of the reality of program operations

Manipulation of the model to examine the relationships between and among components

Selecting the more important components for detailed attention

ls	Knowledge	Attitudes
ract thinking about rams	Vocabulary of systems Analysis	Models are useful representations of reality
rstanding of inter- ve relationships	Health and Family Planning Program Operations	Models are useful for teaching
le out a component detailed analysis out losing sight of place in the overall ext	Planning and Decision Making Program Design Goals, Objectives, Targets Inputs Processes Outputs Utilization Time Knowledge Attitudes Practice Health Nutrition Fertility Evaluation Population Environment Constraints Total societal context	Models are useful for analytical purposes

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e	Objectives and Procedure	Materials
in entation min scussion	At the end of the session the participant will be able . Describe an overall framework for planning, implementing and evaluating community-based programs . Recognize the relationship between inputs and process and changes in contraceptive practices . Identify and develop key topics for special attention in training programs	Overhead Projector Transparencies Handouts

llowing presentation and discussion of the program model, a work group or oups will be formed to develop adaptations of the approach ~~for use in TOT~~ ograms.

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ect: Planning

s: Conducting Needs and Resources Assessments
Selecting and Defining Problems
Setting Objectives, developing strategies, and specifying evaluation criteria
Setting objectives, developing strategies, and specifying standards for service delivery

ls	Knowledge	Attitudes
ining qualitative and itative information	Information Sources	Community resources are useful
lyzing information	Simple statistical counts distributions projections indices	Qualitative info is often as important as quantitative
	The variety of strategy community based hospital and clinic based self sustaining inexpensive local resources volunteer vs paid workers simple interventions combinations of interventions and phasing acceptability availability effectiveness integrated/vertical urban/rural post partum strategies use of tradional health workers	Clear objectives are important

Quantitative Approaches

Sources and Use of Existing Data

.Census data and projections
.Vital statistics
.Demographic surveys
.KAP (Knowledge, attitude and practice) surveys
.Morbidity/Health Service Statistics
.Program service statistics
.Administrative statistics
.Other surveys

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Survey Modules Design and Utilization

- .knowledge of contraceptive methods, sources and supplies
- .contraceptive use, present and past (history of contraceptive use method, source, reasons for discontinuation, etc.)
- .Birth history
- .Lactation and weaning infant feeding practices in relation to contraception, weaning practices, attitudes towards breastfeeding and local foods
- .Maternal health
- .Child health

Survey Methodology

- .Sampling
- .Questionnaire design and pretesting
- .Interviewer selection and training
- .Interviewing techniques
- .Organization and administration of fieldwork
- .Coding and data editing
- .Data processing
- .Data analysis and reporting

Qualitative Methods

- .A comparison of quantitative and qualitative methods
- .The need for qualitative data in community-based health projects
- .The perception of needs: programs vs. community
- .Qualitative methods: what, when, how, who
- .The utilization of qualitative data

Objectives and Procedures	Material
ıy At the end of the session, participants will write at least four planning exercises.	On Being in Charge
	Exercises

a. For needs and resources assessment

- gathering information
- identifying useful information from records
- analyzing and interpreting information
- tabulating data
- reviewing existing health work
- collection information on resources

2. For selecting and defining problems ~~the~~

- identifying and listing problems in the community
- selecting important problems according to criteria
- recognizing problems which are the responsibility of sectors

3. For setting objectives, developing strategies, specifying evaluation criteria, and setting standards for the quality of service delivery

- writing program objectives
- specifying measurable targets
- setting objectives that are relevant, feasible, measurable and observable
- selecting appropriate program design
- specifying the evaluation measures to be used
- listing the measures to be used to assure that standards of service delivery are met

owing Presentation and Discussion of the key themes for planning, the icipants will be divided into four to six groups in which specific ning exercises will be completed

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PLANNING EXERCISE I

Needs and Resources Assessment

As the regional director of a community-based program scheduled to be launched in six months, you have decided to look at the situation as a first step in planning for the family planning component of this program. Using the material on pages 269-277 as a guide, prepare an outline for this task. Be sure to include a mix of quantitative and qualitative measures. (The format below is optional)

Needs and Resources Assessment Exercise

Problem Statement:

Quantitative Approaches

Information Needed	Intended Use	Source and Method of Obtaining Information

Qualitative Approaches

Information Needed	Intended Use	Source and Method of Obtaining Information

Select one quantitative and/or one qualitative approach and specify in detail the type of information needed and the steps to be followed in its collection. Describe in detail the tool you will use to gather the data.

PLANNING EXERCISE 2

Selecting and Defining Problems Exercise

Using pages 278-283 as a guide, indicate how you would identify malaria as an important problem in a community.

PLANNING EXERCISE 3

Setting objectives, developing strategies, and specifying evaluation criteria.

Consider a community-based oral rehydration program integrated into the national PHC program. Write several objectives for this program and for each objective specify the strategies to be followed and the evaluation criteria to be used.

PLANNING EXERCISE 4

Consider a community-based nutrition surveillance program integrated into the national PHC program. Write several objectives for the program and for each objective specify the strategies to be followed and the standards required for providing high-quality services in the community.

ect: Implementation

ks: Coordination
Administration Monitoring
Supervision
Monitoring Service Delivery Standards and Norms

lls	Knowledge	Attitudes
ecting needed information igning forms igning information flow cessing information into ndicators ng information for oordination, administrative onitoring, service delivery tandards	Sources of information Flow of information Cost of information Summarizing information Collecting information Developing indicators Using indicators Teaching workers to use information	Informed decisions require accurate and timely information You don't have to be a statistician or demographer to use information

e **Objectives and Procedures**

day At the end of the session, participants will have written at least four exercises in implementation, including:

- o coordination
- o administrative monitoring
- o supervision
- o monitoring service delivery standards and norms

The modules developed will inlcude the following themes:

- o coordinating the activities of a plan
- o coordinating people within an organization structure
- o communicating decisions concerning implementation
- o using a check list to review work standards
- o using records to monitor work
- o using reports to assess work outputs
- o redirecting activities as necessary
- o making a schedule of supervisory visits
- o planning a supervisory visit
- o conducting a supervisory visit in a helpful way

The basic procedure involved is to design an information system for use in a community based family planning program. Following an introductory session and discussion, participants will be formed into work groups to complete exercises, as follows:

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IMPLEMENTATION EXERCISE 1

1. Select a community-based family planning program design.

2. Specify the information needed by the following groups in order to coordinate workers and activities.

   - health workers
   - supervisors
   - managers
   - funding agencies

3. For each item of information specify the following:

   - data source
   - point of collection
   - frequency of collection
   - analysis (counts, distributions, indices, trends, etc.)
   - the upward and downward flow of the information in the organization

4. Design a client record for use in the program. Show how the information is used for client care. Show how the information is used in various implementation activities.

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

IMPLEMENTATION EXERCISE 2

1. Select a community-based nutrition surveillance program design.

2. Specify the information needed by the following groups to accomplish administrative monitoring of targets, supplies and budgets:

   - health workers
   - supervisors
   - managers
   - funding agencies

3. For each item of information specify the following:

   - data source
   - point of collection
   - frequency of collection
   - analysis (counts, distributions, indices, trends, etc.)
   - the upward and downward flow of the information in the organization

4. Design a client record for use in the program. Show how the information is used for client care. Show how the information is used in various implementation activities.

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

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IMPLEMENTATION EXERCISE 3

1. Select a community-based malaria program design.

2. Specify the information needed by the following groups to effectively monitor service delivery standards.

   - health workers
   - supervisors
   - managers
   - funding agencies

3. For each item of information specify the following:

   - data source
   - point of collection
   - frequency of collection
   - analysis (counts, distributions, indices, trends, etc.)
   - the upward and downward flow of the information in the organization

4. Design a client record for use in the program. Show how the information is used for client care. Show how the information is used in various implementation activities.

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

IMPLEMENTATION EXERCISE 4

1. Select a community-based oral rehydration program design.

2. Specify the information needed by the following groups in order to effectively supervise workers and units:

   - health workers
   - supervisors
   - managers
   - funding agencies

3. For each item of information specify the following:

   - data source
   - point of collection
   - frequency of collection
   - analysis (counts, distributions, indices, trends, etc.)
   - the upward and downward flow of the information in the organization

4. Design a client record for use in the program. Show how the information is used for client care. Show how the information is used in various implementation activities.

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

ect: Evaluation

Evaluate achievement
Evaluate progress
Evaluate staff performance
Evaluate use of resources
Management Audit

ls	Knowledge	Attitudes
ifying objectives rmining evaluation iteria and measures gning evaluation systems cting evaluation topics g appropriate methods ng decisions for program provement based on valuation findings sent findings	The place of evaluation in an organization Evaluation approaches Evaluation methods	Evaluation is an important manage ment function Evaluation is not a burden imposed by by external donors

e	Objectives and Procedure	Materials
	At the end of the session, participants will have written at least five exercises in evaluation, including . managment achievement . measuring progress . assessing staff performance . evaluating use of resources . conducting a management audit The modules developed will include the following themes: . measurement of the progress of the health teams in terms of the services delivered and their results . measurement of the progress of the health team work . appraisal of the performance of the health team members . assessment of the efficient use of health team resources . assessment of the management of the health team	

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EVALUATION EXERCISES 1-4

Devise a quantitative and qualitative evaluation system for each of the categories listed below. In each case specify the following:

1. the objective (activity, target) being evaluated;
2. the measures and methods being used to evaluate process and impact and whether these are short-term, intermediate or long-term assessments;
3. repeat 1 and 2 for additional objectives

EVALUATION EXERCISE 1: Achievement in a family planning program

EVALUATION EXERCISE 2: Progress in a malaria program

EVALUATION EXERCISE 3: Staff Performance in a nutrition surveillance program

EVALUATION EXERCISE 4: Use of Resources in an oral rehydration program

EVALUATION EXERCISE 5: Management Audit

Using pages 342-344 as a guide, devise a management audit for a community-based primary health care program incorporating family planning, nutrition surveillance, oral rehydration, and malaria components.

Handout
June Course
June, 1983

FAMILY PLANNING EVALUATION MEASURES

Evaluation starts with the program's objectives -- are they being achieved?

A. **For fertility reduction consider the following:**

1. The Crude Birth Rate
2. Child/woman Ration
3. General Fertility Rate
4. Total Fertility Rate
5. Age Specific Fertility Rate
6. Marital Age Specific Fertility Rate
7. Percent Currently Pregnant

8. Acceptor follow-up surveys may also measure pre- and post-acceptance fertility -- the drop from one to the other can be compared to some standard, such as the fertility trend for other women matched on personal characteristics.

9. Other methods to measure program effect on fertility are explained in two UN Manuals**:

   Trend analysis
   Areal regression
   Field experiments with control areas
   Computer stimulation (Tabrap/Converse; SCYP)
   Potter and Wolfer methods of births averted
   Bongaarts formulas for the relation of prevalence to fertility
   Others

B. **For services provided:**

By contraceptive method
By first vs. repeat acceptors (and also divide the quantity of pills and condoms by first vs. repeat).
By service point (to see what type of outlet works best -- this may vary by method).
By type of personnel who recruit, or have the first contact with clients (again, to learn the paths via which people come to the service).
Also by open interval, previous contraception (both in the program and privately), and past abortions.
Also by personal characteristics -- age, no. children, residence.

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C. For analyzing program mechanics (process measures).

1. Personnel: follow each process separately: selection, training (and re-training), supervision, and especially turnover. Watch monthly, the proportion of authorized posts that are not occupied, as program performance can be very sensitive to empty field positions.

2. Supplies: follow closely the stocks and flow of each contraceptive method, being sure that the pipeline has plenty of inventory at each level. Also small medicines, forms, etc.

   For major equipment items, watch lead times necessary for ordering, transport and installation.

3. Information, Education, Communication: follow each sub-activity by desired output:

   - is the work getting out not just the family planning is a good idea but specifically what services are available: where, when, by whom.

   - via which media (follow each separately)

   - at what cost (the more expensive is often not the one that does the most good).

**UN Population Division: Methods of Measuring the Impact of Family Planning Programmes on Fertility, ST/ESA/SER.A/61.1978.
Also: The Methodology of Measuring the Impact of Family Planning Programmes on Fertility: Manual IX, ST/ESA/SER.A/66.1979

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For program improvement

Do small studies and experiments. Try such examples as:

Small depots in the remoter villages

Volunteers who are ready users, to recruit new clients, or visit them after acceptance for reassurance

New kinds of personnel, especially larger numbers of lay and paramedic staff who cost less and can cover a larger rural population

An intensive small area study to interview every household, see what contraceptive method is used (or preferred), what travel patterns exist between them and the services, what contacts they report with fieldworkers or IEC, and so on.

Ways to activate the private sector, to do more via small drugstores or sidewalk stands, traditional midwives, folk medical practitioners, etc.

Local mothers clubs - to be depots, to focus on health and FP, to back up the field staff

Other

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Supervision Work Group Exercises

Organize into work groups

Choose one example from the list below and design an instrument for supervision:

1. Observation guide for regional level staff to use in a supervision visit to a regional level activity

2. Monthly report form for supervision of growth monitoring

3. Check list for supervision of MCH - FP activities at a dispensary (don't forget outreach!)

4. Observation guide or check list for dispensary level workers to supervise activities of a VHW

5. Activity report for use by VHW to use when dispensary worker comes to supervise

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WORK GROUP EXERCISES FOR TRAINING AND TRAINING OF TRAINERS

1. Choose one aspect of service delivery from this list:

   - Community based oral rehydration activities
   - community based growth monitoring activities
   - community based family planning informationand referral activities
   - community based immunization activities
   - community based maternal health activities

2. For the activity you have chosen, write a task list and indicate who will perform the task

3. Choose one (or more) of the tasks and do a task analysis by:

   - knowledge needed to perform the task
   - skills needed to perform the task
   - attitudes needed to perform the task

4. Write at least two training objectives for each task you have analyzed

5. Suggest how you will evaluate
   - trainee learning
   - trainee competence in the task

6. Make a lesson plan to achieve the above training objective. Be sure to include:
   - an outline of content
   - a detailed description of any training exercises
   - training methodologies to be used
   - time required for the parts / whole lesson
   - training materals you will need

-T r a i n i n g-

At the end of this session participants will be able to:	Training metholog to be used:
1. Complete an example of each step in the competenty based training procedure	Presentation with discussion work group exercises
2. Discuss advantages and disadvantages of CBT compared to conventional training	Discussion and use blacboard to compile group's understanding
3. Discuss issues in training from village based programs -location of training -number of tasks to include -community ownership -training manerals -training program design	Presentation of Masai Project and discussion of issues

- Training of Mainers-

1. Identfy or select appropriate training methods for community based programs	Brainstorming and discussion
2. Select what trainees should learn and not learn	Presentation with discussion
3. Design a lesson plan for community based workers	Presentation with work group exercises
4. Write a training design which ensures adequate practical experience	Presentation and use blackboard to record group responses
5. Describe various evaluation tools which can be used to evaluate trainees, the training program and follow-up assessment	Presentation of evaluation concepts and brainstoming about various tools.

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SUPERVISION TRAINING

1. Describe the important functions of supervision	Brainstorm to elicit the various functions - Tengio Urrio
2. Identify the different resources for supervision in a program which has community based activities	Brain storm Create a diagram on the blackboard Eric Rowberg
3. Discuss functions and styles of supervision after a role play featuring village health workers, dispensary workers district staff and regional staff	Role play using a 3 level situation Observation & discussion guides Players meet Tuesday night to review roles - Tengio Urrio & McGinn, facilitators
4. Describe steps in problem solving method and show how it is applied to supervision	Develop a cycle model on blackboard - Nangawe
5. Design instuments for supervision and show how they will be applied	Work group exercises
6. Discus W.G. reports Summarize supervision training and relate to " Supervision by objectives"	Group reports in summary and wind-up discussion - Training Team (Tengio Urrio - Rowberg - Nangawe - McGinn

WORKSHOP ON COMMUNITY BASED INTEGRATION AND IMPLEMENTATION OF NATIONAL PHC MCH/FP PROGRAMME IN TANZANIA, DANISH VOLUNTEER TRAINING CENTRE ARUSHA 1/12 - 14/12/83

APPENDIX 7.8

REPORT FROM COAST REGION

Coast Region with the population of 599,286 living in an area of 32,482 sq.km. is divided in five (5) districts, and it has 362 registered Ujamaa Villages.

Main ocupation of its peoples is farming, fishing and poultry farming. We have 108 dispensary and 10 health centres among those two are still our under construction. Out of the 108 dispensaries 64 run MCH clinics:- And among 64 MCH clinics 34 run family planning services.

A. PRIMARY HEALTH CARE IN THE COAST REGION:-

Primary Health care in the Coast Region was a direct response to the Alma-Ata conference 1978, which spelt out health for all by the year 2000. In 1982 seminars were organised in Dar es Salaam and Shinyanga whereby Regional and District Health Officials were invited to set up plans for the implementation of Primary Health Care which was deemed as the only feasible way by which universal Primary Health Care can be realised within the constraints of limited health budgets.

As it may be remembered Primary Health Care was instituted in five regions each Region having different targets. The Regions were Dodoma, Morogoro, Iringa, Mtwara and Coast. In the Coast Region Primary Health Care began with ARI namely acute respiratory infection control programme at Bagamoyo District.

PROJECTS AND IMPLEMENTATION COAST REGION:-

OBJECTIVES	IMPLEMENTING UNIT	STAGE OF IMPLEMENTATION
1. Selection of trainers by trainers	Ministry of Health	In December, 1982 the Coast Region selected Medical Asst. I, Health Officer 1, Staff Nurse 1 and 5 other Medical Assts. in ARI Programme. Training of trainers for the Programme was carried out in February 1983 in CEDHA for 10 weeks.
2. Education to Regional District Ward and Village leaders	Coast Region	Regional Health team and teachers of PHC met with leaders in February 1983 discussed ARI/PHC and it was agreed to start in Bagamoyo District as a pilot area.
3. Selection of Village to begin the programme	"	36 Villages were selected in Bagamoyo District.
4. Selection of would be Primary Health Workers	"	72 would be Primary Health Workers were selected for 36 Villages. Criteria for selection: Each villages to have 2 VHW (M+F) married, native aged 20+, accepted by village, literate.
5. Cencus	"	In February 1983, 1 week Seminar was done on how to count (a) No. of families/Village

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5. Census	Coast Region	(c) Letrines (d) under fives (e) Major problems
6. Training of Village Health Workers	"	Eight week course at Lugoba (9/5/83 - 2/7/83 and 67 VHW graduated with five drop outs.
7. Meeting of Workers in the field	"	M.A., R.M.A. and MCHA were introduced to PHW on how to cooperate and supply of drugs. (July 1983)
8. Follow up	"	Work load in dispensaries reduced

SYLLABUS FOR PRIMARY HEALTH WORKERS:-

1. Set up of Village Government
2. Environmental Health
   (a) Contruction of a good house
   (b) " " " " Latrine
   (c) " " " " Kitchen
   (d) Purification of water
   (e) Refuse disposal
3. Cleanlinessy of body, clothes and eyes.
4. Food - (a) Preparation of nutritions food
   (b) What is good food
5. Tabeus and customs
6. Maternal and child health services
   (a) Antenatal care
   (b) Taking history of pregnant mothers and detection of "at risk cases"
   (c) Examination of pregnant mothers
   (d) How to conduct spontaneous vagional delivery
   (e) Post natal case
   (f) Child welfare clinic
   (g) Vaccination
   (h) Family planning clinic
7. Disease prevalence in villages and how to get rid of them
   (a) Helminths
   (b) Gastrointestinal diseases
      - Gastroenteritis
      - Dysenteries
   (c) Malaria
   (d) Measles
   (e) Prenmonia
   (f) Malnutrition - Kwashiorkor
      - Marasmus
   (g) Eye diseases
   (h) Tuberculosis
   (i) Scabies
   (j) Anaemia

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(k) Ulcers or boils
(l) Meningitis
(m) Gynaecological diseases
- Vagional bleeding
- other diseases of genitalia
(n) Sexually transmitted diseases
- Gonorrhoea
- Syphilis
(o) Rabies
(p) Accidents:-
- fractures
- Burns
- Poisoning
- Epistaxis
- Foreign bodies

8. Handling mentally sick patients

9. Health Education
- Education of individuals
- " " groups
- Home visits
- Community participation

10. Running of a health unit
(a) Procurement of drugs
(b) Safe storage of drugs
(c) Upkeep and use of statistics
(d) Decision to patients needing referral

11. Continuing education and progress of a primary Health Worker

PROBLEM OF IMPLEMENTATION:-

Transport:-

With virtually no transport at all available at Regional level and scarce at the District supervision of its workers in the field has not been satisfactory.

2. ALLOWANCES:-

Where it was agreed by the village Governments to a ward 250/= per month to each PHC it appears very few villages are able to do so. It was agreed, however, that every village with a PHW should establish a project such as burning charcoal, gardening, poultry farming etc from which monthly allowances can be obtained.

B. REPORT ON MCH AND FAMILY PLANNING, COAST REGION:-

MCH SERVICES:-

Maternal and child Health Services are supervised by the District MHC coordinator. Activities in these clinics includes Ante-natal care, child health, family planning, Immunization Nutrution and House visiting.

TARGET:-

We expected to Vaccinate 80% of all the children under one year in our Region but only 34% were vaccinated by end of June. That means we will not be able to achieve our target by the end of this year. See Table 1.

BCG	DPT (1)	DPT (2)	DPT (3)	POLIO (1)	POLIO (2)	POLIO (3)
8738	9392	8234	5517	9313	7516	7363

Measles - 7793.

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ANTE-NATAL CARE:-

Most pregnant mothers attend MCH clinics, but comparing the number of hospital and clinic deliveries you will find that most of them are done at home. This shows the Importance of Improving the standard of traditional birth altentants.

FAMILY PLANNING:-

Coast Region, as most of it people are muslims and Pagans, family planning methods used mostly is the natural method - pill follows and other methods are not appreciated due to different believes. This can be testified by the fingures in Table (2).

HOME VISITS:-

It [illegible] done only in small scale nearly in every district. During our Visits to the few clinics we observed that no proper record of the cases visited were kept.

Advices were given to the MCHA how home visit should be done

(1) They out to have a book where they
(a) will write the name of the child or mother,
(b) reasons for the visit.
(c) Advices given etc.

NUTRITION:-

We implement this by having demonstation gardens at each district and dispensary. In gardens we try to show mother how to plant different vegetables and Co-operate with Agricultural expect on keeping of small animal like Rabits and chicken.

NURU - REHALIBILITANTION

In Coast Region we have only one NRC operating. At the begin we had two but now one is not working at all, that is the Kisarawe. The one which is working is at Kibaha District under Kibaha Education Centre. They keep chicken for eggs and for meat. Up to now we have 1,000 chicken for eggs and 400 for meat - They have also gardens of different vegetable such tomatoes in which they earned 18,000/= for this season, 6,000/= for other vegetables and some vegetables were given to mothers and children at the Centre.

They are provided with vegetables seeds and eggs to take at home so that they can produce more vegetables and chickens for their children and themselves.

STAFF POSITION:-

Public Health Nurses:-

They are four ofthem in the Region. 3 are District MCH Co-ordinators for Bagamoyo, Rufiji and Kibaha. The remaining 2 districts have Nurse/Midwives as MCH - Co-ordinators for Kisarawe and Mafia.

MCH AIDS:-

They are 95 in the whole Region and we diveded them as:-

Bagamoyo - 31
Kisarawe - 24
Kibaha - 11
Rufiji - 16
Mafia - 3

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Village Midwives:-

We do have them in our Region waiting to go for their upgrading to become MCHA.

Traditional Birth Attendants:-

We have started to Identify them in three of our five(5) Districts-

Mafia - 31
Kibaha - 84
Kisarawe - 91

All of them we knows by names age and the village they come from. We expect more from Rufiji and Bagamoyo District. Plan is underway to train them by now we have already sent 4 Nurse Midwives to be trained at Mvumi Hospital - for one week and they are expected to go back to Mvumi for more training. On their return they will be stationed at Kisarawe to teach traditional birth attendants modern methods of delivery.

Training:-

Four (4) MCHA were selected to attenda upgrading Course for PHNB at Korogwe and Bagamoyo MCHA school. Also 6 village Midwives were also selected to attend MCHA school at Kibondo.

Workshop -

(a) Expanded Programme on Immunization EPI
Was conducted for one week most of the participants were district Health Officers, Public Health Nurses Plus MCH Co-ordinators and other Invited Medical Assistant from Voluntary agency.

(b) Health Education:-

The workshop was conducted for ten days. 3 days were spent in the class and seven days in the field. Main topic was environmental sanitation.

Supervisour

This was done very little due to luck of transport. Coast Region was divided or separated from Dar es Salaam City. It is a new region with most problems No transport of any sort, this markes it difficult for the Regional team to visits the district and the dispensary for advice etc. We only managed to visit Mafia, Rufiji and Kibaha itself since our arrival on May, 1983. Problems found during visits were report to the people concerned for actions.

During the visit we had a protocal forum which would help us during supervision at the clinics. We welcome comments and ny additons.

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M.C.H. PROTOCAL FOR SUPERVISION

(1) **STAFFS:-**

- How many staffs?
- In what ranqk are they?
- Have they got uniform?

(2) **Refridgirator:-**

- Kind of refridgirator - Is it using kerosene or Electricity
- where is it?
- Is it reserred at the MCH clinics or Doctor's Office
- Cleanliness
- Is it working - Yes or No.
- If the answer is No, whats the probelm

(3) **KEROSENE:-**

- Where is it supplied? District or Health Centre
- How is the distribution per month
- Where is the storage?

(4) **FLOW PATTEN OF PATIENTS:-**

- Good or Bad
- If its bad, what steps should be taken for improvement

(5) **HEALTH EDUCATION:-**

- Is it done? Yes/No.
- If its Yes - How often per week?
- Is it done to a community or individual?
- Lesson notes

(6) **WEIGHING MACHINE FOR CHILDREN AND ADULTS AND OTHER EQUIPMENT:-**

- Are they present?
- Are they working in order?
- Is there a BP machine?
- Is it in order?

(7) **HOME VISITING:-**

- Is it done?
- Is there any record book for home visiting?

(8) **REPORT:-**

- Daily report writting
- Are they reserved?
- Monthly report writting
- Are they reserved? Show the previous reports

(9) **GENERAL PROBLEMS**

(10) COMMENTS FROM THE SUPERVISOR

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CHILD HEALTH ATTENDANCE

DISTRICTS	FIRST ATTENDANCE		RE -ATTENDANCE	
	UNDER 6 MONTHS	SIX MONTH 6 YRS.	UNDER SIX MONTHS	SIX MONTH 6 YERRS
Kibaha	1448	153	4713	11970
Mafia	576	261	2932	6459
Rufiji	2927	1402	8333	28677
Kisarawe	3471	2383	11777	28690
Bagamoyo	2225	634	5862	17663
TOTAL	10647	4833	33617	93617

ANTE-NATA CARE				FAMILY PLANNING					
FIRST ATTENDANCE	RE-ATTENDANCE			FIRST ATTENDANCE			RE-ATTENDANCE		
BEFORE 28 WEEKS	28 WEEKS AND AFTER	BEFORE 28 WEEKS	28 WEEKS AND AFTER	PILLS	LOOP	OTHERS METHODS	PILLS	LOOP	OTHERS METHODS
1552	639	2302	5455	188	-	25	1023	-	76
512	295	677	1520	40	-	1	25		36
1608	1612	1249	6190	137	1	4	351	5	5
2683	2086	4546	7796	262	-	36	905	1	27
1801	597	2568	6141	72	-	-	494	2	-
8156	5229	12342	27102	719	1	66	2798	8	144

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IMMUNIZATION

DISTRICTS	BCG	DPT			POLIO			MEASLES	TETANUS		
		1st	2nd	3rd	1st	2nd	3rd		1st	2nd	3rd
Kibaha	1185	1304	1344	135	1286	1271	1314	823	864	762	68
Mafia	529	622	613	613	664	269	661	726	382	267	219
Rufiji	1620	1601	1182	947	964	890	708	742	956	538	418
K Kisarawe	2944	3596	3448	2431	4283	3433	3217	3810	1937	1702	1635
Bagamoyo	2460	2269	1647	1391	2116	1652	1463	1692	975	547	561
TOTAL	8738	9392	8234	5517	9313	7516	7363	7793	5114	3816	2901

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D I S C U S S I O N

On this project a few interventions were given detailed attention for example oral Rehydration Therapy and Growth Monitoring and treatment and prevention of common illnesses such as simple conjunctivitis, malaria and scabies.
This list of subject may seem too small for most of us in Tanzania and this brings us to the common debate on how much should be taught to the VHW's. Should they be limited from getting any clinical skills? It is surely necessary to mix clinical and disease prevention skills according to the needs and resources of the community.
How much should be taught to the VHW at a given time period is deterfined largely by the competence level desired and priority problem orientation of the program.

Community health workers in Tanzania are supposed to be mature respectable adults with strong community/ties. They normally have a lot of responsibilities which more than anything else contributes to the high drop out rates. Enhanced community support could alleviate this problem. It is therefore important to pay particular attention to community participation to an adequate degree before commencement of training and continuously during training , then only the post training period.

Training health workers at whatever level needs people with teaching and training skills. Getting healthful behaviors to happen in a community needs communication skills and choice of appropriate courses of action and stimulation by the health workers. It is time we questioned critically the effectiveness of "health education talk/lecture", a phrase commonly given by health workers in this country in response to questioning about their preventive medicine activities.

Implementation of PHC has political implications and this is even climaxed in a situation of limited resources and capabilities

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to handle the massive pool of problems at hand.
In developing countries, in order to achieve coverage of majority of people and a great proportion of the common problems it is necessary to reallocate resources and services from the minority haves (usually the urban elite/ rich sector) to the majority have-nots (usually the urban slum and rural people). Existing medical and health services have to be reorganised to generate more community reaching activities rather than dwelling whooly on dispensary or hospital based patient a care activities.

This brings us to the question of how to reorganise those services and activities which calls for skills in program design, revision or replanning of work schedules in those units. The other very important question that arises is who should be responsible for the health activities in terms of management, implementation and support? A careful search of the answers to these questions leads us make an in depth examination of the following issues:-

Community - based programs.

Community participation

Supportive supervision.

Community "Health education"

It is proposed in this paper that among other things this workshop pays some attention to the above issues.

::::::::::::::::::::::::

THE ARUSHA REGION PRIMARY HEALTH CARE PROGRAM

PAPER PREPARED FOR COMMUNITY BASED INTEGRATION OF NATIONAL PRIMARY HEALTH, MATERMAL AND FAMILY PLANNING PROGRAMS OF TANZANIA

By: Dr. Moshi, E. E. (R.M.O.)
&
Mubiru (R.P.H.C.)

Primary Health Care is not a new concept in Tanzania. Many programs have been initiated in the Country under the umbrella of P.H.C. to amention a few they are: MCH/FP, TB& Leprosy, School Health Programs, Essential Drugs, & E.P.I.

Although these programs have been going on at considerable period of time, and their objective was to reduce morbidity and moratality in the whole population at large much has not been achieved.
I:M:R: is still high from preventable diseases. T:B: & Leprosy still rampant oral feacal transimitted diseases still a manance malarial amoungst the 4 top killer and a an economic draw back to the country.

In view of all these Health programs and lack of personalle to excute then in vertical manner, the government agreed to ~~go~~ decentralize these activities and also integrate them in one program as P.H.C. However this idea has not yet been conceived by the implementors, that is the Regional Medical Staff down to the V.H.Workers.

The Arusha Region started to implement its P.H.C. September 1982. Before the implementation the Region had to present a plan in the R.M.O's conference 1981 at Mbeya.

The plan was as follows:-

1. To consolidate the existing health delivery system; by increasing the ability and skills of the curative health workers through the continueing Education project for Health Workers at all levels, a project founded by USAID and with Ministry of Health. Later this project has to

be maintained by the Ministry of Health throughout the country.

2. To support more rigorously the existing Health delivery system and programs. - especially in their logistics.

3. Training of VHW, TBA and others.

Since Training of VHW was new component in this wide subject of PHC so I am going to highlight on the regions PHC in VHW training.

The broad objective was training of VHW.

- Specific objective was training of VHW in those villages without any health facilities.

The Regional Team carefully laid out the plan - for Implementation supervision monitoring and evaluation procedures of the P.H.C. in training.

PRIMARY HEALTH CARE PROGRAMME
ARUSHA REGION - TRAINING OF V.H.W.

First Progress Report - December 1982

Summary: The Primary Health Care Programme in Arusha Region started in September this year.
The programme consists of 3 phases. Due to Financial constraints only phase 1 and 2 can be implemented in the financial year 82/83. Phase 3 will be implemented in 83/84. At this moment phase I has been completed - in this phase the Regional Team prepared the programme and conducted three seminars to brief the district teams. Phase 2 starts now and will be running till June 83 by which time 3 health centre teams will have been trained in each district.
Phase 3, the actual training of village health workers will start after July 83.

Introduction: The Primary health care programme in Arusha region started in September this year. This progress report briefly describes the original proposal, the alterations made during the implementation schedule and the state of affairs as per 1st of December, 1982. The state of affair now is different, for there interrupted the 1983 report will be completed very soon.

Original Proposal

During the RMOs' conference in Mbeya the Regional Medical Officer Arusha presented the schedule for implementation of the National PHC Programe in Arusha Region.

The full proposal can be found in the proceedings of the RMO's conference Mbeya 1982 - some important points are highlighted here.

The Proposal contained 3 phases.

Phase I: Seminars for all district teams to brief then about the programme.

Phase II: Training of trainers. The schedule proposed was as follows:-

District	Place of Training	Facilitation	Trainers	Remarks
Arumeru & Monduli	Arusha Gov. Hos.	DMO's DHN's DNO's DMCHC's	MA's - 5 H/A - 5 MCHA's 5	The curriculum not being ready the duration of TOT is not yet fixed
Babulu	District Hosp.	DMO DNO DHO DMCHC	MA -3 H/A - 3 MCHA - 3	
Longrox2	Loliondo	DMO DNO DHO DMCHC	MA - 1 MA - 1 DMCHC - 1	Since the people here are nomads, the programme of Dr. Bachu will be followed

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iteto	Kibaya RHC	DMO DHO DNO DMCHC	MO - 2 MA - 2 MCHA - 2	Mixed Nomad/ Settled population
hang	Hanang vill. Health Project Training School	DHO DNO DHO DMCHC Teacher from primary school	MA - 3 H/A - 3 MCHA - 3	See Kiteto

ase III: The Training of village Health Workers in Rural Health Centres

For the coming 10 years the programme of training was proposed as follows:

DISTRICT	REQUIRED NO. OF UHW'S	TO BE TRAINED EACH YEAR	TOTAL PROJECT DURATION (YRS)	TOTAL
umeru	194	20	10	200
hang	70	8	10	80
iduli & rongoro	88	10	10	100
ilu	112	12	10	120
eto	56	6	10	60
				560 grand Total

e 10 years plan is summarised here:

ar	No qualified (Summative)
/83	56
/84	112
/85	168
/86	224
/87	280
/88	336
/89	394
/90	448
/91	504
/92	560

dget: The budget for the original proposal was T.Shs.448,000/= for the financial year 1982/83

The ceiling imposed by the region's budget was TShs.300,00/=

fortunately, due to the economic contrainsts facing the region ly TShs.100,000/= was granted for the financial year 82/83. careful revision of the objectives for 82/83 was therefore essary.

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Objectives of phase I: the regional teams to inform and instruct the district teams who will be the facilitators of the training of trainers at the various health centres.

The regional team consists of the following people

RMO
RHO
RPHCC
RMCHC
RNO
Admtr. Officer

Each District team consists of

DMO
DPHCC/DHO
D MCHC

with assistance from

DEO
DCDO
DNO
Ward Secretary and others

with assistance from the Director of the Masai Boma Health Project.

Implementation of phase I : The time schedule was as follows

September	October	November		December
Regional PHC Coordination Committee meeting Preparation for Seminars Budgetting	Seminar for Kiteto & Arumeru in Kibaya	Seminars 1) For Mbulu & Ngorox2 in Karatu	2) For Monduli & Hanang in Monduli	Preparation of Report & Evaluation

the seminars were conducted as follows:

Session I:
- introduction of the national programme
- the regional programme
- other PHC project in the region (part the Masai Health project)

Session II
- objectives of the seminar
- timetable of phase II
- responsibilities of district teams
- training manual
- training of trainers

Session III
- district teams prepare their programme for Phase II i.e. budget, choice of health centres for T,O,T.'s Choice of trainers etc
- discussion of district - presentations
- final programme for Phase II

By the end of phase I now all district teams are fully briefed and starting Phase II.

Phase II: runs from November 82 till June 83
Objectives of Phase II the training manual for VHW's to be prepared. In each district 3 teams of Trainers to be trained.

Implementation of Phase II: After careful consideration it was decided to abandon the original schedule for the TOT's and instead to hold the TOT's in the RHC where each team of trainers is stationed. In this way the TOT will be more realistic ; the District team will be aware of the situation facing each team, constraints can be identified. The Regional PHC Coordinating Committee feels that in this way the TOT will

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The timeschedule is as follows

Nov - Jan	February	March	April	May	June
Development of the Training manual Budgeting Preparation of a detailed map of each district	Week 2 1st Training of Trainers in each District	Week 2 2nd Training of Trainers in each district	Week 2 3rd TOT in each distri-ct	Evalution & Report Prep.	Presen-tation to Rep. PHC Coord. Com.

The places chosen for the training are geographically scattered so as to cover 3 different areas of each district.

The trainers to be trained and the place where they will be trained are listed below:

DISTRICT	KITUC	TRAINERS TO BE TRAINED	MONTH OF TOT
Ngorongoro district	Nainokanoka	1 RMA 1 MCHA 1 H/A 1 School teacher	Feb.
	Malambo	- do -	March
	Loliondo	MCHA M.A H/A Teacher	April
Mbulu District	Dongobesh	- RMA H/A N/E or MCHA Mwalimu	Feb.
	Endabash	- do -	March
	Karatu	- do -	April
Kiteto District	Naberera HC	MA RMA MCHA H/A Mwalimu	Feb
	Nyumba Mungu	RMA MCHA H/A Teacher	March
	Kibaya HC	MA RMA MCHA H/A Teacher	April

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Arumeru District	Mbuguni	MA RMA MCHA H/A	February
	West Meru	MA RMA MCHA H/A	March
	Oltrumet	MA N/A MCHA H/A	April
Monduli District	1. Longido	M.A. R.M.A. N.M. H.A. M.C.H.A Primary School T.	Feb. 83
	2. Mto wa Mbu	M.A. RMA N.M H.A MCHA Primary Sch. Teacher	March 1983
	3. Monduli Juu	R.M.A. MCHA H.A.	April 83
Hanang District	As yet undecided. The team was unable to attend the Monduli seminar due to a cholera epidemic		February 83 March 83 April 83

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In June 1983 Phase II will be finalised and the following staff will have been trained,

DISTRICT	NO TRAINED BY JUNE	TOTAL
Arumeru	3 teams of 4 trainers	12 trainers
Hanang	3 teams of 4 trainers	12 trainers
Monduli	3 teams of 4 trainers	12 trainers
Ngorongoro	3 teams of 4 trainers	12 trainers
Kiteto	3 teams of 4 trainers	12 trainers
Mbulu	3 teams of 4 trainers	12 trainers

done

Grand Total : 72 Trainers in 18 RHC - Teams

Phase III will start in the financial year 83/84, and will run for 8 years

Objectives of phase III: To select candidates for VHW training in cooperation with the village committees

- To train the selected UHW's - one female and one male from each village.
- to supervise and support the trained VHW's

Implementation of Phase III: The district teams are responsible together with the Health Centre teams, for the selection of trainees. The district and health centre teams have to visit all villages concerned, to consult with the village leaders and to select suitable trainees, according to the criteria laid down by the programme.

In one 6 months period each HC team will train 2 VHW's (one female, one Male) from 1 village so that per year each team will train 4 VHW's, 2 Female, 2 Male, so that 2 villages each year will get VHW's. The number of trainees is kept low purposely to make time for the supervision and support - component of the trainers task.

The selection of which villages to serve first will depend on factors like - geographical location
- availability and suitability of existing health service
- felt needs and identified needs etc.

The number of VHW trained each year and their cumulative total are shown below.

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The duration of each T.C.T. is five days and some timetables proposed were:-

1. Monduli

Day 1. Madhumuri ya Warsha
Historia fupi ya huduma za Afya ya msingi Nchini Tanzania.
Mbinu za kufundishwa
Group discussion on teaching Methods.

Day 2. Summary review of previous day
Usafi wa mazingira
Lishe
Practical & discussion - usafi wa mazingira.

Day 3. Summary review
Huduma za MCH
Uzazi wa majira(MCH 5)
Practical and discussion
Home visiting

Day 4. Summary review
Majibu wa Mhudumu wa Afya Vijijini
'Work Schedule'
Magonjwa na matibabu
First Aid Box and Referral system
Muundo wa Serikali ya Mijiji katika mfumo wa kisiasa na kimaendeleo.

Day 5. Summary Review
Tabia, Miiko na Utamaduni wa Mtanzania
Unachusiana na utekelezaji wa Afya Bora Vijijini.
Uhusiano kati ya V.H.W. T.B.A na Mganga wa Jadi.
Discussion, Practical & Presentation ya somo.

2. Mbulu:

Day 1. Madhumuri ya Warsha - Training manual introduction & review.
Historia ya Afya ya Msingi
Teaching methods
Discussions & Presentations

Day 2. Review of previous day
Usafi wa mazingira
Lishe
Discussions/Exercise

Day. 3. Review of the previous day
MCH
Practicals - Clinic Visit
Family Planning
Home visiting -Census etc.

Day 4. Review of previous day
Tasks of VHW, workschedule
Diseases, treatment, drugs, referral

Day 5. Review of the previous day.
Miiko, Tabia na Mila za Mtanzania.
Cooperation between VHW, TBA & traditional healer.
lesson plans
Practicals
Evaluation.

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85/86	18	72	216	108
86/87	18	72	288	144
87/88	18	72	360	180
89/90	18	72	432	216
90/91	18	72	504	252
91/92	18	72	576	288
92/93	18	72	648	324
93/94	18	72	720	360

etc

During Phase II and III the Regional Team has the following tasks.

1. Coordinate and support all district activities
2. Assist in the preparation of the manual
3. Assist in the Training of Trainers
4. Evaluate the programme every year.

During Phase III the District Team's tasks are :

1. Support and supervise the Health Centre Teams. during the training and selection of the VHW's
2. Run refresher - TOT's at regular intervals.
3. Ensure follow-up of VHW's after training
4. Evaluate the programme yearly in cooperation with Regional Team.

- Summary of T-BA Training Program -

Problems and constraints

During the implementation of Phase I various problems were encountered. Some of these will also hamper the smooth implementation of Phase II.

The problems encountered are listed below:

1. During the preparation of the seminar timetables and handouts had to be prepared. Stationary is very expensive and difficult to obtain.
   There are only 3 typists at the Regional Medical Office who are extremely busy. The type writers are in bad condition. In the two weeks preceding the Karatu seminar the cyclostyling machine and both the typewriters were sent for repair to Moshi The cyclostyling machine has not returned to date.
   The preparation and multiplication of the training manual

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SUMMARY OF T.B.A. TRAINING JULY-SEPT. 1983

DISTRICT	TRAINED	NO OF T.B.As TRAIN:	WELL BABY		DELIVERIES		ANTENATAL		FAMILY PLANNING		
			NO OF REFFERALS	NO OF CLIENTS SEEN	NO OB REFFERALS	NO OF CLIENTS SEEN	NO OF REFFERALS	NO OF CLIENTS SEEN	NO OF REFFERALS	NO OF CLIENTS SEEN	NO OF HOME DELIVERIES
ADUMERU	12	240	85	5217	34	399	72	3662	42	8418	9
[illegible]	13	81	49	6285	41	105	53	2004	3	294	Nil
[illegible]	25	135	134	11502	75	504	125	5666	45	712	9

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2. All seminars were held away from the Regional Head Quarters. Transport to the sites of the seminars was a major problem. At present the hospital has 3 Land Rovers at its disposition. One of these was permanently [illegible] to the Cholera ward and out stations, one belongs to the leprosy and TB scheme and is therefore often on field trips.
The third car is assigned to general hospital duties, field trips of all health officers etc(Preventive services).
All cars are in extremely bad condition and constitute health hazards. None of the cars has shockalsorbers, the steering is defective and one of them has no exhaust left.
The Support of and cooperation with the District teams at the time of the T.O.T.'s will be extremely difficult under these circumstances.

3. Each seminar held was serving two different district at the same time to reduce the expenditure.
It is a major logistic problem to get 3 teams together in 1 place at a given point in time. In many districts petrol is virtually unobtainable and road conditions are extremely bad.
The Ngorongoro team had to spend the night in the middle of Serengeti due to a car breakdown.
The Arumeru team arrived late at night in Kiteto because their car was assigned to other duties.

4. The district teams and the district administration must be convinced of the importance of PHC.
All seminars were faced with problem originating from a poor understanding of the district authorities.
Other assignment were thought to be more important than the PHC seminars, cars were allocated to other duties, DMO's and DHO's were called out of the meeting by their DDD's etc.
Unless the district teams brief their administrators extensively the implementation of Phase II and III will be seriously hampered.

5. The presence of the DHO who is also the DPHCC is vital for the success of the seminars and their follow-up (Phase II & III)
We encourage each district team to attend as a whole but in any case we insist on the presence of the DHO/DPHCC.
Unfortunately various epidemics are occurring in the districts at this moment. In the case of Hanang' neither DMO nor the DHO arrived due to the outbreak of cholera in that district.

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Primary health care will in the long run be the way to reduce outbreaks like this - we therefore think it is vital for the DHC/DPHCC to go on with the PHC implementation even when there is pressure from epidemics. In practice this meets with a lot of resistance.

Conclusion: The PHC programme has taken of in Arusha Region under severe financial and logistic constraints. Nevertheless the programme is on schedule and the set target of 560 VHW's by 91/92 will be passed that year.

To ensure that the programme can proceed as planned and that the Regional and District Teams can effectively perform their duties some inputs will be necessary like:-

1. Transport - especially for the Regional Team and for those districts where transport is a problem.

2. A firm financial committment from the Region and possibly the M.O.H.

3. Facilities for typing and duplicating handouts and manuals.

4. A good typist assigned to the programme.

The Regional Team will have to work on these problems and try to ensure a smooth implementation of phase II and III

The next progress report will be forth-coming after completion of phase II.

1 December, 1982 Regional PHC Coordinating Committee

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NATIONAL PHC, MCH/FP PROGRAMS IN MOROGORO REGION

GEOGRAPHY:

LOCATION:
Morogoro Region is situated in the eastern part of Tanzania. In the north Morogoro shares a common border with Tanga and Arusha Regions while in the east it borders Coast Region. The Western border is shared with Iringa and Dodoma Regions, shared in the south it shares borders with Lindi and Ruvuma Regions.

SIZE:
Morogoro Region has an area of 73,039 square Kilometers which is 8.2% of the total area of Mainland Tanzania. The Region is the third largest Region in the Country after Arusha and Mbeya Regions.

PHYSICAL FEATURES:
Morogoro Region consists of both mountaineous areas and river-valley basins. The major mountainous areas are those of the Uluguru mountains, the Ukaguru and Nguru mountain ranges, Udzungwa mountains and the Mahenge hills. These mountain areas have volcanic soil which is quite fertile.

The Region is drained by several rivers, the main ones being: the Kilombero, Great Ruaha, Luwegu, Ruvu, Wami, Ngerengere, Mkondoa and Mkindo rivers. The Region is thus a predominately river-valley basin land mass with alluvial and sedimentary fertile soils.

Forests, woodland and grasslands occupy 64,000 square kilometres. This area comprises the Selous Game Reserve, which is the largest game reserve in the Country with over 13,700 square kil.; the Kilombero game controlled area and the Mikumi National Park. The forests and woodlands are in some areas of the Region infested with tsetse files.

CLIMATE:
Rainfall is between 500 mm and 1,800 mm per annum. In some areas, like the Eastern slopes of the Uluguru mountains, rainfall may reach up to 3,500 mm per annum. Temperature between 16°C and 35°C. River valley basins, especially the Kilombero valley climate is favourable to both agricultural and livestock development.

ADMINISTRATIVE STRUCTURE:
Morogoro Region is divided into five districts, one of which is an Urban District. The others are Morogoro Rural, Kilosa, Kilombero and Ulanga.

DEMOGRAPHY:

POPULATION:
The Region has an estimated population of 1,114,663 as at August, 1983 (This estimate is based on the 1978 population census). This figure is equivalent to 12 people per square kilometer. The population is growing at a rate of 3.1% in the rural areas, and 8.5% per annum in the Urban area. (Source - Office of the Regional Commissioner Morogoro 1982).

AGE GROUP:
Nationally the population grows at a rate of 3.0% annually, so our Region's population growth is a bit lower. Mostly growth is by natural means, while migration, especially for those seeking employment in the sisal and sugar estates and industries in Morogoro town also plays and important part in the population growth.

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The Region has 512,744 people below the age of 15; 540,184 people of 15-54 years and 51,735 people of over 65 years. The number of children below 5 years is estimated at 161,545. Women between 15 - 45 years are estimated to number 174,555. The average family size is between 6 - 7. Life expectance is 54 years for males and 51 for women.

POPULATION MIGRATION AND SETTLEMENTS:
Due to its large sisal estates and sugar Plantation in Kilombero and Mtibwa, the Region has been one of the destinations of migrant labour who come from other Regions to seek employment.

In recent years the Region has also experienced an influence of several herdsmen from Arusha, Dodoma and Singida Regions. They have come here in search of pasture and water for their animals. Also some settler immigrants from the over populated regions of the country like Kilimanjaro, have moved in.

The Industrial Complex at Morogoro Township when completed may add up to 7,000 to 10,000 people. Statistics of immigrants are difficult to obtain, but a rough estimate shows that there are over 70,000 immigrants who comprises labour migrants and livestock peasants and herdsmen.

The villagisation programme, resettled most of the rural population into planned villages. By 1980 there were 450 villages in the Region, 424 of these were registered ones.

Human settlements are concentrated in the mountain and hilly areas followed by the river valleys, and plains, along the major roads and Railway link systems and also near large estates and plantations.

VARIOUS HEALTH DATA:
Most Health Data are not so accurate due to faulty and inconsistent reporting. It will take time before we have reliable data but nevetheless the little that is available may given a true picture of the trend. Meanwhile effort is being done to have improvement in all our data collection

i) Total Population..... 1,114,663
ii) Population density ..... 12 people sq. km.
iii) Crude Birth Rate 48/1000
iv) Crude Death Rate 20/1000
v) Infant Mortality Rate..... 14/1000
vi) Population growth ..... 3.1 %

ECONOMIC PRODUCTION:

AGRICULTURE:
The Region is clearly divided into three agro-ecological Zones. The hill and mountain Zone, The Intermediate Zone, and The River Valley and basins.
Coffee, Cocoa, Cotton, various oil seeds (sunflower, sesame, castor, ground-nuts, soyabeans, cashew nuts), coconuts, Irish potatoes, sweet potatoes, paddy, maize, sorghum, millet, cocoyam, tropical and temperate fruits, vegetables, beans, pigeon peas, grams, cardamom, kenaf, bandias and grown in the Region

LIVESTOCK MANAGEMENT:
The Region is not a livestock keeping one, but due to recent trends thereby a number of herdsmen have immigrated to the region from neighbouring Regions, it may one say that one of the main livestock centres in Tanzania.

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FISHING INDUSTRY:
Fish is obtained from the numerous rivers in the Region. Kilomcero river produces most of the fish which is consumed locally and the surplus exported to other Regions.

EDUCATION:

PRIMARY EDUCATION:
The Region has 378 Primary Schools with a total enrollment of 186,756 pupils. This is equivalent to 85% of all school age children.

LITERACY:
The level of literacy is fair. There are many literacy classes going on in different parts of the Region. These include the functional literacy classes whereby the participants are taught Health, Agriculture, Economics and other subjects. At present we have 47,601 men and 86,924 women in literacy classes throughout the Region.

TRANSPORT AND COMMUNICATIONS:

TRANSPORT:
The Region is transversed by two railway systems - the TRC Dar-es-Salaam to Kigoma / Mwanza and the Uhuru Railway - Dar-es-Salaam to Kapirimposhi Zambia. The Region also is transversed by the Zambia-Dar-es-Salaam Trunk Road which joins the north eastern trunk road at Chalinze. Also the Western trunk road Dar-es-Salaam - Dodoma - Singida Nzega etc. There are many minor local roads some of which become impassable during the rainy seasons.

COMMUNICATIONS:
There are telephone services at Morogoro, Kilosa, Mikumi, Kidatu, Ifakara Mahenge and Ngerengere. The Morogoro service is an STD service. All Police posts have radio calls and there is also a radio call at Mikumi National park.

HOUSING:
Most houses in the rural areas are of temporary nature, they are built of wattle and mud with thatched roofs. In the Trading Centres and towns the houses are of more permanent nature. Housing in this Region could be greatly improved as the nature of the soil is such that, burnt brick can be made in most of the villages. The Regional Government and the Party are currently encouraging villagers to use burnt bricks.

WATER AND SANITATION:

WATER:
Water is a problem in most of the drier parts of the Region especially The Western side. In some other parts water is abundant, but it is grossly polluted, this includes the various rivers and ponds in marshy land of the river basins.
Piped water supply is mostly found in the towns and big trading centres. The shallow well project was started in Morogoro a few years back and to-date 4000 shallow wells with pumps have been constructed.
It is a National target to have a water point not more than 300 meters from each house hold by the year 1990.
Morogoro Township is the only area which gets a proper chlorinated water supply.

SANITATION:
Pit latrines are the ones mostly used in the Region with the exception of V.I.P.s which are installed in some houses in the towns and big trading centres or plantation camps.
The number of house holds with proper latrines is about 70% of all the households in the Region. Out of 113,314 houses inspected in 1982, only 79% had proper latrines. Refuse collection and disposal is carried out in towns whereas in the rural areas refuse is thrown in the farms to act as manure or is burnt. In the trading centres it is either buried or burnt.

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HEALTH SERVICES:

HEALTH INFRASTRUCTURE:

The region has [illegible] hospitals, [illegible] health centres, [illegible] dispensaries, [illegible] clinics and [illegible] Village Health Posts [illegible].
The region has a total of [illegible] medical beds, therefore there is [illegible] bed per [illegible] people. This ratio is [illegible] for the [illegible].
The region serves patients for 20,000 people (National target [illegible]) [illegible] health centre and dispensary caters for 5,192 people while the National target is [illegible] for 10,000 people.

HEALTH MANPOWER:

The region has the following Medical and Public Health staff:-

i) Medical Doctors and Assis. Medical Officers .....[illegible]
ii) Medical Assistants.....31
iii) Rural Medical AIDS 140
iv) Nurses A & B 135
v) Public Health Nurses..... 12
vi) MCH Aids.....100
vii) Health Assistants..... 32
viii) Health Officers..... [illegible]
ix) Pharmacists/Chemists..... [illegible]
x) Dentists/Dental Technicians..... [illegible]
xi) Radiologists/X-ray Technicians..... [illegible]
xii) Laboratory Technicians..... [illegible]
xiii) Physiotherapists..... [illegible]
xiv) Ratio of Doctors to population.....1: 27,000
xv) Ratio of Nurses to population..... 1: 7,000
xvi) Ratio of Medical Assistants 1: 10,000
xvii) Ratio of Health Assistants..... 1: 21,000
xviii) Ratio of Health Officers 1: 79,000

COMMON DISEASES:

Morogoro Region has been notorious for major outbreak of infectious diseases. In a few years Typhoid Fever used to cause a big problem in most areas of the region. This problem has stopped only to use Cholera taking its place.
Major causes of morbidity are:-
Malaria, Measles, Gastroenteritis, Schoistosomiasis, Hookworms, Cholera, Dysentary, Kwashiokor, Typhoid, Viral hepatitis, pregnancy complications
Major causes of mortalit are:-
Measles, Malaria, Cholera, Typhoid, C.S.Maningitis, Viral hepatitis, Tuberculosis, Dysentary & pregnance complications.

PUBLIC HEALTH PROGRAMME:

PRIMARY HEALTH CARE:

In a few years ago, the need for health services in the villages which were far from National Health Units was strongly felt, hus necessitating the setting up of village health posts with First Aid boxes in various villages in the region. They were manned by First aiders and were trained to cope with injuries and minor ailments. 129 such first aid boxes were established. The introduction of these village health posts did not have any impact on the health of the people as the workers were only waiting to give minor & First aid treatment.

THE ALMA-ATA DECLARATION OF SEPTEMBER:

Four Months and with all the preparation Tanzania has taken, Morogoro Region has chosen to be among the five pilot Region to implement the "Proper Primary Health Care Concept" as defined under the Alma-ata conference.
Twelve pilot villages were chosen, three from each District. These villages have no proper health services and are far from such services.

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~~Seminars on~~ [illegible] PHC ~~were conducted in all~~ the districts, divisions, Seminars on PHC were conducted in all the districts, divisions, wards and villages in all the Regions. Each of the pilot villages selected two people, a man and woman of their choice, to undergo a six months course on PHC. Their training started on [illegible] so we are still in the initial stage.
After the completion of the course, these workers will be the nucleus of all health services in the villages. They will carry out preventive, promotive, curative and rehabilitative work in the areas.

FUTURE PLANS:

Our target is to have PH workers in all our villages in the Region, starting with those villages which do not have any health service. After finishing with the pilot villages, the PHC course will be decentralised so that each District trains its own PHC workers.
Primary Health care, being an integral part and nucleus of the National Health Service, it is our intention to liaise with all the other community based health programmes such as MCH/FP (of which we are doing in this Seminar National TB and Leprosy Project, School Health Programme and Mental Health programme, so as to chart implementational strategies and set our targets.

MCH/FP SERVICES:

MCH services were established in 1963 in Morogoro. The Region was lucky to have an MCH Aid school which was recently converted to Public Health Nurses School.
The Region has 175 MCH clinics and 100 MCH Aids. Each District has an MCH Co-ordinator who is either a P.H. Nurse or Staff Nurse and is under the Regional MCH Co-ordinator.
Services rendered include antinatal and post natal MC welfare clinics including Health Education, Vaccinations, nutritional demostrations, home visiting and family planning.
Family planning is mostly carried out in the urban centres as in the Rural areas most of the mothers or couples are not in favour of F.P.

MCH CLINIC ATTENDANCES:

	CHILDREN		PREGNANT MOTHERS	
YEAR	N. ATTEND	REATTEND	NEW ATTEND	REATTEND
1981	48,755	592,781	50,144	156,273
1982	45,305	697,348	47,280	162,716

FAMILY PLANNING:

	1982		1982	
Device	New	Re-Atten.	New Attend.	Re-Atten
Pills	[illegible]	[illegible]	3034	[illegible]
Loop	186	[illegible]	169	[illegible]
Shots	[illegible]	[illegible]	[illegible]	[illegible]

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FUTURE PLANS:

It is our intention to open 2 MCH clinics in every two years so that we shall have an MCH clinic in every dispensary by 1990. In every village with Primary Health Workers, we shall have an advisory MCH clinic to be conducted by the Female ANC workers. We have started already all the Traditional Birth Attendants in the Region. After this exercise is completed, those concerned will be enlightened on proper Mid-wifery services and will be advised to work closely with the Primary Health Workers in the villages.

[illegible] IMMUNIZATION:

Vaccinations against the Childhood diseases are carried out in all MCH clinics. The Region receives adequate supply of all types of vaccines is and when required. Attendances have been fair, but some do not complete the full course of vaccinations for those which require more than one dose.

Vaccination coverage for most of the vaccines shows an average of over 8[illegible]%. We intend to make a random assessment in chosen localities to check on this to see if there is over reporting.

In the last two years the following vaccinations were performed:-

YEAR	D.P.T.	POLIO	T/TOXOID	B.C.G.	MEASLES
1981	1st 45084 2nd 33075 3rd 35869	38353 27917 32194	25712 19099 14784	44587	41352
1982	1st 32430 2nd 30767 3rd 33374	33621 30383 [illegible]	24644 16377 12864	33754	36170

NB: Randomly the Region expects 34,000 births per year.

CHILDHOOD DISEASES:

CONDITION	1981	1982
Measles	1857	1440
Low B.W.t.	32762	36870
Kwashiokor	2395	2330
Marasmus	3920	[illegible]
Severe Anaemia	3297	3817
Diarrhoea	17232	17[illegible]

PROGRAMME MANAGEMENT:

The Regional Medical Officer is the overall incharge of all the Health services in the Region. The Regional Health Officer is the Regional Primary Health Care Co-ordinator.

Since the Primary Health Care Programme is now being implemented, we have yet to evaluate all the existing projects, re-organize and set our targets accordingly. Frequent meetings will be conducted in order to review implementation progress. Reports will be an essential component of the evaluation process.

PROBLEMS:-

Problems are many which have been hindering and may go on hindering implementation of the programme. Chief among them are lack of trained manpower of all cadres, lack of transport for easy access of all areas for easy supervision and evaluation, financial constraints which hinders availability of adequate facilities and equipment.

Drug availability and supply has also been a major problem, but it is hoped this will disappear after take off of the Essential Drugs Project.

To conclude, I would say that,

Health is Wealth, and it is the right of everyone. So we shall endeavour to do all that is in our power to ensure that everybody in the Region gets at least, the minimum essential Health care that will enable him/her live happily as a free and useful citizen of the United Republic of Tanzania.

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TRAINING AND SUPERVISION - PRE

1. Competency based training design must include:

   a. behavioral objectives, core curriculum, what and how and a bibliography
   b. task analysis, behavioral objectives, procedures for delivery of content, material and equipment, evaluation criteria
   c. task analysis, title of session, methods and materials
   d. objectives, title of session, methods and materials, bibliography

2. Training design is important because it helps the trainer to carefully develop

   a. logical, sequential, step by step training sessions
   b. an evaluation based on results
   c. core curriculum
   d. learning tasks

3. Choose the response that includes at least three methods that are most effective for building skills.

   a. lectures, brainstorming, programmed instruction
   b. open-ended discussion groups, simulations, role-plays, supervised practice
   c. lectures, panels, films, readings
   d. brainstorming, group discussions, slide and tape presentations

4. Learning to perform a task is frequently thought of as a composite of

   a. skills, knowledge and age
   b. knowledge, skills and attitudes
   c. practical experience, education and beliefs
   d. attitudes and abilities

5. Task analysis of primary health care skills includes all but which of the following:

   a. observation of clinic services
   b. random observation of work using a stop watch
   c. interviews with patients in a family planning clinic
   d. reading procedure manuals
   e. interviews with clinic personnel

6. Lectures, panels, films and readings are methods that are best applied when

   a. building skills
   b. changing attitudes
   c. communicating information
   d. all of the above

7. Select the response that includes at least <u>three</u> methods that are most effective in changing attitude.

   a. buzz groups, lectures, brainstorming, programmed instruction
   b. informal open-ended discussion groups, simulations, role-plays and demonstrations
   c. lectures, panels, films and readings

8. A program for community workers should be:

   a. 50% theoretical and 50% practical
   b. 75% theoretical and 25% practical
   c. 70% practical and 30% theoretical

9. Below you will find three training objectives. Indicate if you find each one to be well written or not. If you find it is not well written, re-write it so that it is.

   a. To give trainees knowledge about planning training programs

      _____ well written
      _____ not well written

      If not well written, rewrite here.

   b. At the end of training, participants will be able to describe 3 strategies for introduction of ORT in the community.

      _____ well written
      _____ not well written

      If not well written, re-write here.

c. Trainees will appreciate the value of four types of information systems.

_____ well written
_____ not well written

If not well written, re-write here.

10. Non-literate village workers can be taught to safely initiate and distribute oral rehydration salts using the following methods:

a. lectures and tests
b. demonstration and return demonstration
c. role-play and discussion
d. repetitious recall exercises
e. b, c and d

Instructions: For questions 11, 12, 13, & 14 select from the following lettered answers the one that most closely applies and enter the corresponding letter on the blank line.

a. behavior change
b. learning
c. reaction
d. results

11. How well the trainees liked a particular part of the training program. _____

12. On-the-job use of principles, facts and techniques that were understood and absorbed by the participants. _____

13. Program improvement due to training. _____

14. The principles, facts and techniques that were understood and absorbed by the participants. _____

15. Supervision of rural dispensary personnel in Tanzania should be done

a. frequently when the worker is a new graduate
b. once a month
c. on a completely random basis so the worker never knows when the supervisor will visit

16. The most important functions of supervision of isolated rural health personnel are

    a. continuing education, monitoring quality of care and service statistics assuring logistic support and correcting deficiencies
    b. monitoring work schedules, observing cleanliness of workers, collecting service statistics and correcting bad habits
    c. providing morale counselling, keeping up the drug supply, observing cleanliness of work post and monitoring vacation schedules.

17. Three important elements of supervision by objectives are:

    a. clinic attendance records, worker monthly reports and pharmacy requisition lists
    b. a statement of observable program objectives, reports of service statistics by age, sex, diagnosis and outcome, and health personnel who are aware of the program objectives.
    c. a statement of program objectives, monthly death reports and attendance record of health personnel

18. As a specialty program, supervisor (PHC, MCH, Nutrition or FP) you will directly supervise medical assistants and nurses. Three styles of supervision are available to you: Autocratic, Democratic, Anarchic.

    Which do you think is generally appropriate for

    a. providing technical advice
    b. handling grievances and disciplinary problems
    c. evaluating performance and motivating health workers

19. Supervision problem solving involves five basic steps:

a. identify the trouble maker
gather evidence about the problem
decide who or what is wrong
correct the problem
write a report

b. identify the problem
identify possible solutions
select a solution (or combination of solutions)
carry out the solution
evaluate results

c. identification of the cause of the problem
get rid of the things that cause the problem
teach people about prevention
write a report
issues policies or protocols to prevent further trouble

20. Phased training is

a. training done by the moon cycle
b. training which is done be a logical sequence of modules which go from simple to more complex
c. training which is done after completion of school

P O S T T E S T

IDENTIFICATION _____

PROFESSION _____

SELECTED PRIMARY HEALTH CARE INTERVENTIONS

ORAL REHYDRATION THERAPY FAMILY PLANNING & GROWTH MONITORING METHODS

1. The most effective treatment of common childhood diarrhoea is

   a- antibiotics
   b- Lomotil-type, Kaolin
   c- oral rehydration solution
   d- water
   e- withhold all food

2. Who should be responsible for keeping the growth record of a child?

   a- the dispensary in the child's community
   b- the community health worker
   c- the child's mother (or caretaker)
   d- the MCH aide

3. Which of the following is not a useful evaluation measure in an ORT program?

   a- distribution of OR supplies
   b- utilization data
   c- referral for severe cases of diarrhoea
   d- the status of the cold chain
   e- family member's ability to mix solution correctly

4. Which growth monitoring method may not be sensitive to indentification of the stunted child who is growing well of the very tall child who is malnourished?

   a- arm circumference
   b- weight for age
   c- weight for heitht

5. What instructions would you give to a woman who forgot to take her oral contraceptive pill?

   a- skip 2 more days and complete the cycle
   b- take 2 pills the next day and complete the cycle
   c- wait until the next menstrual period and complete the cycle
   d wait until the next menstrual period and start a new cycle
   e- use condoms and foam for three days
   f- none of the above

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6. Growth monitoring of children can significantly improve community helth by

a- identifying malnourished children and predicting mortality and morbidity risk in time to save lives
b- enabling workers to target limetd food supplies to the most vulnerable children
c- teaching families through participation in monitoring activity how diet affects health and motivating them to implement dietary improvements
d- involving communities and families in informed decision making and preventive action initiatives
e- a and b only
f- all of the above

7. Which of the following is not an essential screening item for the nurse or MCH aide at the dispensary or health center level for identification of women who can safely use the pill?

a- Pelvic exam
b- Age
c- History of headache, jaundice, severe chest or abdominal pain
d- blood pressure
e- Date of last menses

8. Which of the following categories of personnel can be taught to select women who are good candidates for the IUD, as well as to insert and remove the IUD

a- Nurses and midwives
b- Doctors
c- Medical assistants
d- MCH aides
e- b and c only
f- All of the above

9. Which growth monitoring method best indentifies children at risk of death in the first 3 years of life?

a- periodic measure of weight for height
b- periodic measure of arm circumference
c- periodic measure of weight for age

10. In preparation of ORS which is most true?

a- The formula needs to be made accurately
b- Only salt needs to be measured accurately
c- The amount of salt and sugar are not very important
d- Any liquid will help
e- Only ready-made packets should be used

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11. ORT is beneficial because it

a- maintains hydration following intravenous rehydration
b- rehydrates the dehydrated patients
c- substitues for breast milk
d- many prevest dehydration if begun as soon as diarrhoea starts
e- a, b, and d
f- b, c, and d

12. Family planning education and counselling needs to be planned to reach special target groups. Which of the following represent special target groups?

a- All women 15 - 44
b- Women 15 - 19 and 35 and over
c- Pregnant women
d- Women in the post-partum period (0 - 45 days after delivery)
e- a and c
f- b, c, and d

13. Which group among the following should be a priority in teaching about oral rehydration solutio (ORS)?

a- Nurses
b- R.N.A.s
c- Mothers
d- C.H.W.s
e- Children
f- All of the above.

14. Which of the following activities should be integrated into the child growth monitoring activities in a rural dispensary?

a- treatment of acute children's illness
b- family planning counselling and services
c- immunizations
d- all of the above
e- none of the above

15. Which of the following contraceptive methods could <u>not</u> be recommended for a woman 25 years of age with no apparent health problems who has just delivered a healthy newborn 6 weeks ago and who is nursing her baby?

a- an IUD
b- foam and condoms
c- low dose contraceptive pills.
d- injectable DMPA (depot medroxyprogesterone acetate)
e- natural family planning by cervical mucous and basala temperature observations

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TRAINING AND SUPERVISION

(TEST)

1. Supervision of rural dispensary personnel in Tanzania should be done

   a. frequently when the worker is a new graduate
   b. once a month
   c. on a completely random basis so the worker never knows when the supervisor will visit

2. Phased training is

   a. training done by the moon cycle
   b. training which is done be a logical sequence of modules which go from simple to more complex
   c. training which is done after completion of school

3. A program for community workers should be:

   a. 50% theoretical and 50% practical
   b. 75% theoretical and 25% practical
   c. 70% practical and 30% theoretical

4. As a specialty program, supervisor (PHC, MCH, Nutrition or FP) you will directly supervise medical assistants and nurses. Three styles of supervision are available to you: Autocratic, Democratic, Anarchic.

   Which do you think is generally appropriate for

   a. providing technical advice
   b. handling grievances and disciplinary problems
   c. evaluating performance and motivating health workers

5. Competency based training design must include:

   a. behavioral objectives, core curriculum, what and how and a bibliography
   b. task analysis, behavioral objectives, procedures for delivery of content, material and equipment, evaluation criteria
   c. task analysis, title of session, methods and materials
   d. objectives, title of session, methods and materials, bibliography

6. Non-literate village workers can be taught to safely initiate and distribute oral rehydration salts using the following methods:

   a. lectures and tests
   b. demonstration and return demonstration
   c. role-play and discussion
   d. repetitious recall exercises
   e. b, c and d

7. The most important functions of supervision of isolated rural health personnel are

   a. continuing education, monitoring quality of care and service statistics assuring logistic support and correcting deficiencies
   b. monitoring work schedules, observing cleanliness of workers, collecting service statistics and correcting bad habits
   c. providing morale counselling, keeping up the drug supply, observing cleanliness of work post and monitoring vacation schedules.

8. Learning to perform a task is frequently thought of as a composite of

   a. skills, knowledge and age
   b. knowledge, skills and attitudes
   c. practical experience, education and beliefs
   d. attitudes and abilities

9. Supervision problem solving involves five basic steps:

   a. identify the trouble maker
      gather evidence about the problem
      decide who or what is wrong
      correct the problem
      write a report

   b. identify the problem
      identify possible solutions
      select a solution (or combination of solutions)
      carry out the solution
      evaluate results

   c. identification of the cause of the problem
      get rid of the things that cause the problem
      teach people about prevention
      write a report
      issues policies or protocols to prevent further trouble

10. Training design is important because it helps the trainer to carefully develop

    a. logical, sequential, step by step training sessions
    b. an evaluation based on results
    c. core curriculum
    d. learning tasks

11. Select the response that includes at least <u>three</u> methods that are most effective in changing attitude.

    a. buzz groups, lectures, brainstorming, programmed instruction
    b. informal open-ended discussion groups, simulations, role-plays and demonstrations
    c. lectures, panels, films and readings

12. Three important elements of supervision by objectives are:

    a. clinic attendance records, worker monthly reports and pharmacy requisition lists
    b. a statement of observable program objectives, reports of service statistics by age, sex, diagnosis and outcome, and health personnel who are aware of the program objectives.
    c. a statement of program objectives, monthly death reports and attendance record of health personnel

13. Choose the response that includes at least three methods that are most effective for building skills.

    a. lectures, brainstorming, programmed instruction
    b. open-ended discussion groups, simulations, role-plays, supervised practice
    c. lectures, panels, films, readings
    d. brainstorming, group discussions, slide and tape presentations

14. Lectures, panels, films and readings are methods that are best applied when

    a. building skills
    b. changing attitudes
    c. communicating information
    d. all of the above

15. Task analysis of primary health care skills includes all but which of the following:

    a. observation of clinic services
    b. random observation of work using a stop watch
    c. interviews with patients in a family planning clinic
    d. reading procedure manuals
    e. interviews with clinic personnel

Instructions: For questions 16, 17, 18, & 19 select from the following lettered answers the one that most closely applies and enter the corresponding letter on the blank line.

    a. behavior change
    b. learning
    c. reaction
    d. results

16. The principles, facts and techniques that were understood and absorbed by the participants. _____

17. On-the-job use of principles, facts and techniques that were understood and absorbed by the participants. _____

18. Program improvement due to training. _____

19. How well the trainees liked a particular part of the training program. _____

20. Below you will find three training objectives. Indicate if you find each one to be well written or not. If you find it is not well written, re-write it so that it is.

    a. To give trainees knowledge about planning training programs

       _____ well written
       _____ not well written

       If not well written, rewrite here.

    b. At the end of training, participants will be able to describe 3 strategies for introduction of ORT in the community.

       _____ well written
       _____ not well written

       If not well written, re-write here.

c. Trainees will appreciate the value of four types of information systems.

_____ well written
_____ not well written

If not well written, re-write here.

Management Test

Please read each question carefully. Then check the letter which you believe to be the correct answer.

1. Which of the following statements about coordinating the work of the health team is <u>not</u> correct. The person responsible must:

   a . Coordinate members of the team
   b . Coordinate the activities of the team
   c . Convince communtity leaders that the team knows best
   d . Communicate decisons to the team

2. Which of the following statements about objectives is not correct.

   a. The intended result of a program or activity.
   b. Essential for making plans and evaluating results.
   c. Operational targets are expressed in the same way as objectives but they refer to shorter periods of time and to parts of, or steps towards, an objective.
   d. Objectives and targets should be set prior to reviewing problems and their underlying causes.

3. Which of the following is <u>not</u> a characteristic of a useful objective

   a. Relevant
   b. Replicable
   c. Feasible
   d. Observable
   e. Measurable

4. Below are eight criteria for selecting a problem for "high priority consideration".

   - Affects large numbers of people
   - Causes high infant mortality
   - Affects maternal health
   - Affects children and young persons
   - Causes chronic conditions and handicaps
   - Affects rural development
   - Causes worry to the community
   - Simple ways to deal with the problem exist

   To select a problem for "high priority" considertion it should meet:

   a. One of the criteria
   b. All of the criteria
   c. At least 3 of the criteria

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5. It is often easy to confuse causes and problems. Which of the following statements is a problem?

a. Well water is contaminated
b. There are too many flies
c. Many people have diarrhea
d. Sanitation is poor
e. The people need health education

6. Which of the following statements about evaluation is <u>not</u> correct?

a. Evaluation is finding out the value of what has been achieved.

b. Evaluation depends on monitoring of information

c. Management audit is evaluation of management by external consultants and accountants.

d. Feedback is necessary if program improvement is to occur.

7. Which of the following statements about baseline information is <u>not</u> correct?

a. It should be collected when a new service is introduced to a community.

b. It should be understated to permit the best possible evaluation in the future.

c. It enables management to decide what kinds of health services and activities are needed.

d. It permits calculation of the number of people who should receive different kinds of services.

8. Which of the following statements about the implementation function of management is <u>not</u> correct? Implementation deals with:

a. Annual decisions about execution of activities.
b. Organization, Direction, and Supervision of manpower.
c. Mobilization, allocation, monitoring, and control of resources.
d. Processing and communication of information.

9. Which of the following statements about the planning function of management is <u>not</u> correct? The Planning function of management is:

a. To anticipate implementation and evaluation decisions
b. To set a future course of action for the organization
c. To deal with decisions about objectives, activities, and resources.
d. So complex that it is best carried out by Central Ministry Planners.

10. Management is a process which involves planning, implementing, and evaluating the activities of an organization to achieve certain objectives. A manager is:

a. A person trained in management, usually holding an advanced University degree.

b. A high level executive in a private corporation.

c. A government official with at least 5 years of experience supervising more than 6 subordinates.

d. Any person in an organization who takes responsibility for all or part of the management process.

11. Which of the following questions should <u>not</u> be the subject of administrative monitoring?

a. Is fertility declining in communities served?
b. Do health units receive adequate drug supplies?
c. Do midwives fill out the family planning records correctly.
d. Is the referral system being used as intended.

12. Supervision may be autocratic, anarchic, or democratic. Supervisory activities are:

a. The same for all three styles
b. The same for autocratic and democratic but different for democratic
c. The same for autocratic and anarchic but different for democratic
d. Different for all three styles

For questions 13, 14 and 15. For various program costs are related to Benefits, Effectiveness and Efficiency. The following statements concern resources and results.

a. Could some resources be used to achieve better results/ outputs?

b. What are the results projected 20 years into the future, of the resources used in this program?

c. What resources could be obtained from other development sectors?

d. Could some results be obtained with less resources?

13. Which statement concerns cost/benefit? _____

14. Which statement concerns cost/effectiveness? _____

15. Which statement concerns cost efficiency? _____

16. Which of the following statements about monitoring is <u>not</u> correct?

    a. Monitoring means watching the progress and standards of the work in a program

b. b. Monitoring may be done by supervisory visits using a checklist

    c. Monitoring may be done by interviews, discussions, and by studying records and reports

    d. Monitored information should never be used to redirect a program.

17. Which of the following is <u>not</u> generally considered to be a method of supervisory monitoring?

    a. observing
    b. checking supplies against inventories and stock lists
    c. pretending to be a client of a community-based program
    d. examining records
    e. discussion with staff and community

18. The general approach for evaluation consists of 5 steps: These steps are given in an illogical order below.

1. Collect information needed to provide evidence.
2. Judge to what extent targets and objectives have been met.
3. Decide whether to continue, change, or stop the program.
4. Compare results with targets and objectives.
5. Decide what is to be evaluated and select indicators.

The correct order of the steps is:

a. 1-2-5-3-4
b. 5-3-1-4-2
c. 1-5-2-4-3
d. 5-1-4-2-3

19. Which of the following is generally <u>not</u> asked in an evaluation of work progress.

a. Did the team reach its targets
b. Was the work of expected quality
c. Was the budget underspent by at least 15%
d. Was the work carried out on time

20. Which of the following documents is <u>least</u> useful in assessing staff performance.

a. The job description
b. The work plan
c. Worker's school examination grades
d. Technical procedure manuals

TITLE OF SESSION I M P L E M E N T A T I O N

N = 24

	0	1 & 2	3	4 & 5	MEAN
1. WORTHWHILE	0	0	6	18	4.38
2. PERSONAL NEED	0	0	5	19	4.41
3. OTHERS' NEED	0	2	4	18	4.04
4. TRAINERS' PERFORMANCE	0	0	4	20	4.42

What did you like most about the session?

- I liked the whole of the subject and methods used in teaching
- Good lecturer arranged his topics in a way that every body understand it - thanks -
- All lectures
- Supervision style
- More knowledge needed in implementation
- Working groups
- I like the whole session because it has expanded my knowledge than what I knew before
- I like it most about the session bacause I learned new things which I didn't know before as I can manage & evaluate
- The whole presentation
- The implementation procedure as a whole
- The section on activities scheduling and information using was well handled
- Exercise
- Everything was done at its best
- All
- The exercise
- The Co-ordination and supervision
- Management process - Planning, Implementation & Evaluation
- Lessons were understable
- How to approach and implement the plan
- I like all the subject given
- The presentation was systematic & clear

...../2

What did you like least about it?

- Supervision
- Supervision schedule
- No time to revise my notes & reference
- Management evaluation
- None
- Nothing
- Nil
- None
- The supervision
- The facilitator was quite clear.

Any other comments or suggestions?

- More lectures on PHC MCH & PF
- I very much appreciated the reasons of collecting information
- To tight teaching program
- The workshop is very useful, so I advice every leader at the MCH, Regional Zonal level to be given chances to attend these courses
- Repeat the session again - so that I shall be able to implement my programme well
- The sessions are too long. There should be short stratches in between to allow consentrati
- More time is needed in such programs
- It was good to give the practical exercises
- Thanks for feeding us with grand information and the way you instilled it into our brains
- Language took too long to understand some of issues
- The people holding post of manager of regional and district level should be taught this lec
- Next time proper timetable it was too tight
- He is a very good facilitate
- Time was sufficient - conviniently short or long.

::

TITLE OF SESSION WORKGROUP SESSIONS IMPLEMENTATION PLANNING

N= 26	0	1 & 2	3	4 & 6	MEAN
1. WORTHWHILE	0	1	5	20	4.35
2. PERSONAL NEED	0	0	6	20	4.38
3. OTHERS' NEED	0	1	8	17	3.88
4. TRAINERS' PERFORMANCE	0	1	5	20	4.19

What did you like most about the session?

(GROWTH MONITORING)
- Practical exercise
- Working together and sharing the idea from one another
- Working out the exercise
- This session was very useful to me
- All participants tried to participate fully

(F. P.)
- Group discussion
- Supervision
- Supervision
- Being group secretary

(ORAL REHYDRATION)
- Working group
- I liked the session because it expanded my knowledge than I had before
- Preparing monthly and daily form
- Emplementation

(CONTROL PROGRAM)
- The way used on teaching me how supervision should be done in program
  Both the presentation and the group wo·
  Both theory and practicals

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(E. P. I.)
- The lecture was very clear and understand
- I liked the way he presented the topic and how we shared ideas
- The use of information in various implementation activities
- It gave me chance to learn more

What did you like least about it?
(GROWTH MONITORING)
- None
- Every body had chance to participate
- Too many subjects taught simultaneously

(F. P.)
- Co-ordinating - Implimentation
- Co-ordinating - Implimentation
- Some members of any group did not take part in the discussion
- Supervision

(ORAL REHYDRATION)
- Implementation
- Management and evaluation
- No
- I like most because group work is useful through discussion and you know where you are
- Teaching the VHW about ORT

(CONTROL PROGRAM)
- Time being very short to finish the program preparations in time
- Nothing

(E. P. I.)
- N/A

Any other comments or suggestions?
(GROWTH MONITORING)
- Dr. was a nice practice, which I feel will equip me to take such projects in my place of work
- It was the best teaching methodology I ever had. I felt that I was in the real situation and made me think seriously I presume I will be able to remember 90% of it
- Some more exercises and that these exercises should be well rewritten and given to participa

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(E . P .)
- More lectures PHC MCH & FP
- More lecture
- More lecture

(ORAL REHYDRATION)
- The workshop is very useful so I advice every leader at the MCH District, Regional Zonal level to be given chances to attend the courses
- Repeat the session so that I do my work with correctly & concidently
- This kind of information about ORT is very useful for the 0-5 years child. It should be taught properly and follow up should be done to those VHW or mothers.

(CONTROL PROGRAM)
- The program is too tight
- Enough time should be given

(E. P. I.)
- We were supposed to show the vaccines to be given to the mother
- N/A
- Teaching method was clear

::::::::::::::::::::::::::::::::::

TITLE OF SESSION M C H PROGRAMME IMPLEMENTATION, DISCUSSION AND REACTION PANEL

N = 27	0	1 & 2	3	4 & 5	MEAN
1. WORTHWHILE	0	1	3	23	4.33
2. PERSONAL NEED	0	0	4	23	4.26
3. OTHERS' NEED	0	1	3	23	4.62
***4. TRAINERS' PERFORMANCE	0	1	5	20	4.00 (n= 26)

What did you like most about the session

- I liked the class because it widened my knowledge I had before
- Every bit
- Discussions
- The discussions were lively
- We were able to hear discussion from many groups
- Discussion about Nutritional Rehabilitation centre
-- The discussion
- Some of the coordinators & participants contributions on ideas of solving the constrains of the programs
- Implementation
- I like this subject
- The hot discussion
- The discussion period
- Discussion
- Specificity of examples after many sessions of general principles
- Discussion about who would provide services
- The subject was of interest - especially Transport is the greater problem we are facing
- I liked the subject well

*** "That one participant didn't k any number on question 4"

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- Problems encountered by MCH services particularly in its delivery

What did you like least about it?
- Presentation
- All about how to make programs and the Implementation
- That we can't have finantial leaders RDD to answer some of our questions
- To improve
- Nothing may doing well like transport
- Time limit
- Figure given by presenter contradicting those given in MCH evaluation paper
- Discussion not tightly focussed - degenerated into gripe session at times
- Interceptions by other trainers
- N/A

Any other comments or suggestions?
- Facilitators should go slowly so that we go together
- We need rest
- Motivation to staff in MCH please!
- If possible the discussion should continual if it this could be fitted somewhere in the schedule
- O K for today
- Comments from reaction panel were very informative
- We should have more time
-- To improve
- To added the equipments so that the work
- Go back and study the notes given frequently for continous remembernce
- We should strengthen the MCH services to get better results for our Nation
- N/A

::::::::::::::::::::::::::::::::

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TITLE OF SESSION "C O M M U N I T Y B A S E D " D I S C U S S I O N

N=, 23	0	1 & 2	3	4 & 5	MEAN
1. WORTHWHILE	0	0	6	17	4.21
2.8 PERSONAL NEED	0	3	2	18	3.69
3. OTHERS' NEED	0	1	3	19	4.34
4. TRAINERS' PERFOMANCE	0	1	5	17	4.04

What did you like most about the session?

- It gave everyone opportunity to say what he/ehe know about it
- The way we could coordinate with the community in program implementations than depending much on the Ministry level
- Correct interpretation & Community based
- I liked it all - couse it has widened my knowledge - Now I shall be able to do my work as a manager propaly
- The discussion from several groups was very much useful
- The whole presentation
- The essence of Community participation
- Nothing
- Discussion
- The discussion
- The comments
- The discussion
- I liked the subject
- Definition of community - based programme

...../2

What did you like least about it?

- Nothing
- Nil
- Nothing
- None
- Problem in implementation
- Nothing
- N/A

Any other comments or suggestions?

- The facilitator should have summarised the opinions of the different participants and give a proper definition
- Summary of the subject should be sent to the Ministry, to give them our view on this new way of easyness of health withn the community, then that organized from Ministry towards the community
- Facilitators should go slowly so that we go together
- The program is well arranged
- National PHC body policy on community ownership of programs needs to come out strongly
- Time for break is essential
- More time for discussion
- These seminars are very useful
- To discus more about the lecture
- We should continue do discussion
- N/A

TITLE OF SESSION COMPETENCY BASED TRAINING

N = 25	0	1 & 2	3	4 & 5	MEAN
1. WORTHWHILE	0	0	2	23	4.56
2. PERSONAL NEED	0	0	4	21	4.24
3. OTHERS' NEED	0	0	2	23	4.48
4. TRAINERS' PERFORMANCE	0	0	1	23	4.54 (n = 24)

What did you like most about the session?

- Group discussion
- Task analysis
- Presentation as a whole
- All
- Brainstorming and the handout provided
- The presentation method
- All
- The very real understanding of the difference between conventional training and competency based training; and the way competency based training is of more importance in community based programs
- Task lists and analysis
- The lecture
- The explanation on the difference between competency and conventional
- C. B. T.
- Training method
- Task analysis
- The subject was of interest - The facilitor explained well
- Conventional vs competence based
- The method of evaluation
- Well presented
-

- Practical examples
- The difference between convation training and competency based training did implies me
- Training method
- Training methods
- Development of tasks
- I like the subject
- Everything

What did you like least about it?
- I liked ORT session
- Nothing
- Nothing
- None
- N/A
- Objective
- Nothing
- Training the HVW & Reviewing method
- Too much limited time
- To repeat again that may help me to understand throughly

Any other comments or suggestions?
- More discussion are useful
- More exercises on task analysis
- None
- N/A
- None
- The subject should be repeated
- More time for writing objectives
- More group participation in the tasks development and objective analysis
- I enjoyed

.....

TITLE OF SESSION S U P E R V I S I O N

N = 20	0	1 & 2	3	4 & 5	MEAN
1. WORTHWHILE	0	0	2	18	4.55
2. PERSONAL NEED	0	0	2	18	4-65
3. OTHERS' NEED	0	0	1	19	4.50
4. TRAINERS' PERFOMANCE	0	0	3	17	4.35

What did you like most about the session?

- The check list or guide
- Check list preparation
- Exercise
- Tried their best
- Exercise
- The whole subject
- Almost everything
- The whole session was exelent
- The whole subject - The role play was very interested
- Exercises
- The whole subject
- Group work 2 discussions
- Supervision plan
- Training
- Preparing checklist
- All
- It gave me quite an experience to apply in my region

What did you like least about it?

- Supervision
- The role play
- Too long
- Nil
- None
- About planning my work
  to add more time

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- Discussion
- N/A
- Nothing
-

Any other comments or suggestions?
- Nil
- Keep on, the method in teaching used
- We should such session onee yearly in our country
- I think it is better to do the same session for next workshop
- I think it is high time we all practice the supervision methods we have learned. We need continious education on thie subject
- If at all we could get more
- N/A
- More exercises on group work
- None

::

TITLE OF SESSION _____ E V A L U A T I O N _____

N = 28

	0	1 & 2	3	4 & 5	MEAN
1. WORTHWHILE	0	0	7	21	4.39
2. PERSONAL NEED	0	0	3	25	4.50
3. OTHERS' NEED	0	0	5	23	4.25
4. TRAINERS' PERFORMANCE	0	1	4	23	4.32

What did you like most about the session?

- Group discussions
- The whole process
- All the subjects
- The session was not tiresome as some previous ones
- Not bad
- The whole of the session was interesting
- Principles of evaluation i.e. steps to put in mind during evaluation
- Practical examples used by the trainer
- Presentation gradual flow of material given
- I like various methods of evaluation
- All
- Evaluation approaches
- Group work
- Very systematic, and its relevancy
- Practical, how to approach
- The five important things in evaluation
- Excelent work
- It was a good
- The discussions in groups
- It has expanded the knowledge I have - I think I will be able to do my work better

..../2

- Not bad
- The whole presentation
- Group discussion.

What did you like least about it?
- Nothing
- Nothing
- About the management
- Nothing
- None
- Too much hand-out
- Nothing
- None
- N/A
- Mnagement
- Could have been longer
- Group work
- None
- None than before.

Any other comments or suggestions?
- Nothing
- Presentation time is very short for such important managerial processes
- Too many papers to read
- The workshop should be repeated again sometimes next year
- The subject looks clear. I liked the use of charts as way of evaluating
- None
- Not at all
- So much work
- More courses should be initiated
- Well done
- No
- Too limited time to go through the text-books
- Other groups have slow people to catch up.
  1) Go slowly in your teaching - simple clear slowly English
  2) Repeat the subject so that we all follow you
- So many papers to read but time limited
- There are so many books to read at a short time
  I liked ORT session

: ::::::::::::::::::

TITLE OF SESSION _____

QUICK FEEDBACK SHEET

Please answer the following questions by circling the number that comes closest to how you feel right now.

	No, Waste of Time			It Was Useful		Yes, Very Worthwhile
1. Do you think this session was worthwhile?	0	1	2	3	4	5
	Not At All					Very Much
2. How much do you feel you personally needed this session?	0	1	2	3	4	5
	Not At All					Very Much
3. How much do you feel others in the group needed this session?	0	1	2	3	4	5
	Poorly			Well Done		Very Well Done
4. How well do you think the trainer(s) did his/their job?	0	1	2	3	4	5

What did you like most about the session?

What did you like least about it?

Any other comments or suggestions?

1 ADDRESS

DANISH VOLUNTEER TRAINING CENTRE
P.O. Box 254
ARUSHA, TANZANIA

Participants' mail should be sent to:
P.O. Box 1203
ARUSHA, TANZANIA

Cable address:
MELLEMSAM, ARUSHA

Telex No. 42074 DVTC ARU

Telephone: Usa River 1
Participants' phone:
Usa River 13

2 MAIL

Mail is posted and collected at least once a day, except on Sundays. Incoming letters are placed alphabetically in the pigeon holes in the language lab corridor where there is also a box for outgoing mail, a letter balance, and the latest postal rates.

3 STAMPS

The participants choose a stamp officer to be in charge of selling stamps. The stamp officer should contact the office for details.

4 PARCELS

If you receive a parcel advice from the post office you must collect the parcel yourself. Remember to take your passport.

5 TELEPHONE AND TELEX

Usa River Exchange operates round the clock. To phone from Arusha, dial 0163, get Usa River Exchange and ask for the number: Usa River 1.

Unfortunately our lines are very poor and frequently out of order. For private calls there is a coin telephone (Usa River 13) outside the dining hall. Regrettably, no private calls can be made or received at the office.

In case of emergency our telex can be used. Please contact one of the secretaries for charges and operational assistance.

6 TYPEWRITER

There is a manual typewriter in the Teacher's Room for the use of participants.

7 OFFICE HOURS

The office is open Monday - Friday 8.00 - 12.30 and 14.00 - 16.30
Saturday 8.00 - 12.30
except during coffee break 10.00 - 10.30 every day.

However, please use the following hours for all business with the accountant such as settlement of bills, safe deposits/withdrawals etc.: Monday - Friday 13.30 - 14.00 excluding Wednesdays.

8 STAFF ON DUTY

The name of the staff member on duty during the weekends and public holidays is posted on the office door.

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DAILY ROUTINE

1 MEAL TIMES

Breakfast	7.15 - 7.45	(Sundays 8.00 - 8.30)
Morning coffee/tea	10.00 - 10.30	
Lunch	12.30 - 13.00	
Afternoon tea	16.00 - 16.15	
Dinner	19.00 - 19.30	

2 DINING HALL

If you are not going to eat a particular meal, please sign out on the form provided in the dining hall. These forms can also be used for ordering lunch packs and meals for guests. Please order lunch packs one day in advance and extra meals a half day in advance.

For official excursions the teacher responsible will arrange lunch and signing out.

After finishing a meal, please stack your plates and place all cutlery on the empty trolleys.

If you wish to contact the kitchen staff, please ring the bell in the corridor.

Plates, cups and cutlery may only be taken out of the dining hall area when taking a meal to a patient. They must be returned again immediately after use.

For hygienic reasons the kitchen is out of bounds.

3 COURSE LANGUAGE

The official language at DVTC is English. Please use English as much as possible during meal times and leisure hours too. When using another language you exclude many participants and staff members from your conversation. Swahili students, of course, are encouraged to speak Swahili as much as possible.

4 ATTENDANCE AT DVTC COURSES

All timetables lessons are compulsory and full participation is expected.

Outside activities or errands such as going to the bank or postoffice should not in any way interfere with the timetable or course programme.

5 NOTICE BOARD

As changes of the programme are likely to occur frequently and at short notice, it is necessary to make a point of checking the notice board in the dining hall very often for last minute information.

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LEISURE TIME AT DVTC

1 SPORT

Equipment for badminton, volley ball, football and table tennis is available and each group is requested to elect a Sports Officer to take charge of the equipment for the duration of the course. The Sports Officer should contact the administration for further information.

2 DARK ROOM

DVTC has a fully equipped dark room. The key can be obtained from the Vice Principal.

3 LIBRARY

The DVTC library is development and Africa oriented but you will also find a number of reference books on many subjects, as well as a wide range of newspapers and periodicals.

The 66-key you have been given allows you to use the library at any time. The last person to leave the library in the evenings should switch off the lights and lock the door.

4 NATURE WALKS

The DVTC premises and the immediate surroundings provide many possibilities for walks, bird watching etc.

5 DVTC BAR

Each group should elect a bar committee which will be responsible for running the bar during the course period.

The bar committee should contact the Accountant for further information.

Profits from sales go into a fund which is being used for the improvement of recreational facilities at DVTC.

6 ENTERTAINMENT

Each group should elect some members for the Entertainment Committee and any arrangements related to entertainment should go through this Committee.

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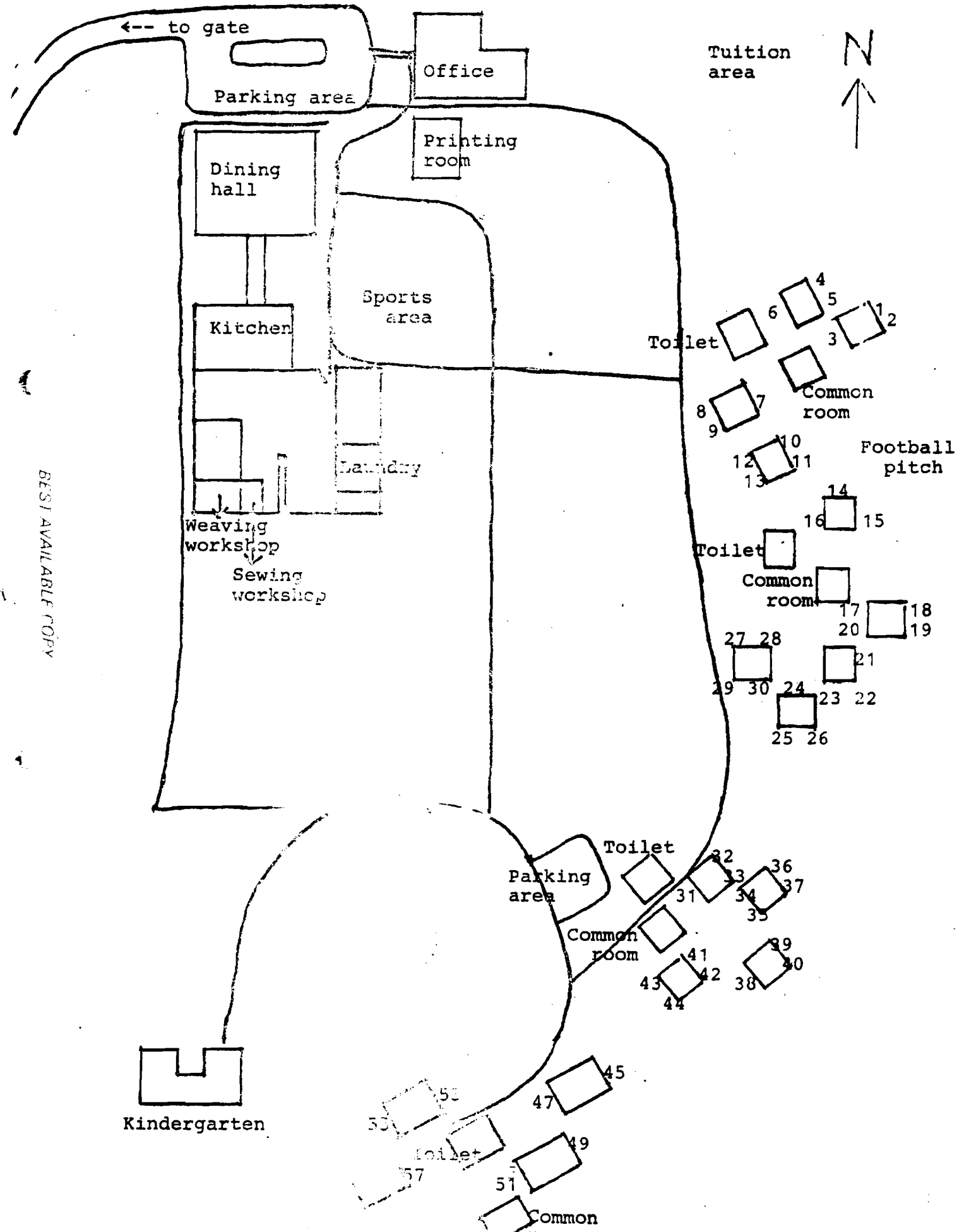
MAP OF ACCOMMODATION FACILITIES



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DVTC
P.O. BOX 254
ARUSHA

INFORMATION

ABOUT THE CENTRE

3 A 11/82-20

The Danish Association for International Co-operation sends volunteers to several African Countries. The volunteers are all professionally qualified and have a minimum of one year's working experience in Denmark before being selected and sent to Africa on a two year contract. However, as the average age of a Danish volunteer is now about 30, this means that they have in fact several years on-the-job experience.

ENGLISH COURSE

For those volunteers who require it there it there is a three week English course prior to the Main course.

MAIN COURSE

All volunteers participate in a 3 week orientation course at DVTC dealing with Third World development problems, with special emphasis on the African situation.
Volunteers going to Southern Africa then leave for language and orientation courses in their respective countries of service.

SWAHILI COURSES

Volunteers for Tanzania attend a 3 week beginners' Swahili course prior to the Main course. After the Main course they have a one week Field Visit and then continue with a four week extended Swahili course.

Volunteers for Kenya also have a one week Field Visit followed by a four week beginners' Swahili course.

Moreover, both these groups learn something of the social, political economic and cultural aspects of Kenya and Tanzania, respectively.

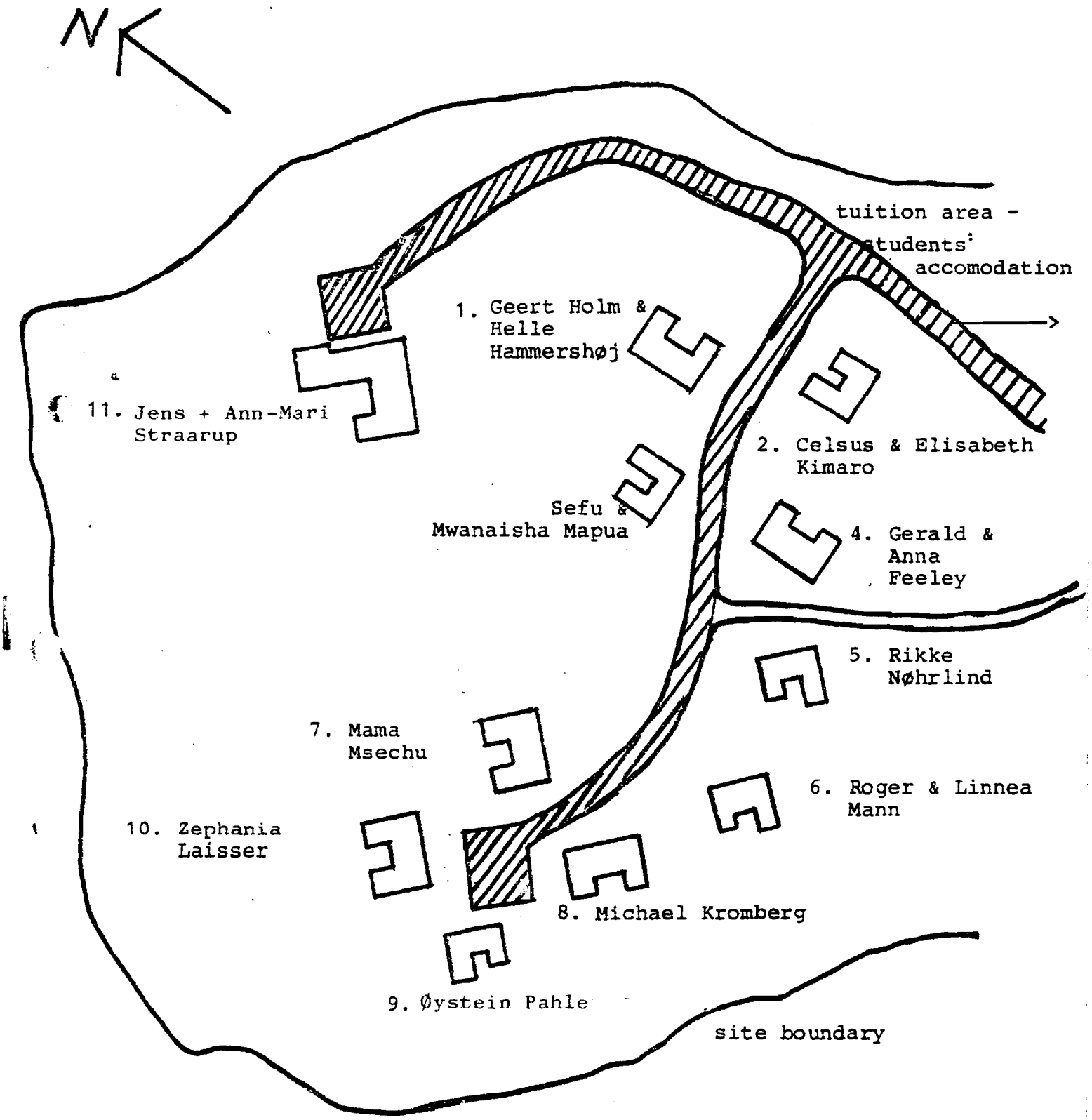
In addition to training volunteers, the Centre arranges Open Swahili for Beginners (3 week courses), especially for DANIDA personnel (DANIDA = Danish International Development Agency) working in Tanzania, but also for other aid personnel.

The Centre frequently receives volunteers and other technical assistance personnel from other organizations on various types of orientation/language courses, and organises Swahili courses for other agencies from time to time.

OUTSIDE GROUPS

Organizations can also rent the Centre's facilities and run their own seminars or courses on the premises.

SENIOR STAFF HOUSES



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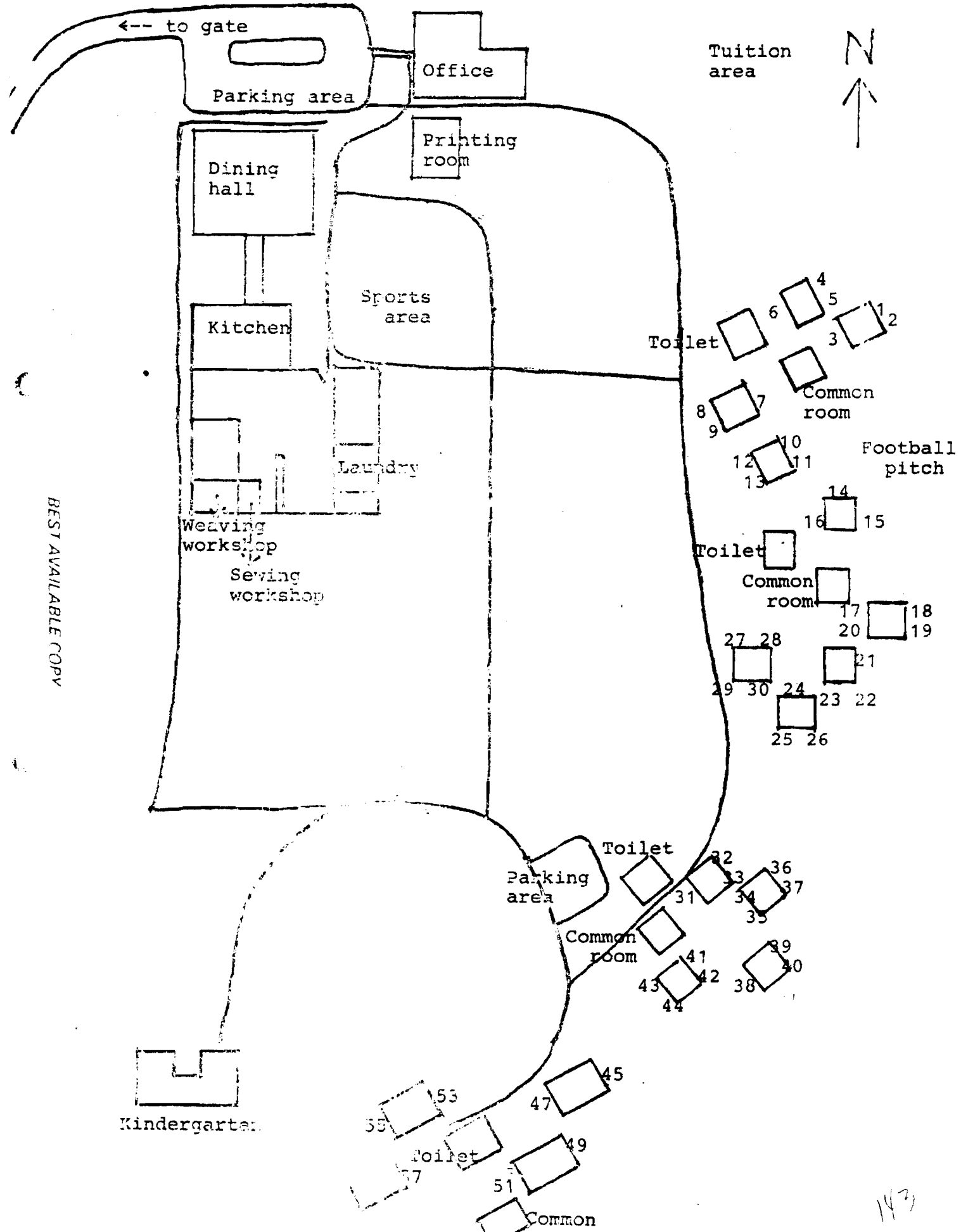
MAP OF ACCOMMODATION FACILITIES



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		Amount Budgeted		Amount Spent	
		TSh	US $	TSh	US $
..	Participants				
1.1	Food/Lodging	105,000	10,938	113,360	9,216.26
1.2	Travel	50,000	5,208	51,260	4,167.48
2.	Tanzania Faculty				
2.1	Food/Lodging	15,960	1,663	23,938	1,946.18
2.2	Travel	14,000	1,458	7,982/50	648.90
2.3	Pre/Post Workshops	7,920	680	6,471	526.10
2.4/2.5	Honorarum	13,200	1,375	12,400	1,008.13
3.	New York Faculty				
3.1	3 roundtrip tickets	-	6,000		
3.2	Add on Nai-Kili		1,000		
3.3	Per diem		5,850		
4.	Local Travel				
4.1	Field Trip	11,299	1,177	12,850	1,044.72
4.2	Petrol	2,880	300	2,630	213.82
5.	Conference	1,500	156	0	0
6.	Secretary	4,000	416	1,840	149.59
7.	Materials	-	1,500	-	
8.	Air Freight	-	500	-	1,011.00
9.	Admin/Misc.	9,600	1,000	5,934/50	482.48
		235,359TSh	$39,221	238,666TSh	$20,414.66

* New York based faculty and materials expenses are not included in the expenditures column.

Cash Flow (in TSh)

Cash In:

xchange $10,750 @123,821	133107/58	
Less Back charges	55/50	
	---	133052/08
Exchange (2 transactions $3000 & $4000) @ 12.3821 (approx)	86674/70	
Less back charges	36	
	---	86638

Reimbursement for hotels by staff or per diem

Mt. Meru	Martin Gorosh	2112
	Therese McGinn	1298
	Erik Rowberg	1056
Danish Volunteer Training Center	Martin Gorosh	1530
	Therese McGinn	3825
	Erik Rowberg	3825
	SS	1785
Refund of Tanzanite Deposit		1000

		236121/08

TITLE OF SESSION O R T

N= 28

	0	1 & 2	3	4 & 5	MEAN
1. WORTHWHILE	0	0	5	23	4.29
2. PERSONAL NEED	0	2	3	23	4.32
3- OTHERS' NEED	0	0	2	26	4.50
4. TRAINERS' PERFOMANCE	0	0	7	21	4.07

What did you like most about the session?

- The demostration
- Type of solutions as appopriate to locaties
- Discussions
- Practical demonstration
- C B D
- Contributions and comments
- I like the whole of the session
- The demonstration of ORT
- Growth monitoring
- Preparation of ORT using
- The preparation and the rice poweder tube added
- Home Remiches
- The topic -Attempt to mix solution
- All
- I would like to do demonstration again
- How to make ORT home much
- Everything
- Practical example
- The practical
- Physiology of rehydration
- Formula of calculating how much fluid a child/patient need in the first 4 - 6 hours to countract rehydration
  Tactfully given so easily understood

...../2

- The presentation view that most diarrhoeas doesn't need antibiotics but OR Solution
- Preparation of home made OR Solution
- It has increased my knowledge, I pressure I shall be able to do my work with properly and concidence.

What did you like least about it?
- None
- The part of demonstration on how to make ORS
- All about the lessons
- Nothing
- Demonstration exercise not well done - everyone needed to see what is happening
- To use a bowel to the mothers
- Too many things at a time
- Nothing
- Preparation of ORS
- About the demonstration of solution
- Nothing
- Theories

Any other comments or suggestions?
- Everything was alright
- Group discussions are very important
- I would suggest that we must take more time to teach the mother - on how to prepare, how to use the solution
- Time is needs for rest please
- More lecture about monitoring
- Nee to clarify the exact quantities of salt & sugar..... and need to practice until skill is mastered
- Try to let us rest mostly in the evenings
- It is a good subject
- Discussion about the implications of the demo to management levels was needed
- I'd suggest that because everybody here has own method of making ORS we should have time to share the knowledge
- The session is very useful to the community
- More demonstrations in preparing ORT to make us compentent

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...../3

- The trainer should have showed the proper preparation or we should have welcomed any trainer to show and all should leave with the same idea
- Careful attention should be taken when teaching mothers in rural areas regarding mixture of the components
- Go slowly, repeat so that we follow you. There are people who are slow to understand.

::::::::::::::::::::::::::::::

TITLE OF SESSION L E S S O N P L A N S / T R A I N I N G O F T R A I N E R S

N = 23	0	1 & 2	3	4 & 5	MEAN
1. WORTHWHILE	0	0	2	21	4.43
2. PERSONAL NEED	0	0	2	21	4.52
3. OTHERS' NEED	0	0	5	18	4.30
4. TRAINERS' PERFORMANCE	0	0	3	20	4.52

What did you like most about the session?

- Presentation, Exercises & result evaluation
- Consciousness of the facilitator to needs of participants
- Lesson planning evaluation planning for Tr. Programme and group presentations
- I like the whole session
- Lesson plan
- Making lesson plan
- Lesson plan
- Lesson plan
- Lesson planning was very interest as we sometime teach but we no nothing about lesson plan
- Lesson plan
- Exercise we did to make use of the lesson (i.e. Planning lessons)
- It will be useful to me to in carring out TOT in my region
- Lesson plan
- Planning my lesson plan
- All
- Work plan which will be useful for our workplans
- Lesson plan
- Lesson plan
- Teaching methods used

...../2

- The teacher tried his best
- Approach to designing lesson plans for teaching VHW
- Planning or preparing lesson plan

What did you like least about it
- Length with no rest (tiring boring)
- None
- None
- Nothing
- Evaluation - planning for training programs
- Lesson plan
- Lesson plan
- Being tired
- Discussion
- Group work.

Any other comments or suggestions?
- None
- Participants needed to be given at least one exercise in practice teaching just to get a feel of it
- I suggest to continue doing lesson plan
- Lesson are very tight with one trainer for the whole day its needs changing
- The teache is exellent in giving knowledge and skill
- More sessions on TOT programs
- This should be introduced to the Managers in many areas
- Pleas when participants appear to be unable to participate due to tiredness concider and have in mind that no good effective learning takes place ::: R e s t
- Time was very short
- Very tired
- Time for discussing the exercises shouldn't be too long to bore people
- The lessons was too tight
- Such a useful session should be given more time and not only a day which becomes so congested
- It made me realise how much one needs to learn new things continuosly, because I had been teaching thinking that I was using a good preparation before teaching while inactual fact it was very much incomplete
- With all the good approach the session was too long
- I also appreciated the evaluation approaches in training programes

;;::::::::::::::::: ::::::::::::::::::::::::;;

Cash Out (TSh)

Participants lodging & per diem (113.360 - 17000 deposit)	96360
A. Tanzania trip purchased in Arusha	16150
Participants land travel	22620
Air Tanzania tax paid to participants directly (Kiveba 1750, Ziotta 1750, Mwago 1750, Keleb 875, Sobayi 875)	7000
Local staff lodging DVTC	19890
Jitti Ri Ram - Mt. Meru	1098
Per diem (not include Tengio Urrio)	2250
Travel	4482/50
Pre-Post Expenses Mt. Meru	7230
Mt. Meru deposit reimbursed to ER	3000
Mt. Meru miscellaneous expenses	195
Tengio Urrio - New Arusha - post workshop	1924
Honorarum (not include Tengio Urrio)	7900
Field Trip (state travel)	12850
Local transport - petrol	2630
Secretarial fees	1840
Administration & Miscellaneous	5934/50
Tanzanite Deposit	1000
New York Staff DVTC	17850
Loans - Susan Nalder	350
Therese McGinn	60
Handed over to MHSP (Nangawe)	3891/20

	236505/20

Cash Out	236505/20
Cash In	236121/08
Difference	384/12

The excess of 384/12 TSh ($31.03) can be explained by the approximate exchange rate and bank fees used for the second and third exchange transactions ($3000 and $4000). The actual receipts were taken at the customs control on leaving Tanzania.

APPENDIX 7.13

MATERNAL AND CHILD HEALTH - NUTRITION UNIT

of the

MINISTRY OF HEALTH

of the

GOVERNMENT OF TANZANIA

in collaboration with

THE CENTER FOR POPULATION AND FAMILY HEALTH OF COLUMBIA UNIVERSITY

in

NEW YORK

Recognize the participation of

_____

In the Training Workshop: Community Based Integration and Implementation of National Maternal and Child Health/Family Planning/Primary Health Care/Nutrition Programs in Tanzania, held at the Danish Volunteer Training Center, Usa River, 1st through 15th December 1983.

_____

Allan Rosenfield
Director
Center for Population and Family Health

_____

Susan Nalder
Assistant Clinical Professor
Center for Population and Family Health

_____

A.Y. Mgeni
Director of Preventive Services
MINISTRY OF HEALTH

_____

Tengio Urrio
Senior Medical Officer
MCH/Nutrition Services
MINISTRY OF HEALTH

FIELD VISIT OBJECTIVES

Planning

- -Conduct a community needs and resources assessment.
- -Determine the extent of and mechanisms for community participation.
- -What are the objectives of the program in question and do workers and community members know the objectives?
- -Describe special plans for special target groups (if any)?

Implementation

- -Describe services actually delivered. How do these services compare with those planned?
- -Describe community outreach activities.
- -Describe IEC activities.
- -Comment on the Information systems (forms, records, reports, analyses, etc.).
- -Describe coordination within the program and with other programs.
- -How is progress monitored?
- -Describe the preservice and inservice training activities.
- -Describe the system of supervision used.
- -How are standards of care monitored?
- -What special problems exist (logistics, transportation) and how have they been handled?

Evaluation

- -Describe the overall evaluation system used.
- -What measures are used to evaluate coverage, achievement, staff performance?

These objectives may be met for the site as a whole or for selected program components (EPI, family planning, MCH, growth monitoring, etc.) at the site.

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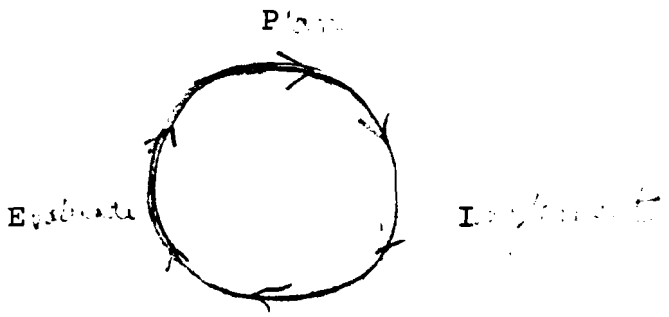
RECOMMENDATIONS

1. I recomend this work-shop has been useful to me as it has increase my knowledge skill and attitude in performing my duties. I have learn many areas which will able me to teach other staff at my unit how to perform the duty properly. By using the ~~visiors~~ managers circle I will do a lot.



2. a) For ourselves- We promise to apply all the skills obtained from this workshop to reinforce supervision of our duties in our regions in order to achieve the desired goals-

   b) For our Region- We expect to get a moral support in implemetation of programme activities.

   c) For the M.O.H- We expect the Ministry will provide the required supplies and materials for the various activities of the programme.

   d) For C P F H- We kindly request your follow-up in one year time. You will be proud of what you have done.

3. a) For ourselves- In order to do proper, in management we would apply technique of management by objectives.
   - Develop supervisory checklist which will enable us to do a proper supervision.
   - Develop a training checklist to supervise a training programme.

   b) For our Region- We shall develop a training programme for the VHW in our region.

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c) For the Ministry of Health- The Ministry of Health should conduct a seminar like this for the District staff.
   - They should be ready to provide us with required resources.

d) For the Center for Population and Family Health
   - Conduct a management and T.O.T Training for the other regional heads of Tanzania
   - Do a followup workshop for the December, 1983 participants.

4. i) The MOH should organize more workshops of this kind in collaboration with the Center of Population and Family Health to anable the managers manage their work properly.

   ii) We request the facilitators from the Center of Population and Family Health to do a follow-up visit in two years time concerning this program we have planned.

   iii) We request the MOH to give priority to this program by supplying us with necessary equipment or supplies when requested, including some funds to run the program in case of problem arises.

5. For the Region- To strengthen supervision system.

   For the Ministry of Health - To introduce management in Primary Health care in medical and paramedical school's curriculum.

   For the Center for Population and Family Health- They should come back and evaluate the result of the workshop in one years time.

For our selves- We are going to use the knowledge and skills we have aquired in this workshop to improve our work output and efficiency.

6. a) The knowledge and skills we have gained from this workshop will enable us to perform effective management in planning, implementation and evaluation of our PHC programmes, a task which we will embark on as soon as we go back.

b) We recommend that in the Region, the DMO, DMCHC, DPHCC should undergo the same training for effective of efficient performance of their functions.

c) We would like to ask the Ministry of Health to allocate more funds and arrange more such workshops for all the RMOs', RMCHC and RPHCC in Tanzania.

d) For the CP/FH - Columbia University, we would like to congratulate them for the good work they have done in conducting this workshop.

If time and funds are available we would ask them to conduct more short courses of this type in collaboration with the MOH up to the District level.

If time allows, the Center for Population studies in collaboration with the Ministry of Health, should carry out an evaluation practice for the effectiveness of this course after a period of one year.

::

TRAINING LEADERS FOR PRIMARY HEALTH CARE:

A FORMULA FOR SUCCESS

Martin Gorosh, Dr. P.H. [1]

Susan Nalder, C.N.M., M.P.H. [1]

William Van Wie, Dr. P.H. [1]

Abdel Rahman El Tom, M.D. [2]

K.E. de Graft-Johnson [3]

Tengio Urrio, M.D. M.P.H. [4]

for presentation at the World Federation
of Public Health Associations IV International
Congress, Tel Aviv, Israel, February 19-24, 1984

and

submitted for publication in PUBLIC HEALTH REVIEWS

---

1. Center for Population and Family Health, Columbia University, New York, N.Y., U.S.A.

2. Department of Community Medicine, Faculty of Medicine, University of Khartoum, Khartoum, Sudan.

3. Centre for African Family Studies, Nairobi, Kenya.

4. Ministry of Health, Dar es Salaam, Tanzania.

The program described in this paper was supported by a grant from the Rockefeller Foundation (1980-82) and by USAID Cooperative Agreement No. 0662-A-00-2068-00 (1983-84).

ABSTRACT

Since 1980, the CPFH (Center for Population and Family Health) of Columbia University has offered an intensive workshop in "Family Planning, Nutrition, and Primary Health Care: Program Design, Management, and Evaluation." Initially, this was a New York-based, English language course, open to participants on a world-wide basis. One hundred seventeen participants (in teams of at least two per country) from 31 countries attended the first three annual workshops. Evaluation of these programs and participant follow-up were highly positive. Knowledge gain was high and participants were able to implement concepts and skills learned upon return to their own programs. This paper reports on the lessons learned in this experience and on the evolution of this training program including: a geographic focus on Africa (34 African trainees from 12 countries participated in the fourth annual program held 1983); a bilingual French-English format; and an in-country follow-up component using participants who attended the New York course as faculty for in-country training. (Workshops have been completed in the Sudan, Kenya, and Tanzania and others are planned for Senegal and Togo.) Lessons learned to date include: documentation of the continuing need for this type of training; the need for supporting in-country programs; the role of evaluation in training; the value of the training context for early dissemination of findings from the field; and, approaches to simultaneous translation which facilitate full participation and exchange between Anglophone and Francophone trainers. The changes that have taken place in the four year history of this training activity have led to important improve-national and local community-based programs, and training and participant evaluation. The lessons learned may have important implications for training programs worldwide.

INTRODUCTION

The provision of health services to millions of of unserved and underserved people throughout the world will require large numbers and new categories of additional health workers. The development, management , and evaluation of the health systems in which these workers will be trained and utilized is one of the major tasks of Public Health leaders in both the developing and developed world. This paper describes the recent experience and the lessons learned in an international training program designed to equip developing world public health leaders with the concepts and skills needed to operate programs whose goals are to achieve "Health for All by the Year 2000." (1)

The basic model for extending health coverage to all includes a health care system adapted to local conditions, resources, and political considerations, incorporating community level workers at the periphery and offering second and third level workers and facilities to provide increasingly complex services to those whose needs exceed the capacities of lower level workers and facilities. (2) In this model, the community level worker --

include the provision of contraceptives, (pills, condoms, and foam) together with simple approaches to the treatment of diarrheal diseases, parasite infestations, and respiratory infections.

CPFH assistance has focussed primarily on areas such as management information systems based on simplified data collection; evaluation; supervision; logistics and supply; qualitative and quantitative analytical approaches; training of trainers; training lay and allied health personnel, including methods to identify appropriate lay community volunteer or paid agents, and general public health, epidemiologic, and demographic research techniques.

In providing technical assistance and in collaborating in operational research projects, the CPFH has always included training as an implicit component of its activities. In many projects explicit training objectives were specified in program design. (6) In a number of instances, project involvement led to the development of training materials. (7)

CPFH WORKSHOPS IN FAMILY PLANNING, NUTRITION AND PRIMARY HEALTH CARE

In 1980, the Center offered the first annual workshop in Family Planning, Nutrition and Primary Health Care. The offering was stimulated by a variety of factors. The decade of the 1970's closed with the call for greater attention to program design, management, and evaluation in the delivery of primary health care and family planning services in the developing world. Our Center's capability to provide training in these areas was growing as a result of our involvement in the operations research and technical assistance activities described earlier. As a Division of the School of Public Health at Columbia University, many of our staff members also held academic appointments and were involved in teaching activities, many of which drew on our international program experience. Over the years, we had received numerous requests from individuals and organizations to arrange ad hoc training programs for key workers. A final important factor was an interested doner agency.

With core support from the Rockefeller Foundation and with participant support from numerous donors, the Center offered annual workshops in 1980, 1981, and 1982. These annual one-month workshops were conducted in June of each year and were designed to teach the underlying principles, practical techniques and tools for designing, implementing, managing and evaluating integrated service delivery programs. Attention is given to increasing the epidemiologic, demographic, and management skills required in community oriented programs which provide family planning, nutrition, and primary health care to low income groups living in urban slum or rural areas.

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Workshop content included four basic areas:

Approaches to the Assessment of Community Needs and Resources -- Identification of major fertility, health, and nutrition problems and health systems, community resources, and cultural factors relevant to the delivery of health services.

Selection of Program Design Strategies -- Development of a variety of community based service delivery models including links with the formal health structure and with other development sector program activities.

Review of Specific Problems and Interventions -- Examination of the epidemiology of major health, nutrition and family planning problems, including demographic and ecological considerations, specific interventions available, and alternative information and communications strategies.

Management, Research and Evaluation Issues, Approaches and Methodologies -- Discussion of top-level management and strategy, principles of program planning and evaluation, management science approaches, organization design, and planning.

In 1983, continued support for this training activity was obtained from AID. While the basic goals, objectives, and content of the workshop were retained, several important modifications were introduced. Consistent with our shift to a greater emphasis on African programs, the workshop was limited to participation from sub-Saharan African countries. To provide access to this type of training to participants from Francophone countries, the workshop was offered in both French and English using innovative simultaneous translation techniques to maximize group participation and to foster interchange among trainees. Finally, to enable participants to develop adaptations of the workshop to be conducted in their own countries, emphasis was placed on training of trainers and funding was programmed to conduct five in-country follow-up workshops. (In-country workshops in Sudan, Kenya, and Tanzania are described in the appendix.)

In four years, 151 participants from 35 countries attended the New York workshop. An additional 100 to 125 participants will have attended the five in-country follow-up workshops (Sudan, Kenya, Tanzania, Senegal and Togo).

The fundamental difference between the New York and in-country workshops is that in the former we offer a training program and curriculum based principally on our institutional capability and a general needs assessment of the field, while in the latter we attempt to tailor the training program to the particular needs of the host country and institution. It should be noted, however, that in the New York workshop numerous opportunities exist for meeting particular groups of participant needs. Starting with the participant selection process, trainees are chosen in part for the types of programs in which they function. On arrival in

2. Networking.

There are numerous lessons learned which fall under the general heading of networking, including: training is facilitated when it takes place as part of a larger collaborative relationship; participant selection; and, the conduct of in-country workshops. These lessons are discussed briefly below; however, the importance of the networks established as a part of this training process cannot be understated, and the networking that occurs impacts upon many of the other lessons learned.

Since many workshop participants come from the staff of ongoing collaborative projects, we are able to select them for qualities such as aptitude, ability, and the likelihood that training will be applied when they return to their positions after training. Moreover, participants so selected will already have established professional relationships with both New York and overseas resident staff thus facilitating the ease with which they adapt to the workshop and its conduct.

An additional important factor related to networking is the support given to participants of the New York workshop who subsequently become faculty for in-country workshops. With New York and field staff available as resource faculty, participants who are put in the position of faculty for in-country training programs can experience a transition period in which technical and emotional support is offered prior to their having to conduct an entire training activity on their own.

Finally, the exposure to colleagues in in-country programs enables participants to identify locally available resources and expertise for future consultation.

3. In-country workshops

Many of the important lessons learned come from our experience to date in participating in in-country workshops (see the appendix for a description of workshops held in Sudan, Kenya, and Tanzania.

The Multiplier Effect of Training

Most training programs have as an explicit or implicit goal of having a multiplier effect, i.e. trainees, upon completion of training, pass on new learning to their colleagues. As can be seen, the in-country workshops do achieve this goal. This is facilitated by building into the overall design of our training activity the capacity to provide both technical and financial support for in-country programs.

formal and informal way. In particular, this has focused on issues of job relevance and application of the training. CPFH resident field staff and New York-based staff continue to provide personal follow-up on an informal basis wherever possible as part of their ongoing technical assistance activities. Trainee participation as faculty in in-country workshops is an important part of long-term evaluation. A more scientific follow-up of participants is planned for 1984.

Results

For the pre-and post-course surveys, the curriculum was broken down into major subject areas.

In some cases, a curriculum area corresponds to only a single session in the unit evaluations (e.g. Epidemiological Perspectives). In other cases, several unit sessions comprise a curriculum area, (e.g. Needs Assessment), and in the final category, the curriculum area constitutes a major theme, dealt with specifically in certain sessions, but also addressed throughout the course, (e.g. Program Design, Management and Evaluation).

Table 1 presents the results of these pre and post-surveys for all New York workshops conducted from 1980-1983. Table 1A presents the same results for the 1983 New York program which included several new curriculum units. The generally large absolute changes in pre-to-post course self appraised competence levels and the achievement of high post-course scores are important indicators of knowledge and skill gain by participants.

Figure 1 presents the result of a similar pre and post survey done in the Sudan workshop.

Pre-test of self assessment of level of competence showed that 14% of 43% of respondents rated themselves high or very high in each area except Primary Health Care (77% high or very high). Post training assessment showed an increase from 77% to 82% for Primary Health Care and even more substantial increases in other areas.

Pre-training levels of importance indicated high values for all areas (range 58%-95%). Post-training levels were higher in thirteen out of fifteen areas.

Overall, the pre-post evaluation of this training program is a positive one. Generally high expectations with respect to both concepts and skills were met. Dramatic increases in post training levels of competence were recorded.

We are now moving toward a more objective methodology for assessing the short-term impact of training. In the Kenya workshop, pretest and posttests were prepared and administered in three categories: Contraceptive technology, management, and

the importance of all topics to themselves, which were rated very high (87 on a scale of 100). Participant reaction to sessions was evaluated by participants as to whether sessions were worthwhile, were meeting participants individual needs and group needs as well as an assessment of the quality of the trainers delivery. These evaluations were used to identify participant needs and concerns, and to adjust training accordingly. The most frequent observation was a desire for more time and for trainers to go more slowly. The overall scores on trainee reaction indicated a high degree of satisfaction. Table 3 presents the results of the Tanzania workshop evaluation.

In addition to the evaluation of the courses, continued contact with course participants over the years point to concrete benefits and opportunities for CPFH staff to follow-up and to continue to work with program participants.

Process Evaluation

Using a variety of approaches, we have attempted to obtain feedback from trainees on the process and progress of training. Our explicit purpose in doing so is to be able to respond promptly to trainee needs in a current course as well as to improve future offerings.

In Kenya, for example participant reaction to training was solicited in three ways:

A. Use of "Quick Feedback" questionnaire at the end of many of the major content sessions.

B. Trainers and participants had many spontaneous sessions in which workshop presentation and materials were discussed. The feedback was used to restructure training events, reorganize sessions to allow for more discussion of work group time and to clarify content further group discussion.

C. The final evaluation of the course consisted of a self-evaluation of participants' perception of how well the training objectives were attained.

The information submitted on the quick feedback was useful in many ways. (See Table 4) It told trainers the degrees to which participants felt the material was useful, and their reactions to the trainer. The majority of responses were in the high range of being "worthwhile."

In addition, the feedback forms solicited subjective comments about participants likes, dislikes and other comments about the sessions. This was useful to all to gain insight into individual perceptions and to pick up on participants' insights. The information was tabulated and shared with the participants as one

role playing sessions, and training exercises freely and effectively.

Spontaneity and interaction can be maintained when using simultaneous translation. Lightweight, wireless equipment is essential but even the best equipment requires experienced and innovative professional translators who are willing to take a chance.

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Sudan

The first in-country training program was held in the Democratic Republic of the Sudan from 2-14 December, 1982. Thirty participants (21 full-time and 9 part-time) representing the Ministry of Health, University faculty, and front-line medical officers and specialists of the Sudanese Health Service attended the program entitled "Workshop in Planning, Implementing, and Evaluating Community Based Primary Health Care, Birth Spacing and Nutrition Programs."

Faculty were drawn from the Department of Community Medicine (DCM) of the University of Khartoum Faculty of Medicine and included numerous Sudanese leaders and experts in specialized areas of primary health care programs. Technical support was provided by Center for Population and Family Health (CPFH) staff (including the Resident Advisor in Khartoum) who have worked closely with Department of Community Medicine faculty in collaborative operational research and training projects during the past four years.

The curriculum included: overview of planning, administration and evaluation; primary health care, family planning, and nutrition interventions; needs and resources assessment; goals and objectives; program design; community involvement; implementation planning and phasing; training; supervision; logistics; information systems; monitoring; budgeting; and evaluation techniques.

Teaching methods emphasized "learning by doing" through small work group development and projects in Family Planning, Diarrheal Disease, Maternal and Child Health and Nutrition. The model used involved four steps in relation to each curriculum component. First, general concepts and specific skills were introduced, explained and discussed. Second, each work group applied these concepts and skills to its assigned project. Third, each work group presented the results of its efforts to the larger group, and fourth, incorporated suggested improvements into its project. In addition to the work group projects, other methods used included lectures, discussions, role playing, training exercises, and participant presentations of their own programs in the communities they served. The overall context for these approaches was provided by field observations of the DCM-CPFH collaborative operational research project and visits to other selected health and development programs. The training site at Sennar, 200 miles from Khartoum, reinforced the field orientation of the program and facilitated visits to nearby villages for training activities such as needs and resources assessment.

Immediate outcomes include substantial gains in competence as measured by pre and post training testing; positive qualitative assessments by participants, faculty, and resource persons; and, demonstration of the Department of Community Medicine's capability to plan, organize and carry-out an effective training program. (Note: The training logistics alone presented a

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There were fourteen participants from family planning programs and associations from Kenya and Tanzania, and clinical and teaching staff from health and family planning programs. The group included 3 physicians, 5 nurses and midwives, 4 family life and social development educators, 2 managers, and 1 nutritionist.

The group of participants constitutes a resource of potential trainers for future training programs, with whom CAFS has developed collaborative relationships.

Faculty for this workshop came from the Center for Population and Family Health. Because of the last minute decision about CPFH role in the workshop, there was inadequate lead time to identify collaborative faculty and to develop joint training materials in Nairobi. Therefore, participants assumed leadership and resource roles within the plenary sessions and work groups in their various areas of expertise, which included family planning and socio-economic development, clinical family planning, training of trainers, community development and family life education.

An in-depth training needs assessment was not possible due to the short lead time, however, a pretraining questionnaire was developed to provide information to the training team about the educational and experience background of the participants.

Tanzania

Since 1975 Tanzania has been developing an integrated MCH program that is mainly clinic based. At the central level, the MCH services are administered by the MCH Nutrition Unit at MOH headquarters. A Senior Medical Officer heads the unit. Implementation, supervision and evaluation of the services at zonal, regional and district levels are the responsibility of Zonal, Regional and District MCH coordinators respectively.

Each regional MCH coordinator works under the regional medical officer who is the coordinator of all the health programs in the region. The Regional Medical Officers, MCH coordinators, and Primary Health Care coordinators are important members of the Regional Team.

The workshop involved senior managers of health programs from the Regions, the Ministry, the Zones (there are 5 MCH zones). These participants, particularly zonal MCH Coordinators, Regional Medical Officers and Regional Primary Health Care coordinators, are responsible for planning, management, supervision support and evaluation of community based programs. The workshop provided skills to this group which is essential to their roles as leaders and is particularly important to the support of field level personnel i.e. those who have recently been trained in primary health care and have received a training of trainer course in primary health care and the District MCH Coordinators and MCH Aides who administer MCH services at district and community levels respectively.

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The workshop was organized in two, one-week sessions. During the first week participants examined the issues of village level health care through several types of sessions. After an introduction to the concepts on community based integration and implementation of services, the participants visited field sites in the Arusha Region to observe community based program activities, to conduct needs and resources assessment exercises and to gather visits helped set the stage for the remainder of the workshop by providing real circumstances or rural communities. The findings of the field visits were discussed in work groups and by the large group followed by discussions of the essential concepts of community based approaches and an examination of examples of programs from the literature.

The National Program of Primary Health Care, Maternal and Child Health and UMATI (family planning) were discussed. Emphasis here was placed on a close examination of objectives, implementation issues and evaluation reports. An update on selected issues in primary health care, maternal/child health and family planning was offered including malaria treatment and prevention, the implementation issues of oral rehydration in the reduction of childhood diarrheal morbidity and mortality, the health impact of family planning services and childhood nutrition surveillance program issues and problems. The workshop concluded with sessions in training and supervision.

Table 1A:

Pre and Post Workshop Survey
Participants Self-Assessed
Competence Level

Curriculum Unit	% Rating Themselves "High" and "Very High"			
	Pre-test (1)	Post-test (2)	Absolute Change (3)	% Change (4)
Primary Health Care	55	91	36	65
Maternity Care	47	83	36	—
Family Planning	38	63	25	66
Pediatric Issues	25	68	43	172
Oral Rehydration	46	83	31	56
Immunizations	55	86	31	56
Nutrition	40	86	46	115
Malaria and Parasitic Diseases	49	70	21	43
Water and Sanitation	20	64	44	220
Overall Program Design, Management and Evaluation	28	69	41	146
Problem Definition Objectives, Strategies Evaluation Criteria	32	67	35	109
Needs and Resources Assessment	22	72	50	227
Villager Run Programs	40	81	40	98
Use of Village Based Workers	41	81	40	98
Training	53	91	38	72
Supervision	60	88	28	47
Information Systems	26	76	50	192
Budget and Finance	11	46	35	318
Logistics	14	53	39	279
Implementation Planning	23	71	48	209
Policy and Legal Issues	5	56	51	1020
Operational Research	5	65	61	1220

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Table 3: Evaluation of Tanzania Workshop

A. Results of Pre-Post Testing for 23 Participants

Measure	Management 20 Questions Pre	Management 20 Questions Post	Primary Health Care 15 Questions Pre	Primary Health Care 15 Questions Post	Training Supervision 30 Questions Pre	Training Supervision 30 Questions Post
Mean Score	11	12.35	9.3	9.26	11.4	14.86
Mean %	56%	62%	62%	62%	55%	74%
Median	12	12	9.5	9	11	15
Mode	13	15	10	9	11	15/18
Range	4-16	9-15	6-13	5-11	5-17	10-20
Net Gain (Mean)	6%		0		19%	

B. Results of Pre-Post Testing of Professional Background of Participants

Professional Category	Management Mean Score		Training & Supervision Mean Score		PHC Mean Score	
	Before	After	Before	After	Before	After
Physicians	58	70	50	73	58	67
Public Health Nurses	51	59	58	74	61	57
Health Officers	64	70	65	82	62	65
Nursing Officers	50	58	43	69	61	62
Teacher (1)	60	65	75	95	73	73
Nutrition Officer (1)	40	45	25	60	53	53

C. Percent Answering Yes or Scoring "High" or "Very High" on Subject Areas, Pre and Post-Workshop

Subject Area	Expect to gain concepts		Expect to gain skills		Personal level of competence		Personal Level of importance	
	Percent answering "yes"				Percent "high" or "very high"			
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Management principles	96	100	81	96	15	48	88	90
Planning programs	100	100	88	96	31	35	92	95
Implementation	96	96	88	91	38	35	96	95
Information systems	88	87	88	91	12	48	85	86
Evaluation	96	100	92	96	42	52	96	81
Malaria	77	74	50	70	12	52	65	76
ORT	88	100	73	87	35	83	81	86
Family Planning	85	96	77	87	38	39	65	76
Nutrition Surveillance	92	96	85	91	23	43	81	86
Cit/Nutrition Implementation	96	100	92	91	35	43	88	86
Competency based training	77	100	92	96	15	43	77	90
Training of trainers	88	100	88	96	23	48	88	95
Supervision by objectives	81	96	88	91	31	56	85	81
Progress & issues/ MCH	92	96	92	91	15	39	88	86
Community based strategies	88	91	81	96	15	39	92	90
Overall means	89.3	95.1	83.7	91.1	25.2	47.1	84.5	86.5

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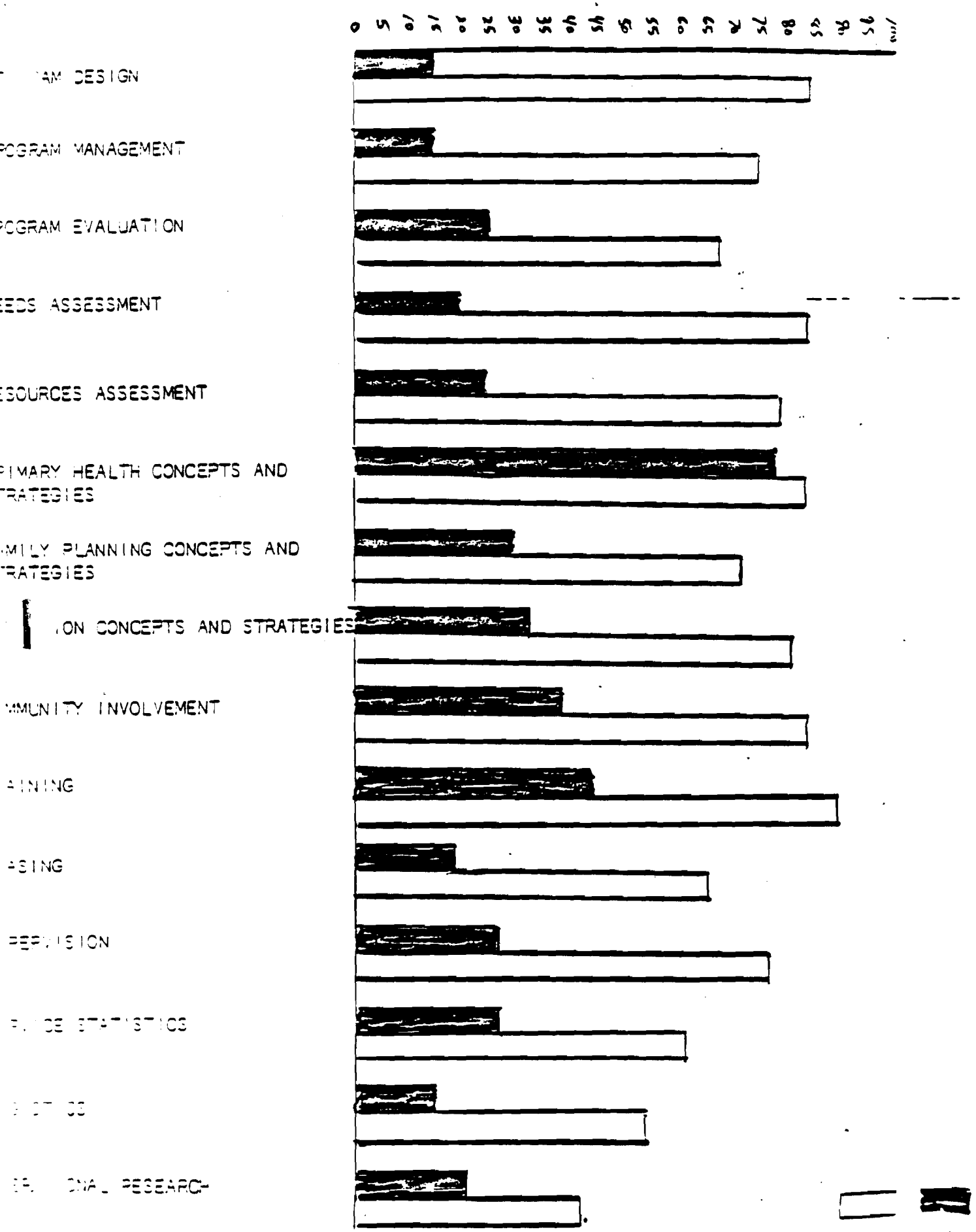

FIG 1. [illegible] AS "HIGH" OR "VERY HIGH" (SUDAN WORKSHOP, 1972)

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Disseminating Operational Research Findings Through Training: Workshops as a Forum for Sharing Field Experiences, Identifying Research Opportunities, and Launching New Projects.

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Abstract

The international operation research and technical assistance program of the CPFH (Center for Population and Family Health) is focussed on the design, implementation, management and evaluation of innovative family health and family planning programs. The international training program of the CPFH teaches the underlying principles, practical techniques and tools for designing, implementing, managing, and evaluating integrated service delivery programs. The workshops conducted in New York and in Africa are important vehicles for disseminating findings from operational research, for providing a foundation for replication of successful approaches, and for the development of new operational research projects.

This paper examines the relationship between international research and training and offers guidelines for developing closer linkages among organizations involved in these activities to improve the content and relevance of training.

Introduction

There are numerous channels available for disseminating the findings of operational research on family planning and primary health care service delivery. Written channels include published and unpublished articles 1-5/, text books 6/, monographs 7/, newsletters 8/, manuals 9/, working papers 10-12/, trip reports, quarterly reports and memoranda. Oral or verbal approaches may be combined with written material in conferences 13/symposia, colloquia, seminars 14/, workshops 15-17/ , academic programs, and retreats. Personal channels employing long and shortform advisors and consultants are often employed to disseminate findings and to assist in their appropriate application and adaptation in new and different settings. Finally, modern media such as the television coverage of Ibadan, Nigeria pilot CBD project, which was instrumental in its replication, may be used to disseminate findings.

Each of these channels has strengths and weaknesses and it is rare to find an instance where any one channel is used exclusively in disseminating research findings, particularly when the objective of dissemination is wider application of the findings. This paper describes the unique role of a training workshop, employing multiple dissemination channels, as a forum for communicating operational research findings and as a vehicle for developing new opportunities for operational research projects.

Operations Research and Technical Assistance Activities

The the international program of the Center for Population and Family Health (CPFH) of Columbia University is focused on the design, implementation, management and evaluation of innovative family health and family planning programs. Despite the remarkable expansion of family planning programs over the past twenty years, it is estimated that perhaps half of all couples in the Third World still do not have even limited access to family planning information and services. Furthermore, the majority of pregnant women in rural areas of the Third World deliver their babies at home, without any assistance from trained health workers. Their infants and young children have unnecessarily high rates of illness and death due to diseases such as diarrhea, respiratory infection and malnutrition.

In order to deliver basic services to these families, innovative programs are needed, most especially, programs which break with the Western model of clinic-based care provided exclusively by physicians and other highly trained professionals. Poor countries do not have the financial or human resources to provide all their people with this level of care. Nevertheless, much can be accomplished and the Center contributes to this accomplishment by providing financial and technical assistance to governmental and private agency projects and programs in Africa, Asia, the Caribbean, and Latin America. Brief descriptions of recent CPFH activities are contained in Appendix A.

CPFH Workshops in "Family Planning, Nutrition, and Primary Health Care"

In 1980, the Center offered the first annual workshop in family planning, nutrition and primary health care. The workshop, designed for developing country participants was stimulated by a variety of factors. The decade of the 1970's closed with the call for greater attention to program design, management, evaluation and in the delivery of primary health care and family planning services in the developing world. The Center's capability to provide training in these areas was growing as a result of its involvement in the operations research and technical assistance activities described earlier. As a Division of the School of Public Health at Columbia University, many staff members also held academic appointments and were involved in teaching activities. In fact, many courses were developed on the basis of international program experience. Over the years, numerous requests had been received from individuals and organizations to arrange ad hoc training programs for key workers. A final important factor was an interested donor agency.

With core support from the Rockefeller Foundation and with participant support from a host of other donors, the Center offered annual workshops in 1980, 1981, and 1982. These annual one-month workshops were conducted in New York City in June of each year and were designed to teach the underlying principles, practical techniques and tools for designing, implementing, managing and evaluating integrated service delivery programs. Attention is given to increasing the epidemiologic, demographic,

and management skills required in community oriented programs which provide family planning, nutrition, and primary health care to low income groups living in urban slum or rural areas.

Workshop content included four basic areas:

Approaches to the Assessment of Community Needs and Resources -- Identification of major fertility, health, and nutrition problems and health systems, community resources, and cultural factors relevant to the delivery of health services.

Selection of Program Design Strategies -- Development of a variety of community based service delivery models including links with the formal health structure and with other development sector program activities.

Review of Specific Problems and Interventions -- Examination of the epidemiology of major health, nutrition and family planning problems, including demographic and ecological considerations, specific interventions available and alternative information and communications strategies.

Management, Research and Evaluation Issues, Approaches and Methodologies -- Discussion of top-level management and strategy, principles of program planning and evaluation, management science approaches, organization design, and planning.

In 1983, continued support for this training activity was obtained from AID. While the basic goals, objectives, and content of the workshop were retained, several important modifications were introduced. Consistent with a programmatic shift to greater emphasis on African programs, the workshop was

having them focus on specific assignments such as training, supervision, community involvement, evaluation, etc., the New York workshop is able to meet specific needs of individual participants.

Some participants needs can be met by the flexible use of New York faculty resources. As one example, in 1983, numerous participants responded enthusiastically to a short presentation on the use of microprocessors in the field and a special session was arranged by CPFH data processing staff for additional training in this area. As we accumulate additional experience in the use of microprocessors in field operational research settings, we will be offering training sessions incorporating this new knowledge in the curriculum.

New York Workshops as a Forum for Dissemination of Findings

A natural expression of the New York workshop's being a statement of our Center's institutional capability is the extent to which findings from operational research projects are included in the curriculum. The principal faculty for the workshop are drawn from two sources. New York-based members of our international staff and CPFH field staff posted as resident advisors in countries where collaborative projects are in process. Together with participants from ongoing projects (roughly 1/2 of the 151 participants between 1980-1983 were selected from countries in which the CPFH was involved in a collaborative project) New York and field staff often made presentations based on project experience and included in these presentations many of the lessons that were being learned in the

- Experience with integrated versus categorical service delivery (Haiti, Mexico).
- Use of surveys and development of survey models for obtaining baseline information and for evaluation of project progress (all projects).
- Impact of liberal contraceptive distribution policies in producing higher acceptance and continuation (Haiti).
- Impact of paid versus free services and paid versus volunteer workers (Nigeria).
- Approaches to studying cost-effectiveness of programs and program components (Brazil, Sudan, Mexico).
- Findings concerning multiple service outlets showing them to be competitive in some settings and complementary in others.
- Approaches to post location to maximize post-effectiveness (Brazil).
- Training approaches used in preparing different levels of workers to perform different packages of tasks (Tanzania, Sudan).
- The importance of phasing in the systematic introduction of interventions (Sudan, Tanzania, Nigeria).
- The use of mini-surveys and focus groups techniques in needs and resources assessment, ongoing management, and

Sudan.

In Tanzania, the workshop had similar objectives. Of particular importance was sharing findings from the collaborative Maasai Rural Health Service Project with Central and Regional Health Officers to enable them to select approaches to be used to improve the delivery of Primary Health care in other areas of the country.

Training and Project Development

To this point we have discussed our New York and in-country training activities as forums for dissemination of findings. The workshops also serve as mechanisms for initiating new projects and for facilitating the development of existing projects.

The Tanzania project described above was initiated by a request from a Tanzanian participant in the New York workshop for CPFH assistance in developing a collaborative project. Three additional Tanzanians attended subsequent New York workshops, leading to the in-country workshop for disseminating project findings.

A project in Kenya involving working with the Center for African Family Studies (CAFS) to strengthen its training capability in clinical family planning and service delivery management developed out of an in-country workshop designed to explore the feasibility of CAFS becoming a major African resource for this type of training.

A newly designed project in Togo will use an in-country workshop to train key workers in the project during the first months of the project's life.

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Appendix A summary descriptions of recent CPFH international activities.

Bolivia. In Bolivia, CPFH has helped the Center for Social Studies (CSS) explore the acceptability and feasibility of family planning activities in industrial settings. Programs are being developed with labor unions to present seminars on family life and family planning, and to offer contraceptive services both at worksites and in a private clinic. CSS will compare the cost to employers of this program with the cost of pregnancy-related benefits for employers.

Brazil. For several years, CPFH has been assisting BEMFAM (one of the world's largest private family planning programs) in its development and expansion of research and evaluation activities. In addition to general technical assistance to the central research and evaluation unit, intensive work has been done in the poor northeastern state of Piaui. Activities in which CPFH has assisted include a large baseline survey of contraceptive prevalence, and ongoing operations research testing the effectivenss of such elements as household delivery of contraceptives and new patterns of supervision in a community-based program. Since 1980, a CPFH resident advisor has been assigned to BEMFAM.

Burundi. CPFH staff are assisting members of the Department of Community Medicine at the University of Burundi with the development of a community-based health project. The objective of the project is to improve services at rural health centers by utilizing community health workers to do outreach, by expanding

to a small project in the village of San Pablo Autopan. There, following baseline anthropoligical studies, village health workers were trained to provide family planning services to their neighbors. This was one of the first village-based distribution programs in Mexico, and it served as a model when the government expanded rural services. In 1977, the Ministry of Health and the National Family Planning Coordinating Council asked CPFH to assist in rural areas and in the slums of Mexico City in which community agents were trained to provide family planning and primary health care. The projects generated useful information on the recruitment, training and supervision of community workers which helped shape the national program. These projects have now been absorbed into the growing national program. New York-based Center staff provide ongoing general technical assistance to the Mexican government.

Nigeria. Since 1979, CPFH has been assisting one of the first community-based service systems in sub-Saharan Africa. Under the direction of University College Hospital (UCH), Ibadan, the program brings basic medicines and family planning services to rural villagers. Services are delivered by traditional birth attendants and other community members (most of them illiterate) who work under the supervision of government-trained midwives. CPFH staff have helped develop systems for training, logistics, record-keeping, management and evaluation. The success of the program has encouraged the Oyo State Health Council to expand the project throughout the state. The CPFH assigned a resident advisor to the UCH.

technical assistance in program research and evaluation to the Family Health Division of Thailand's Ministry of Public Health, primarily through a resident advisor. Among the various activities in which assistance has been provided are developing an improved management information system to provide data for ongoing evaluation, contraceptive prevalence studies, needs and priority assessments, analysis of program strategies, and processing of clinical data. In addition, CPFH has assisted the research efforts of Thailand's innovative private family planning association, the Population Development Association and its subsidiary, Community-based Family Planning Services.

Togo. CPFH staff are collaborating with Togolese Ministry of Social Affairs and the Status of Women on a community-based project which will involve existing rural women's self-help groups in the delivery of nutrition, primary health and family planning services.