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**REGIONAL PRIMARY HEALTH  
CARE PLANNING WORKSHOP**

**ETHIOPIA MINISTRY OF HEALTH AND BASICS/ESHE/USAID**

**Awassa, April 3-5, 1996**

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## ABBREVIATIONS

AAU	Addis Ababa University
ARI	Acute Respiratory Infection
BASICS	Basic Support for Implementing Child Survival
CDD	Control of Diarrheal Diseases
CEU	Clinical Epidemiology Unit
CHA (CHW)	Community Health Agent (Community Health Worker)
CHU	Community Health Unit
EPI	Expanded Programme on Immunization
ESHE	Essential Services for Health in Ethiopia Project
DTC	Demographic Training Center
GOE	Government of Ethiopia
HMIS	Health Management Information System
IEC	Information, Education and Communications
MOH	Ministry of Health
NGO	Non-Governmental Organization
PPHC	Preventive and Primary Health Care
RTC	Regional Training Center
RZW	Region/Zone/Woreda
SNNPR	Southern Nations and Nationalities Peoples Region
TBA	Traditional Birth Attendant
TOT	Training of Trainers
USAID	United States Agency for International Development

## EXECUTIVE SUMMARY

A regional primary health care planning workshop for the BASICS/ESHE project was conducted April 3-5, 1996 in Awassa, the capital of the Southern Nations and Nationalities Peoples Region (SNNPR). This regional planning meeting was designed to review proposed activities for the BASICS/ESHE project in close collaboration with regional and zonal health staff in the SNNPR and to further develop plans and strategies for project implementation based on the priorities and suggestions of Ministry of Health (MOH) staff at all levels. It is hoped that this workshop will be the first step in a process of regular project review meetings which will allow on-going monitoring and revision of project activities. Workshop participants came from a number of different governmental and non-governmental groups. Workshop activities consisted of general presentations, large-group discussions and small group discussions on focused topics. Small group discussions were focused on the following aspects of primary health care delivery at the health facility and community levels: 1) health management and information systems; 2) training; 3) supervision and other support to health facilities; 4) logistics of primary and preventive health care; and 5) the development of community-based health care strategies.

On the final day, a large group discussion was held to determine criteria for the selection of focus woredas within each of the BASICS project focus zones. The workshop process clarified the key implementation strategies for the BASICS project and the MOH. In addition, the workshop resulted in valuable input into the process of defining the most effective strategies and approaches for primary health care delivery in the SNNPR, all of which will be applied to the development of implementation plans. Key activities that will immediately follow the workshop were summarized as follows:

1. The BASICS project implementation plan for 1996-97 will be revised based on the workshop recommendations and then discussed and finalized with regional and zonal staff and the project steering committee.
2. Meetings with zonal health staff will be conducted to select focus woredas and communities in each focus zone. Implementation strategies will then be developed in each of these focus sites.
3. A training plan will be developed with staff of the regional training center (RTC) to begin the process of training trainers in priority PPHC topics.
4. A strategy for providing support to the regional training institute will be developed.
5. Baseline qualitative and quantitative studies at the level of households, communities and health facilities will be conducted in September, 1996.

## **I. BACKGROUND**

The Essential Services for Health in Ethiopia (ESHE) project is a major health program implemented by USAID/Ethiopia in collaboration with the Ministry of Health and the Southern Nations and Nationalities Peoples Region (SNNPR). The BASICS project has been selected as the primary implementing partner for maternal and child health activities for the ESHE project in the SNNPR. This regional planning meeting was designed to review proposed activities for the BASICS/ESHE project in close collaboration with regional and zonal health staff and to further develop plans and strategies for project implementation based on the priorities and suggestions of Ministry of Health staff at all levels. It is hoped that this workshop will be the first step in a process of regular project review meetings which will allow on-going monitoring and revision of project activities.

## **II. WORKSHOP PURPOSE AND OBJECTIVES**

The **overall objectives** of the workshop were:

1. to develop a one year implementation plan for BASICS project activities in collaboration with regional and zonal health staff; and
2. to identify strategies for implementing project activities.

**Specific workshop objectives** were:

1. to discuss key management issues including financial management, supervision, health facility management, HMIS, and roles and responsibilities of regional, zonal and woreda (RZW) health staff;
2. to discuss technical issues and identify priority areas for PHC interventions and strategies based on the 'essential package' of care;
3. to review proposed training activities and plans including short-term and long-term training and support for training institutions;
4. to review proposals for community-based activities and strategies for developing effective PHC interventions, including the use of CHA/TBAs; selection of IEC communication channels; behavioral change strategies; involvement of appropriate existing community organizations;
5. to discuss types of interventions and support to be provided for static health facilities, including a mechanism for distributing support equitably;

6. to discuss the involvement of academic researchers (AAU: CEU, DTC and CHU) in operational research;
7. to discuss areas of collaboration with other sectors, other organizations and NGOs;
8. to discuss mechanisms for involving zonal and woreda health bureaus and communities in the planning process, including monitoring and evaluation throughout the project cycle; and
9. to discuss proposals regarding non-formal training approaches to improve health worker performance and generate ideas based on the experiences of participants.

### **III. WORKSHOP PROCEEDINGS**

#### **A. Conduct of the Workshop**

The workshop was conducted April 3-5, 1996 at the Shebele No.1 Hotel in Awassa, the capital of the SNNPR. A schedule of workshop activities is attached in Appendix A. Workshop participants came from a number of different governmental and non-governmental groups, including the MOH Planning Department, the SNNPR Regional Health Bureau, the SNNPR Planning Bureau, the SNNPR Bureau for Women's Affairs, the SNNPR Relief and Rehabilitation Bureau, the four focus zones within the SNNPR, the Family Guidance Association, Southern Branch, the Awassa Health Professionals Training School, the UNICEF Southern Field Office, the BASICS project and USAID/Ethiopia. A list of workshop participants is attached in Appendix B.

Workshop activities consisted of general presentations, large-group discussions and small group discussions on focused topics. Four small discussion groups were formed and small group discussions were conducted on days 1 and 2. Each small group was given a discussion topic and a set of key discussion questions. For each small group discussion, a chairman and a rapporteur were appointed who then presented a summary of the small group findings and led a discussion on these findings with the larger group.

On day one, each small group was given a different discussion topic on the following aspects of facility-based primary health care:

1. health management and information systems
2. training
3. supervision and other support to health facilities
4. logistics of primary and preventive health care

On day two, each small group was given the same discussion topic:

5. the development of community-based health care strategies.

The guidelines for each small-group discussion are presented in Appendix C. On the final day, a large group discussion was held on criteria for the selection of focus woredas within each of the BASICS project focus zones. A summary of group discussions is presented in this report.

## **B. Summary of Workshop Presentations**

### **1. Overview of the BASICS/ESHE Project Objectives and Strategies** (Day 1: Dr. Barbiero, Dr. Freund, Dr. Murray)

The presentation included a general introduction to the ESHE/BASICS project and a summary of the project objectives, strategies and approaches to primary health care delivery. This information is summarized below.

#### Overview of the BASICS project

The overall goal of the BASICS/ESHE project is to improve the health status of women and children in Ethiopia and begin to reduce population growth. The project purpose is to assist the GOE to increase the use of primary and preventive health interventions at health facilities, and in households and communities in the ESHE project focus areas within the SNNPR.

The BASICS project is a maternal and child health project that focuses on children under five years of age and their mothers. The project emphasizes the links between child survival programs and reproductive health. In particular there is an emphasis placed on the development of integrated maternal and child health programs. It was stressed that integration can be defined in different ways; it can mean the integrated provision of services at health facilities and in communities (such as the provision of child health, EPI, antenatal and family planning services), and it can also mean an integrated approach to the management of children so that all important causes of mortality and morbidity (ARI, CDD, vaccine-preventable diseases, malaria, malnutrition) are addressed by each health worker each time the mother brings a child for care.

A conceptual model of the pathway between wellness, sickness and death for infants and children was presented. This has been termed the "Pathway to survival" and can be used to identify areas where primary health care programs should focus activities. The Pathway to Survival is presented in Appendix D. It was emphasized that in Ethiopia, as in many developing countries, many mothers do not recognize illness in their children, do not seek care appropriately, or do not have access to health facilities. This may result in elevated infant and childhood mortality. In order to address this problem, programs need to focus at the level of the household and community and need to change the behavior of caretakers to both seek care appropriately or to

better manage their children themselves in the home. Programs that focus on the health facility level are not reaching a large population of mothers and children who are at high risk of mortality. The BASICS project recognizes the importance of changing critical health behaviors (those of both caretakers and caregivers) to effecting any public health change and is working in a number of countries to develop effective strategies in order to do this.

It was also emphasized that the BASICS project focuses on the development of practical, realistic and cost-effective primary health care strategies which are manageable under local conditions. Sustainable solutions to all public health problems must come from collaboration with local health staff and local communities.

#### BASICS' role at the national level

The major categories of BASICS activity at the national level were summarized as follows:

- a. Contribute to the development and dissemination of key primary and preventive health care policies and guidelines.

Activities which may be undertaken in this area include technical assistance for the process of policy reform (PPHC, essential drugs, cost recovery), short and medium-term out of country training, and support to national-level health care financing (management, accounting and budgeting).

- b. Strengthen the capacity to conduct primary and preventive health care management and planning.

Support in this area may include training in management and planning topics as well as assistance with systems and program reviews.

#### BASICS' role in the SNNPR

The major categories of BASICS activities in the SNNPR were summarized as follows:

- a. Conduct joint planning/programming of primary and preventive health activities with regional, zonal and woreda health staff in project areas.

Activities in this area may include training in program management and planning for RZW staff; project planning with RZW staff locally; development of the Regional Training Center (RTC) and a regional training plan; development of regional health education strategies; and the development of plans and strategies for assessing facility equipment and supply needs and for distributing equipment and supplies regionally.

- b. Strengthen local capacity to manage health care financing at all levels.

Activities may include a systematic review of health care service financing, accounting and budgeting systems at the regional, zonal and woreda levels (including cost-recovery systems), the testing of approaches to strengthening health care financing at RZW and health-facility levels, short-term in-country training of RZW staff in accounting/financial management which is tailored to their roles and responsibilities; and on-the-job training in project financial management through the BASICS country office.

- c. Strengthen the routine health management and information systems (HMIS) in project areas to improve the availability of useful, timely data for public health decision-making at all levels.

Activities may include the development of an HMIS implementation plan for project areas, including the design of forms to collect essential information, local problem solving strategies and the development of an implementation plan in project areas (linked with training and non-training support activities). The HMIS system will then be implemented in project areas and a baseline and follow-up evaluation of performance will be conducted.

- d. Improve quality and availability of key maternal and child health services in the project areas.

Key activities in this area will be baseline and follow-up facility-based assessments which will be used for the evaluation and monitoring of program outcomes, the development of training materials and approaches, the development of health education strategies and the development of community-level approaches for the delivery of primary health care. Other activities may include procurement of essential books/training materials and office equipment for the regional training school; assistance with the development of the training curriculum and materials for nursing students; training for RTC and zonal staff in training methods and training materials development; in-service training in PHC topics for zonal, woreda and health facility staff; development and implementation of approaches to improving and sustaining health worker performance (motivation, supervision, clinic organization); development and implementation of a supervision and monitoring strategy; and the strengthening of an integrated logistics and supply system (drugs, cold-chain, equipment and supplies).

- e. Increase the use and knowledge of key primary and preventive interventions at the household and community levels.

Baseline household and follow-up community qualitative and quantitative assessments will be key to the development of community-level activities. Baseline data will be used in project areas to evaluate and monitor program outcomes, to develop training materials and approaches, to develop health education strategies and to develop community-level approaches to primary health care. Other activities may include the development of community health groups in focus communities; the development and implementation of community strategies around health stations in focus woredas (with RZW staff and health workers and involving a number of community groups including CHWs, TBAs, drug sellers, traditional healers, churches and mothers groups); the development and implementation of approaches to improving health education at the local community level and at RZW levels; the development and implementation of community cost-recovery in focus woredas; and the development and implementation of operations research in key community topics.

- f. Expand lessons learned from successful program activities throughout the region.

Activities will focus on three key areas. First, lessons learned from successful program activities will be disseminated using workshops, presentations at conferences and the publication of articles. Secondly, strategies will be developed for expanding project activities throughout the four target zones, including the use of focus woredas as training sites for health workers from surrounding woredas. Thirdly, plans will be developed expanding PPHC strategies throughout the southern region.

**2. Training**  
(Day 2: Dr Carlson)

It was emphasized that training of health personnel at all levels is essential to the development of a functional public health system that provides quality primary health care to communities. All staff at all levels should see themselves as trainers for others; at the lowest level of the health system, health staff are trainers for communities and household members. By developing a system in which all staff at all levels are training and educating those around them, changes in health behavior are much more likely to occur. It was stressed that this principle must be taught and stressed from the beginning of pre-service training and then continuously reinforced. It was also stressed that training and education must be seen as a continuous process and all health personnel must commit to on-going revision and re-training throughout their lives. For this reason, it is essential that the public health system commit to providing on-going training to these staff on a regular basis. The investigation of strategies for providing on-going training and education should be an important element of all primary health-care programs and should be reinforced by the BASICS project. For this reason, the development of the RTC will be an important first step in the process of institutionalizing on-going training. It was stressed that on-going training and educational support for health workers is one key element in the

development of committed and motivated health staff who will remain within the health care system in the long term. Other issues stressed included the importance of training materials and approaches which are practical, realistic and use practical hands-on training methods.

**3. Operational Research**

(Day 1, Day 3: Dr. Freund, Dr. Solomon)

It was stressed that operational research is critical for the design of effective public health programs. Information is required in a number of different areas including the knowledge and perceptions of caretakers regarding the major causes of childhood morbidity and mortality; attitudes and perceptions in the area of reproductive health; care-seeking behavior; the knowledge and practices of traditional healers and rural drug vendors; and communication between health workers and mothers. Further research is required in the use of community groups to develop and transmit health messages. Further research is required on the measurement of key health behaviors and the development of strategies for changing those behaviors. Community health financing strategies need to be better developed and tested. The basic epidemiology of malnutrition, vitamin A deficiency, Shigella dysentery, malaria and pneumonia needs to be better defined as well as the antimicrobial resistance patterns for malaria, dysentery and pneumonia in the southern region. Current breastfeeding and weaning practices, including the type of foods used in local communities, need to be better investigated. The BASICS project in the SNNPR will assist with the design and implementation of operations research projects in areas of programmatic importance. MOH staff at all levels were encouraged to develop proposals for research projects which they feel are of importance. It was mentioned that operational research projects will be conducted in collaboration with academic departments including the AAU, CEU and CHU. Guidelines for the submission of research proposals will be developed in the next two months. Two studies conducted last year by the BASICS project in collaboration with regional health staff; a health facility survey and a community demand study, were described.

**C. Summary of Group Discussions**

Small groups met and discussed primary health care topics on days 1 and 2. A summary of small and large group discussions on these topics is presented below.

**1. Health Management and Information System**

(Day 1: Group 1: presenter Dr.Solomon)

Major problems/barriers to a functional HMIS system

A number of problems or barriers were identified:

*Time delay in reporting:* Reporting forms are not submitted in a timely fashion for a number of reasons, including lack of health worker training and a lack of effective methods of transmitting reporting forms to the next level of the health system.

*Poor reliability of reporting:* Reports are often incomplete and the reliability of diagnostic categories is uncertain since standard case definitions are not routinely used.

*Time limitations for health workers:* Health workers often do not have enough time to complete all routine reports as well as complete all their other duties.

*Budgetary constraints:* Financial resources are important for the provision of transport for reporting forms.

*Communication:* In many areas of the southern region, distances are great, roads are poor and no regular transportation is available. Feedback and supervision often do not occur regularly.

*Reporting forms are too long and complicated:* The current reporting forms are too long and take too long to complete. This adds to the burden for health care workers who are less likely to complete them.

*Lack of training and awareness of the importance of health information:* Most health workers are not aware of the importance of health information, why it is being collected, and how information can be used. They often have had no training in the collection of basic epidemiological information.

*Lack of stationary:* There is sometimes no paper available for routine reporting.

#### Possible solutions to strengthen the HMIS system

Within the group a consensus was reached on the most important strategies for strengthening the HMIS system:

*Improve the availability of trained manpower:* Some participants thought that it was important to get more staff at health facilities who can be responsible for conducting all data collection and reporting activities.

*Improve communication:* Improved transmission of information between peripheral health facilities, woredas, zones and the region was considered important. The use of radios for transmitting information was considered to be a feasible option, as well as improving the availability of vehicles.

*Improve staff motivation:* It was considered important that staff who perform well should be rewarded in some way. The provision of additional training courses was considered as a possible motivator.

*Training:* In-service and pre-service training should have more information on the importance of data collection and the use of an HMIS system.

*Simplify data collection forms:* Forms should be simplified and should collect only essential information.

*Frequency of reporting:* Consideration was given to reducing the frequency of reporting for all non-essential information. This information may not be required every month.

*Improve the quality of supervision at RZW levels:* Improved supervision which systematically reviews the data collection process and the use of reporting forms would improve health worker reporting.

#### Next steps

Possible solutions for strengthening the HMIS were prioritized by the group and the three most important were selected. These were: improving communication, improving health worker in- and pre-service training and simplification of data collection forms. This information will be used by the BASICS project and MOH staff to develop a strategy for improving the HMIS system.

## **2. Training**

(Day 1: Group 2: presenter Ato Getachew)

### Training priorities

The group identified the most important facility-based training priorities.

*Priority health workers for facility based training:* At the health post level: community health agents, community health workers, traditional birth attendants and primary midwives. At the health center level: health officers, nurses, sanitarians, laboratory technicians and support staff.

*Priority in-country training needs:* Developing a training of trainers (TOT) network within the southern region was identified as a first priority. A TOT network should be based in the RTC and should emphasize realistic, practical training using appropriate technology. The development of a system for providing post-basic training was also thought to be a high priority. Post-basic training was encouraged because it is

cost-effective, requires relatively short periods of time, will improve the quality of service delivery and will encourage the development of a formal career structure.

*Out-of-country training:* Out-of-country training was not considered to be a high priority for meeting local needs. It was thought to be useful as an incentive for health workers, to learn about new approaches to primary health care delivery which are not available in the country, and for capacity building in essential technical issues.

#### Possible solutions to improving training programs

Two primary bodies were considered essential for the development of improved training programs, the regional training center and the health professionals training institutes:

*Development of the regional training center (RTC):* The regional training center is seen as the key group which will be responsible for developing in-service training programs and a training of trainers network. The RTC currently needs support in a number of areas including improved physical facilities; equipment and furniture; teaching aids including books, periodicals and journals; vehicles; per diem and running costs; and assistance with curriculum development and in training methods and approaches.

*Development of the health professionals training institutes:* These institutions in Awassa, Arba-Minch and Hossana all require improved physical facilities (classrooms, offices), teaching aids and materials, office equipment, demonstration equipment (such as for laboratory services), vehicles and assistance with the development of updated and appropriate curricula for all categories of health worker.

*Cascade training approach:* The cascade approach to training trainers is favored. RTC staff will train staff in the training division at the zonal level (including nurses, sanitarians, pharmacists, health assistants and administrative staff). These trainers would then be responsible for training staff in the woreda training units. It was mentioned that woreda training units are not staffed in many areas and that this will be a barrier to effective cascade training. In addition, it was mentioned that in the short-term, there is a shortage of medical manpower at many health facilities. These problems will need to be carefully considered as training programs are developed.

#### Next steps

Ministry of Health and BASICS staff will further investigate priority steps for providing assistance to the RTC and the health professionals training institute and will work on the development of a medium- and long-term training strategy.

**3. Supervision and other support to health facilities**  
(Day 1: Group 3: presenter Ato Kassahun)

The group addressed the barriers to effective supervision and the possible strategies for improving supervision as well as other support necessary to improve facility-based services.

Barriers to effective supervision

*Limited resources:* Resources are limited for the provision of vehicles, fuel and manpower.

*Lack of a formal supervisory program:* supervision is not effectively planned and scheduled or monitored in any systematic fashion. Supervision is given a low priority in most health programs.

*Supervision does not focus on improving the quality of care:* When supervision does occur, it often is not conducted systematically, does not use checklists, does not focus on observing case-management practices, is vertical in nature rather than integrated, and does not provide any feedback to health workers.

*Training in supervision:* Training in supervisory methods is not conducted and is required to improve performance.

Possible solutions to improving the quality of supervision for primary health care

The following possible solutions were discussed:

*Establish a supervisory coordinating committee:* Such a committee could consist of representatives from all key primary health divisions as well as other sectors which may need to be involved in the process of regular supervision such as the pharmacy. a mechanism for supervising community health agents (CHAs) and traditional birth attendants (TBAs) needs to be developed; ideally they would be supervised by staff at health posts and by community groups.

*Develop a supervisory training program with the RTC.*

*Develop a simple, integrated supervisory checklist for all key primary health care services.*

*Ensure that NGOs are included in the development of a supervisory program:* NGOs may be able to assist with the provision of regular supervision.

### Other possible approaches for improving the quality of facility-based services

A number of possible strategies were discussed, although there was not enough time to address each strategy in detail:

*Improve the provision of basic equipment and essential drugs to all health facilities:* Essential equipment and drugs are critical to the provision of quality primary health care services. A review of the drug management and distribution system is required.

*Renovate health facilities:* The condition of some health facilities is considered to be so poor that persons in the community are reluctant to visit.

*Develop strategies for improving the motivation of health workers:* Suggestions included the provision of regular in-service training; the use of incentives such as equipment and supplies; the regular supply of drugs; and improved communication between health workers and communities, etc..

*Improve the resources available for better educating communities:* Options discussed included improving communication skills of health workers; developing and distributing health education materials; the development of "model areas" for demonstrating hygiene and sanitation practices, agricultural practices, etc.; and ensuring that trained community health workers are present in all communities around health facilities.

*Encourage intersectoral collaboration:* Better coordination may allow sharing of resources, vehicles and staff.

*Train and equip community health workers (TBAs and CHAs):* Training of community workers should be updated to reflect an integrated approach to primary health care and a mechanism needs to be developed for providing on-going training and supervision. The contents of basic kits provided (delivery kits and treatment kits) needs to be further clarified. A concern was raised that in many areas community health workers are giving injections illegally; a national policy will need to be established on whether community health workers should give injections in remote areas.

*Encourage community participation:* Increased responsibility of communities for their own health will improve the prevention of disease as well as care-seeking practices with sick children and for vaccinations.

### Next steps

All points raised in this section will be used to develop approaches to improving facility-based care in the project areas. Further discussion with local health staff and communities will be required.

**4. Logistics of primary and preventive health care**  
(Day 1: Group 4: presenter Mr. Amare)

Barriers and possible solutions to the development of an improved logistics system for all primary health care services

Barriers to an effective primary and preventive health care logistics system were discussed and included:

*Lack of an effective logistics management system:* Peripheral health centers have no functional mechanism for ordering materials, supplies, equipment and drugs. In addition, systems are not integrated; vaccination logistics is often separate from other systems.

*Shortage of commodities:* All essential commodities (vehicles, office equipment, facility equipment and drugs) are often not available.

*Lack of storage facilities:* Storage of essential commodities is often not possible.

*Lack of communication:* There is no functional system for facilities to record their commodity needs and then order commodities in a timely fashion.

*Poor maintenance and unavailability of spare-parts:* There is an inadequate number of trained staff to undertake maintenance and repairs of essential equipment including vehicles. There is no regular maintenance program for health facilities in the southern region. Spare parts often cannot be obtained for basic repairs.

*Poor infrastructure:* The poor condition of roads makes it difficult to regularly visit many health facilities.

Possible solutions to logistics problems

*Develop and strengthen the logistics management system:* Staff who will be responsible for logistics activities in the longer term should be identified for training. It would be considerably more cost-effective if logistics activities could be better integrated. Visits to a health facility to review the cold-chain could also be used to review the availability of essential equipment and supplies. Training may involve a number of different divisions including training, planning, administration and finance, pharmacy and the family health department.

*Reduce the shortage of essential commodities:* As a first step to improve the availability of essential drugs it was thought to be important to reduce the wastage of drugs by reducing their inappropriate use; this could be addressed through primary health care training materials and the RTC. Overall, however, the group felt that there is a need for

an increased commodity budget; this will need to be addressed in the long term at both the regional and national levels by the administration and finance department.

*Improve the availability of storage facilities:* Construction of storage facilities is required and will be a long-term undertaking. This should be addressed by the planning and engineering departments and by administration and finance.

*Improve communication from health facilities:* This area overlaps with improving the HMIS system. A radio system has been proposed, with a radio available at each health facility.

*Improve vehicle maintenance:* A central garage at the regional level has been proposed. A garage would need to be constructed and then equipped and staffed with appropriately trained staff. A system and schedule for providing regular vehicle maintenance would then need to be developed and implemented. The planning and engineering departments as well as the administration and finance departments at the regional level would need to be involved.

*Improve the road infrastructure:* This is a long-term problem that will require input from the central government. It was suggested that NGOs could work on roads in their areas, possibly using labor from local communities.

#### Next steps

Two activities were proposed as the most important next steps. First, a needs assessment should be made of the logistics management system at all levels and possible strategies identified for improving the system with existing resources. Secondly, an integrated logistics management training course for appropriate staff should be developed and implemented. The BASICS project and MOH staff at the regional level and in the focus zones will incorporate these suggestions into the workplan.

#### **5. Developing community-based primary health care strategies**

(Day 2: All groups: presented by all groups)

Rapporteurs:

Group I-	Dr. Tsedeke	Group II-	Sr. Werkenesh
Group III-	Ato Mekonnen	Group IV-	Ato Meskele

A number of key elements of community-based programs were discussed by all groups.

#### Existing community groups or individuals which could be utilized to promote effective community interventions

A number of possible groups were identified:

*Traditional groups:* Ekub, Edir, Mahber, women's groups, village health committees, self-help committees.

*Religious groups:* religious leaders, church organizations.

*Political groups:* kebele leader/kebele administration, farmers' associations.

*Individuals:* Village leaders, elders in the community, teachers, kalichas, traditional healers, drug vendors, development agents.

*Other groups:* Health post workers, CHAs, TBAs, schools, school clubs, health committees, water committees, saving and credit committees, youth clubs, peasant associations, urban associations, community development associations.

### Principles for implementation of community-based programs

*Formation of a community-coordinating group:* All groups thought it essential that a coordinating group, composed of respected members of the community, be formed before any health activities could be conducted. It was felt that this committee should be selected by the community. Such a group should be comprised of respected individuals, educated persons such as teachers, the kebele chairman, and the community health workers. In addition, it was stressed that it is critical that women are included in such a group; they are essential if maternal and child health issues are to be addressed. Community groups should set their own priorities and drive all health activities in their own communities.

*Link between community group and the health post:* Community groups should be supported and directed by community health agents, who should participate in meetings, assist with planning and prioritizing activities and liaise with the health post. The health post may be able to provide technical support, education materials, simple medications and training. Health worker training will need to focus on community-based program development and the development of simple health education messages and strategies. Community-level activities may be best managed by multi-disciplinary teams comprised of health workers, sanitarians, midwives, community nurses and woreda training staff.

*Improved training of community health workers:* Training of health staff at all levels in IEC principles and in the development of community-based programs is required. As discussed in the training section, training materials in this area will be developed by the RTC and then cascade training of trainers will be conducted. A mechanism for conducting effective training below the woreda level will need to be developed. Training of CHWs (TBAs and CHAs) could be conducted by staff at many levels.

### Mechanisms for rewarding community-health workers

A number of possible options for rewarding community health workers and encouraging sustained performance at the community level were considered:

*Recognition of service:* This was thought to be a critical element for sustaining performance. Recognition could be given by the MOH in the form of training courses, technical updates and refresher courses, and participation and recognition in review meetings at the woreda level.

*Support and supervision:* Performance will be strengthened by improving simple supervision of CHWs by health post staff, perhaps by ensuring that monthly review meetings occur and by providing immediate feedback (positive and negative). Other forms of support could include the provision of uniforms to CHWs, and the provision of simple drugs and supplies for community-level activities.

*Rewards for community service:* Reward mechanisms were discussed by all groups. Non-financial mechanisms include non-monetary exchange with communities (such as the exchange of food and materials or farming assistance by community members), and the provision of free health care to CHWs by health posts and health centers. Two financial mechanisms were discussed: charging a small fee for materials and supplies (such as condoms and contraceptives) that can be retained by CHWs, and payment of CHWs from facility income generated by cost-recovery arrangements at health posts. Overall, financial mechanisms of this type require further discussion and significant policy decisions by the MOH.

### Principles for implementing community-based programs

A number of key steps were thought to be important for approaching communities and beginning community-level programs:

*Contact local leaders and groups:* Communities should be approached carefully and always through key community members. The objectives and principles of community-based programs should be carefully explained.

*Create a community committee with community participation and ensure that the committee meets regularly:* As described above, the community committee will be a key element of community programs. A working relationship with the CHW should be established.

*Get consensus on health priorities of the community and develop strategies for addressing these problems:* The CHW and local health staff may be able to facilitate this process and provide technical assistance when required.

*Consider mechanisms for financing community activities:* Community committees should investigate mechanisms for collecting contributions from the community for local interventions. Some local projects have already used this system to generate income for a variety of projects including water and sanitation development. A small contribution each month from community members would need to be managed by the committee and used effectively. Communities would need to perceive that contributions resulted in concrete improvements.

#### Next steps

The BASICS project in collaboration with MOH staff will be working to develop community-level interventions in the focus zones and the principles elaborated above will be used to develop implementation plans. Further discussion of community issues is required at the zonal and woreda levels. Community financing will require further policy discussions at the regional and national levels.

#### **D. Implementation of Program Activities in the Focus Zones: Selection of Focus Woredas** (Day 3, Dr. Freund)

It was stressed that all BASICS project activities will be implemented in close collaboration with health staff at all levels. Project activities will be implemented regionally and at the level of the focus zones. Certain activities will be implemented in a more focused fashion in certain focus woredas within the project focus zones. These aspects of the implementation strategy were discussed.

#### Regional and zonal project activities

A number of activities will be implemented at the regional and zonal levels and will have widespread applicability. These activities will include:

*Support to the RTC:* including the development of a regional training strategy, TOT in PHC topics (management, CHW training, supervisory training, PHC topics).

*Support to short-term training:* both inside and outside of the country.

*Strengthening the HMIS.*

*Strengthening logistics and supply systems:* essential drugs, equipment, vaccines.

*Development of a system for providing essential equipment to health facilities in the target zones.*

*Annual planning and review meetings.*

*Health education strategies and materials at RZW levels.*

Focused activities beginning in one focus woreda in each focus zone

The rationale for beginning certain project activities on a smaller scale was discussed. A single focus woreda in each focus zone has been proposed. There are four primary reasons for beginning activities in smaller areas. First, small-scale implementation will allow the effectiveness of program interventions to be determined; activities need to be begun on a small scale in order to determine what facility- and community-level approaches are effective. Secondly, small-scale implementation is more cost-effective; focused activities are more likely to produce a health impact for lower overall costs and a functioning model woreda can serve as a practical training site for surrounding woredas. Thirdly, small-scale implementation is more feasible with the current capacity of the BASICS project and the MOH; BASICS' resources are not adequate to genuinely build capacity and develop local systems which work for all woredas in the project time-frame (2 ½ years). Fourthly, small-scale implementation is more likely to produce an impact; the impact of local programs on the health of mothers and children in households and communities can be better demonstrated in smaller areas before expanding to a large scale.

Focused activities beginning in one focus woreda in each target region

The following types of activities were discussed as important for focused tasks at the woreda level:

*Selection of criteria for selection of focus woredas.*

*Planning meetings in four focus zones: select focus woredas and focus communities.*

*Baseline facility and community assessments: in a number of aspects of maternal and child health knowledge, attitude and practice.*

*Initial implementation of local approaches to supervision, health worker training, community-based strategies and pilot HMIS: using data collected in the baseline assessments.*

*Use of these sites as training sites: for staff from surrounding woredas, beginning in January 1998.*

### Discussion of criteria for the selection of focus woredas

It was generally agreed that specific criteria will be required in order to select focus woredas and that these criteria must be finally decided with the zonal health bureau, zonal health staff and the zonal planning department. Possible selection criteria discussed in the group were as follows:

*The availability of functional health facilities:* focus woredas should have reasonably functioning health posts and a functioning health center.

*Population size and density:* woredas which have a higher population size and density may be preferred sites because the public health impact in these sites would be expected to be greater.

*Patterns of disease morbidity and mortality:* selected sites should have high incidence and prevalence rates of the most important causes of mortality and morbidity in the region.

*Accessibility:* selected sites must be reasonably accessible by road from Awassa.

*Current involvement of NGOs:* focus sites should not already have a lot of NGO activity.

#### **IV. WORKSHOP CONCLUSION AND FOLLOW-UP ACTIVITIES** (Dr. Freund)

In summary, it was agreed that the workshop process had clarified the key implementation strategies for the BASICS project and the MOH. In addition, the workshop had resulted in valuable input into the process of defining the most effective strategies and approaches for primary health care delivery in the SNNPR. Key activities which would immediately follow the workshop were summarized as follows:

1. The BASICS project implementation plan for 1996-97 will be revised based on the workshop recommendations and then discussed and finalized with RZ staff and the project steering committee.
2. Meetings with zonal health staff will be conducted to select focus woredas and communities in each focus zone. Implementation strategies will then be developed in each of these focus sites.
3. A training plan will be developed with RTC staff to begin the process of training trainers in priority PPHC topics.
4. A strategy for providing support to the regional training institute will be developed.

5. Baseline qualitative and quantitative studies at the level of households, communities and health facilities will be conducted in September, 1996.

APPENDICES

**APPENDIX A**

## APPENDIX A

### Agenda for Regional Planning Meeting BASICS/ESHE

Awassa, April 3-5, 1996

#### Day one, April 3

- 08:30-09:00 Registration
- 09:00-09:30 Welcome, introductions, objectives of meeting
- 09:30-10:00 Introduction and overview of ESHE
- Tea Break
- 10:30-11:00 Review of the BASICS project strategies and links with national, regional and zonal health plans
- 10:30-11:00 Overview of bridging activities: health facility survey, community demand study, and implications of the findings.
- 11:00-12:30 Outline of BASICS activity plans, objectives and time frame.
- Lunch Break
- 1:30-2:00 Introduction to group work; selection of 4 groups; selection of chairman and rapporteur for each group; discussion of scope of work for each group.
- 2:00-4:00 Small group work
- Improving the quality of primary health care in health facilities
1. Health management and information system (HMIS)
  2. Health worker training
  3. Supervision
  4. Cold-chain, drug supply, equipment and supplies
- Tea Break
- 4:30-5:30 Presentation and discussion of findings by each working group

#### Day two, April 4

- 09:00-09:15 Review and summary of small group findings from Day 1

09:15-09:35 Review of approaches and strategies to training  
09:35-10:00 Review of key issues in the development of community-based strategies to primary health care delivery

Tea Break

10:00-12:30 Small group work  
Improving the quality of health care for mothers and children in the home and community  
All groups: Developing community-based primary health care strategies

Lunch Break

1:30-3:00 Small group work (continued)  
3:00-4:00 Presentation and discussion of findings by each working group

Tea Break

4:30-5:00 Presentation and discussion of findings by each working group (continued)  
5:00-5:30 Review of operational research issues; collaboration with academic institutions and dissemination of results

### **Day three, April 5**

09:00-09:15 Review and summary of small group findings from Day 2  
09:15-10:00 Review and discussion of timeline for BASICS activities

Tea Break

10:30-11:30 Small group work  
Discussion of criteria for selection of focus woredas within each target zone

All groups: Discussion of criteria for selection

11:30-12:00 Presentation and discussion of findings by each working group

12:00-12:30 Summary of remaining issues and next steps

12:30-12:45 Closing

**APPENDIX B**

**APPENDIX B: LIST OF WORKSHOP PARTICIPANTS**

Abdi Tessema	Planning and Programming, North Omo Zone
Abebe Gesit	Planning Department, MOH
Abraham Amanuel	Head, Adm./Fin. Dept. RHB
Amare Bedada	Head, Family Guidance Association, S. Branch
Ammanuel Abraham	Radio Correspondent, Regional SNNPRG
Ayele Angello	Head, Regional Disaster Prevention and Preparedness Bureau
Ayelework Abebe	Project Assistant, USAID/E
Barbiero Victor K. (Dr.)	Chief of HPN, USAID/Ethiopia
Bassamo Deka	Head, Health Service and Training Department, RHB (RTC)
Bekele Getaneh	Planning and Programming, Sidama Zone
Belayneh Teshome	Head of Department, Planning and Economic Development
Berhanu Legesse	Planning and Program Department, MOH
Carlson Dennis (Prof.)	Visiting Consultant, BASICS
Carmela Abate (Dr.)	Health Advisor, USAID/E
Dana Seffa	Environmental Health Team Leader, Regional Health Bureau
Fikerte Aberra	Training Division, RHB
Fisseha Haile Meskel (Dr.)	Technical Coordinator, USAID/E
Freund Paul (Dr.)	Deputy Chief of Party, BASICS/Awassa
Gebrewold Ashengo	Head, Regional Labour and Social Affairs
Getachew Assefa	Head, Awassa H.A.T. School
Higgs Peter (Dr.)	Sr. Policy Advisor, BESO, USAID
Kassa Daka	Expert, Pharmacy Division, RHB
Kassahun Bellete	Head, Epidemiology Division, North Omo Zone
Lambisso Wonisha	Department Deputy/KAT Zone Health Department
Mathewos Oushe	Expert, Planning Department, KAT Zone
Mekonnen Fara	Team Leader (Head), IEC, Regional Health Bureau
Mekonnen Batisso	Head, BOPED
Menbere Zenebe	Senior Expert, Regional Office of Population
Meskele Lera	Senior Expert, Pharmacy Division & Trainer in RTC, Regional Health Bureau
Meteku Ayele	Expert, North Omo Planning Office
Mulugeta Betre (Dr.)	Coordinator, HB Regional Training Center
Murray John (Dr.)	BASICS Headquarters, Technical Officer
Musie Alemayehu	Sidama Zone Planning & Economic Development Depart.
Sahle Sita (Dr.)	Family Health Team Leader, Regional Health Bureau
Sahlemariam Gebre Senbet (Dr.)	CDC Section Head, Regional Health Bureau
Seblework Paulos	Bureau Head/Acting, Regional Women's Bureau
Senait Philipos (Sr.)	Expert, EPI, Regional Health Bureau
Shiferaw Tekle Mariam (Dr.)	Head, CHRL, Regional Health Bureau
Solomon Worku (Dr.)	Epidemiology, Regional Health Bureau
Tadele Gebeyehu (Dr.)	Health Officer, UNICEF
Taylor Jennifer	BASICS Headquarters. Operations Coordinator

Teshome Tefera (Dr.)  
Tien Marie  
Tsedeke Tuloro (Dr.)  
Tsegaye Mulugeta  
Tsegaye Lankemo  
Werkenesh Kereta (Sr.)

Wondimu Amdie  
Worku Gebre Yohannes  
Wuleta Betemariam  
Zerihun Alemayehu

Head, Sidama Zone Health Department  
BASICS Headquarters. Programme Assistant  
Head, Hadiya Zonal Health Department  
BOH  
Head, Planning and Engineering Section, Hadiya ZHD  
Tutor AHAT School & Awassa Regional Training Center,  
Trainer  
Data Collection Assistant, BASICS/ESHE  
Head, KAT Zone Planning Department  
Population Fellow, USAID/E  
Team Leader, Regional Planning Bureau

APPENDIX C

## APPENDIX C

### GUIDELINES FOR SMALL GROUP SESSIONS

#### Discussion group 1: HMIS

1. What would you do to build a functional and sustainable facility-based HMIS in the focus zones? Address the following issues:

Minimal data required (what information is essential?)

Development of forms

Accuracy and completeness of reporting

Return of forms, analysis

Feedback of information

2. What are the barriers to implementing the changes proposed above?
3. What health staff at woreda, zonal and regional levels should be involved?

Do the job descriptions of these health staff allow them to perform these tasks?

4. What practical and realistic activities are required in order to implement the proposed changes in the focus zones in the next year?

Are these activities likely to be sustainable?

#### Discussion group 2 :Training

1. What categories of facility-based health workers need to be trained in primary health care topics in the focus zones?

2. What are the priority in-country training needs for Zonal and Woreda health staff?

3. What are the priority out-of-country training needs for Regional and Zonal health staff?

What are the benefits of in-country and regional training versus out-of country training?

4. What practical and realistic activities are required in order to strengthen the RTC in the next year? Are these activities likely to be sustainable?

5. Who will be responsible for in-service training at Zonal and Woreda levels?

Do the job descriptions of these staff allow them to conduct these tasks?

**Discussion group 3: Supervision and other support to health facilities**

1. Why do health facilities not receive regular supervisory visits from the Woreda?
2. When supervision is conducted, does it focus on monitoring and improving the quality of health worker practices? What is not done by supervisors? What needs to be done by supervisors?
3. Who should be responsible for implementing these changes at the Zonal and Woreda levels?
4. What are practical and realistic and sustainable solutions to improving supervisory support to health facilities with available resources in the focus zones in the next year?
5. What other areas of support are essential in order to improve and sustain health facility-based services?

**Discussion group 4: Logistics of primary and preventive health care (Cold-chain, drug supply, equipment and supplies)**

1. What are the major constraints to developing a sustainable cold-chain, drug supply, equipment/supply system?
2. What are possible sustainable solutions to these constraints?
3. Who would be responsible for implementing these changes at the Zonal and Woreda levels and what additional support and training do they need?  
  
Do the current job descriptions for these staff allow them to do these tasks?
4. What practical and realistic activities are required in order to develop the cold-chain, drug supply, equipment systems in the focus zones in the next year?  
  
Are these activities likely to be sustainable?

**General discussion group: Developing community-based primary health care strategies**

1. What existing community groups or individuals could be utilized to promote effective community interventions? (be specific)
2. How should programs be implemented in communities using key community groups/individuals and with full community involvement?
3. How should community workers be rewarded?

4. Who should train community groups/individuals?

How and where should training be conducted?

5. Who should be responsible in health facilities for linking/providing support to community groups/workers? How should they provide this support?

6. What practical and realistic activities are required in order to develop community strategies in the focus zones in the next year?

Are these activities likely to be sustainable?

**APPENDIX D**

# Pathway to Survival

