

**TECHNICAL ASSISTANCE TO A NATIONAL
COURSE ON "PLANNING AND
MANAGING DECENTRALIZED HEALTH
SYSTEMS"—PART II**

Addis Ababa, Ethiopia

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ACRONYMS

AIDS	Acquired Immunodeficiency Virus
BASICS	Basic Support for Institutionalizing Child Survival
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSDP	Health Sector Development Plan
MOH	Ministry of Health
STD	Sexually Transmitted Disease
TB	Tuberculosis
TOT	Training-of-trainers
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The Ethiopian Ministry of Health (MOH), together with USAID, requested in 1997 that the BASICS project provide technical assistance and financial support for two national courses on "Planning and Managing Decentralized Health Systems " The fact that Ethiopia, in 1993, had decentralized health services to 11 regions meant that new skills in health planning and management were needed at the regional level to effectively manage health service delivery

The first course was held in May 1998 and focused on concepts and issues linked to the decentralization process Course participants were primarily from regional management teams The main objectives of the course were to—

- Sensitize the regional management teams to planning and management issues related to the provision of decentralized health services
- Provide an opportunity for sharing and discussing the Ethiopian regional individual experiences in this area and comparing them with those from other countries
- Reinforce selected planning and management skills

The second course was held during this consultancy, from September 7-10, 1998, at the Red Cross Training Center in Addis Ababa This 4-day intensive course was attended by 22 participants from 9 of Ethiopia's 11 regions The participants were primarily from the Regional Training Centers, many of them training directors A few of the participants were from the Regional Health Office or Zonal Health Office rather than from Regional Training Centers

The main purpose of the course was to train regional trainers in health planning and management skills, as well as in how to train zonal- and woreda-(district) level staff in health planning and management Specific objectives were to clearly understand and be able to teach—

- Health planning skills in the context of Ethiopia's decentralized health system, including the rationale and principles of health planning, planning methodologies, strategic planning vs operational planning, the logical framework approach, and project planning and proposal writing
- Health management information system skills, including data collection and analysis, definition of indicators, use of data for planning and decisionmaking, epidemiology-based planning, HMIS tools (from the Southern Nations, Nationalities, and Peoples Region experience), and monitoring and evaluation
- Planning for quality of care

Course participants were actively involved in all sessions. The course was taught in a highly participatory manner, so that each session was structured in a way which allowed participants the maximum opportunity to provide input and feedback. Sessions were also designed to serve as examples of different training methodologies, including small group discussions, role-playing, presentations by participants, mini-lectures, and so forth.

The course evaluation was very positive. The participants left the course with a workplan for specific follow-up activities that they were to implement upon returning to their home regions.

PURPOSE OF VISIT

The purpose of this assignment was to assist in facilitating Part II of a national course on "Planning and Managing Decentralized Health Systems"—specifically focusing on training regional trainers in health planning and management skills in a decentralized setting, as well as training them in how to most effectively teach these skills.

BACKGROUND

Ethiopia attempted a bold experiment in decentralization when, in 1993, the country was divided into autonomous regions, with the regions being determined along ethnic lines. Significant authority and responsibility have been granted to each of the 11 regions, but most have had little experience and very limited training in the skills needed to manage programs at the regional, zonal, and woreda levels. USAID and the BASICS project have tried to bridge this gap by providing support and technical assistance as needed and requested by the regional health officials.

The Health Sector Development Program (HSDP), developed by the Ministry of Health with support from donors (including USAID) coordinated by the World Bank, is a major initiative aimed at delivering a package of basic health services to all Ethiopians at an affordable cost and in a sustainable manner. In order for the HSDP to be effective at the local level, health officials in the regions, zones, and woredas need to be able to plan and manage their programs and projects. In order to assist the Ethiopian MOH in strengthening the capacity of local health managers, USAID (through BASICS) has supported two national training courses. The first, held in May 1998 in Nazareth, involved members of regional management teams. The course focused on concepts and issues linked to the decentralization process and had the following objectives:

- Sensitize the regional management teams to planning and management issues related to the provision of decentralized health services
- Provide an opportunity for sharing and discussing the Ethiopian regional individual experiences in this area and comparing them with those from other countries

- Reinforce selected planning and management skills

The second national course, which this consultancy assisted with, focused on regional trainers (especially staff from the Regional Training Centers) from 9 of Ethiopia's 11 regions. A total of 22 participants were involved for an intensive 4-day course (September 7-10, 1998) at the Red Cross Training Center in Addis Ababa.

The main purpose of the course was to train regional trainers in health planning and management skills, as well as in how to train zonal- and woreda-level staff in health planning and management. Specific objectives were to clearly understand and be able to teach—

- Health planning skills in the context of Ethiopia's decentralized health system, including the rationale and principles of health planning, planning methodologies, strategic planning vs. operational planning, the logical framework approach, and project planning and proposal writing
- Health management information system skills, including data collection and analysis, definition of indicators, use of data for planning and decisionmaking, epidemiology-based planning, HMIS tools (from the Southern Nations, Nationalities, and Peoples Region experience), and monitoring and evaluation
- Planning for quality of care

TRIP ACTIVITIES

The first five days of the trip were involved in preparing for the course. Since the course was essentially for training-of-trainers (TOT), it was important that each of the sessions represent a different example of a kind of training methodology. The course was organized in such a way that it would be very participatory. Together with Chief of Party Dr. Vincent David of the BASICS team in Ethiopia, this consultant designed sessions that included lecture/discussion, small group work, role-play, simulations, etc., as types of adult learning methods. I had responsibility for sessions on—

- Regional experience in planning and management training
- Using data for planning and decisionmaking
- Planning for quality improvement
- Preparing for planning and management training (together with David)

All session guides, trainers' notes, and course handouts and overheads were included in the binder of materials given to all participants. Copies are also available at the BASICS office in Addis Ababa.

RESULTS AND CONCLUSIONS

The course was very stimulating, with the majority of the participants actively involved in the discussions. Since most of the participants worked in Regional Training Centers, they had enough in common so that few participants felt their status was too low to enable them to be fully engaged in all aspects of the course. The main results and conclusions were as follows:

- Regional health trainers in Ethiopia have, on the whole, good practical field experience, but usually have had little if any formal training in how to teach. They are eager to learn new teaching techniques and methodologies.
- Regional health trainers have, for the most part, not had much experience or training in health planning or management. Most of them have had clinical training (as doctors or nurses, etc.), but only a few have an MPH or similar training that covers planning and management.
- Although the course participants came from nine different regions and represented at least that many ethnic groups, they worked very well together without any evidence of inter-ethnic or inter-religious tension. This bodes well for future collaboration between regions.
- The course evaluation was very positive. The participants felt that the sessions were practical and that they learned how to use different teaching techniques for different learning objectives.

RECOMMENDATIONS

- 1 In order to maximize the impact and effectiveness of the Health Sector Development Program, it will be very important for the MOH and the donors to support continued training of regional trainers and to strengthen the capacity of the Regional Training Centers.
- 2 Although further training in new teaching techniques for regional trainers will be very valuable, it is even more important that they receive training in the key content areas, such as planning and management (finance, logistics, human resources, information), as well as updates on major disease problems (e.g., HIV/STD/AIDS, family planning/reproductive health, child survival, TB, malaria, etc.).

- 3 Training should begin for those zonal health officials who are actually managing health services in their respective zones. Zones and woredas will increasingly become the levels where actual service delivery will be managed and effective zonal (and woreda) health officers will be instrumental for implementing activities under the Health Sector Development Plan.

APPENDIXES

APPENDIX A

SOME SAMPLES OF SESSION GUIDES AND HANDOUTS/OVERHEADS

SESSION GUIDE

Session II Regional Experience in Planning and in Management Training

Purpose

After having reviewed the planning cycle and after learning the five key questions in planning, the next step is to describe the current situation regarding health planning and management training in each of the regions. In this session, we will be answering the first two of the five questions—Where are we now and where do we want to be regarding health planning at woreda and zonal levels. One of the objectives of this course is to enable the participants to be able to train zonal and woreda staff in basic techniques of health planning and management. Therefore, it is important to clearly understand the current situation so that the training that you will provide will be practical and meet the needs of those whom you train.

Duration 3 hours

Session Questions

By the end of this session, participants should be able to answer the following questions

REGIONAL EXPERIENCE IN TRAINING IN THE AREAS OF PLANNING AND MANAGEMENT

- What training in planning and management has taken place over the past year within your region?
- Who was trained (job and level)?

WHERE WE ARE NOW AND WHERE WE WOULD LIKE TO BE CONCERNING HEALTH PLANNING AT ZONAL AND WOREDA LEVELS

- What is the current situation regarding health planning at zonal and woreda levels in your region?
- What are the major issues, problems, and concerns that you face regarding health planning at zonal and woreda levels in your region?
- Where would you like to be regarding health planning at zonal and woreda levels in your region 3 years from now?

SMALL GROUP DISCUSSIONS ON REGIONAL EXPERIENCE IN PLANNING AND IN MANAGEMENT TRAINING

1—Please break up in to groups, with each group consisting of people from the same region Most groups will have three members

2---Each group will try and answer 5 questions

REGIONAL EXPERIENCE IN TRAINING IN THE AREAS OF PLANNING AND MANAGEMENT

- What training in planning and management has taken place over the past year within your region?
- Who was trained (job and level)?

WHERE WE ARE NOW AND WHERE WE WOULD LIKE TO BE CONCERNING HEALTH PLANNING AT ZONAL AND WOREDA LEVELS

- What is the current situation regarding health planning at zonal and woreda levels in your region?
- What are the major issues, problems, and concerns that you face regarding health planning at zonal and woreda levels in your region?
- Where would you like to be regarding health planning at zonal and woreda levels in your region 3 years from now?

3---Please write down the main points for each of the five questions. Three regions will be selected to present to the entire group the results of their discussions. The other groups will comment on the presentations and tell about their own experiences during the discussion period following the presentations.

SESSION GUIDE

Session IV Using Data for Planning and Decision-Making

Purpose

The purpose of this session is to identify simple techniques for using available data for deciding priorities and making operational plans. Data that are specific for a particular woreda or zone are often lacking. When this is the case, it is necessary to use whatever is available for prioritizing, planning, and decision-making. A manual for making a woreda or zonal health profile can assist with collecting appropriate information (a manual being used in the SNNP will be provided for all participants).

Woreda and zonal staff need to have the basic skills to make decisions and plans from available information. In order to train them in data utilization skills you will need to learn these techniques.

Duration 3 hours

Session Questions

By the end of this session, participants should be able to answer the following questions

- What is a simple but effective technique that can be used to prioritize health interventions?
- How can national or regional survey data be used to help woreda and zonal-level planning?
- How can routinely collected data be used to improve local planning and decision-making?

HOW TO PRIORITIZE HEALTH INTERVENTIONS

Basic Steps

- ◆ List the most important health problems in your woreda/zone. These can be specific diseases (such as malaria or AIDS) or problems like poor access to clean water, or problems such as malnutrition among children <5, or pregnancy-related deaths
- ◆ For each health problem listed, give a score of 0 to 5 for the following items
 - How big a problem is this? (does it cause a large number of deaths or severe morbidity?)
 - are there one or more interventions that are effective in preventing or solving this problem?
 - How feasible is it to implement this intervention in your area?
 - How inexpensive is it to implement the intervention?
- ◆ Add up the score for each health problem listed (possible range of scores is 0-20) and list the health problems in the order of their score (highest first)

AN EXAMPLE OF PRIORITIZING HEALTH INTERVENTIONS

Let's say that in a particular woreda, or zone the following 5 health problems were considered most important

- Malnutrition in children <5
- Tuberculosis
- Pneumonia (especially in children but also in adults)
- Access to clean water
- Cardiovascular disease

How might we score these 5 problems (in order to prioritize them)?

Health Problem	Magnitude of Problem	Effective Intervention	Feasible Intervention	Cheap Intervention	Total Score
Malnutrition in children <5	5	3	2	3	13
Tuberculosis	4	4	4	2	14
Pneumonia in children & adults	5	4	4	3	16
Access to clean water	5	5	1	1	12
Cardio-vascular disease	4	2	1	0	7

SMALL GROUP DISCUSSIONS ON DATA-BASED PLANNING AND PRIORITIZING

- 1 Please break into small groups. Each group has the same assignment. Each group should select a facilitator and a rapporteur to take notes.
- 2 Try to imagine a fairly typical woreda or zone, with the usual set of problems. The group should agree on the main characteristics of the woreda or zone they have chosen (it can be a real woreda or zone or an imaginary one).
- 3 Select about 10 important health problems that exist in the woreda or zone (try and be creative as you identify the problems). For each of them, score them from 0 to 5 regarding the following four criteria:
 - ✓ Magnitude of the problem
 - ✓ Existence of one or more effective interventions
 - ✓ Feasibility of implementing the intervention(s)
 - ✓ Low cost of implementing the intervention(s)

- 4 Review your list and the scoring and choose three interventions that are highest priority for the woreda or zone to implement during the next year. Assume no additional resources compared to what is available this year in the woreda or zone. You don't have to use the top 3 scorers—the scores are only a tool to help you prioritize. You have to make the final decision based on your knowledge of health problems, feasible solutions, the community's inputs, etc.
- 5 Choose someone to present your group's conclusions. Include in the presentation your logic for including the three health problems you chose and tell how you would implement the three interventions. What strategy would you use in the woreda or zone to ensure that the 3 interventions would have a major and sustainable impact?

USING ROUTINELY COLLECTED DATA AT HEALTH FACILITIES FOR BETTER DECISION-MAKING

- Health facilities can use routinely collected data more effectively if they see the usefulness of it. Many health centers report every month or every quarter because it is a requirement of their job and don't pay much attention to the data they are submitting. If they can be trained to use data (such as the frequency of different complaints) to make decisions about their work, they may begin to take data collection more seriously.
- Sometimes health facilities need to know why people don't come to the health center or health station as well as whether those who do come are satisfied with the service. Exit interviews of clients can be very helpful in learning how to improve clinic services. Local Rapid Assessments can also be a simple, practical means of learning about your clients.

USING NATIONAL OR REGIONAL SURVEY DATA FOR PLANNING AT WOREDA OR ZONAL LEVELS

- Ethiopia has excellent national and regional data available from a variety of sources. These data cover MCH, family planning, and basic mortality and fertility, as well as information on specific diseases such as AIDS, malaria, and tuberculosis.
- Although the health situation varies from place to place (especially regarding malaria), you can use the national and regional survey data when you don't have local data for a particular woreda or zone.
- Sometimes some of the most important health problems (which have inexpensive, feasible, effective interventions) have no relevant data. For example, Vitamin A deficiency may be an important contributor to under-5 mortality in many areas of Ethiopia, yet the magnitude of the problem is not known. Where the problem is important, high-dose Vitamin A capsules should be given to children between 12-59 months every 6 months (at a cost of \$ 02 per capsule).

LOCAL RAPID ASSESSMENTS

There are several ways to obtain useful information for planning and decision-making which can be done by staff at zonal or woreda offices, or even by health staff in health centers. These methods are sometimes called “local rapid assessments” (LRAs). Compared with doing large surveys, they are relatively quick and easy and inexpensive to do.

Why would a zone or woreda want to do an LRA? Sometimes the information available from national and regional surveys is not what is needed or is not very relevant. In that case, a zonal or woreda office or a health center needs simple ways to obtain useful information.

The data collected at health facilities only includes people who come to the health center. All those people who don't come to the center are not included. For example, many mothers may not come to the health center or health station for immunizing their children or for family planning. There are many possible reasons for this. Some examples

- They may not know what immunization or family planning are
- They may not know the service is available
- They may have heard a rumor about the service (such as side effects like bleeding for family planning and fever for immunization) and are afraid to come
- They may be too poor to afford the cost of transportation to come to the health facility
- Their husbands may oppose their coming
- They may think that the only reason to come to a health facility is when you are sick
- They may have heard that there are no medicines at the health center so have no reason to come

- They may have been treated badly (with little respect) the last time they came and don't want to go back
- They may think that they will need money if they come to the health center or health station (to pay for the service and/or to pay for medicines) They don't have enough money to cover the possible costs
- They may prefer traditional healers or practitioners, who live closer to them, are culturally more sensitive, and who are inexpensive

This list could go on and on. The point is that health staff working in a health center or health station cannot know the reasons that people don't come to the facility because they only see the people who DO come

A FOCUS GROUPS

One approach to this problem is to use a technique known as a FOCUS GROUP. A focus group is a group of people (usually 6-8 or so) that you bring together to learn from them.

For this example, let us say that in your health facility you seem to have a low immunization coverage. You're not sure why. In this case you would ask mothers with babies up to one year old who live near the health center or health station to come to the focus group.

You would ask only those who HAVE NOT brought their infants to be immunized to come to the focus group discussion. The purpose of the discussion is to find out from the mothers WHY they haven't brought their children to the health center.

You should give the mothers something for their time (like serving them a snack and something to drink), if possible. A focus group discussion is not a survey. It is a QUALITATIVE technique for obtaining useful information. Surveys are QUANTITATIVE means of getting information. Focus groups are an easy and inexpensive and quick way of getting useful information, especially from clients living in the community. It is also a useful way of getting community input.

Focus group discussions can be done by woreda or zonal office staff as well as by health facility staff. Some questions are important for the entire woreda or zone and should be done by woreda or zonal staff. Since it is easy, quick, and low cost, almost anyone who is interested can do it once they have been trained.

B SURVEY OF 50 NEAREST HOUSEHOLDS

This is another simple technique which can be done to get information quickly and easily. If zonal or woreda or health facility staff want to learn more about why people come or don't come to a facility, an easy way to find out is simply visit the 50 households nearest to the health facility.

You can ask those who DO come to the facility about their opinions of the service. You can also ask those who DON'T come to the health facility why not. In either case, you can obtain useful information for improving the quality of the services provided, for meeting the needs of your clients, and for organizing the health facility more effectively and efficiently. This exercise is very useful for woreda and zonal staff who need to learn more about what the community knows and wants.

There are several reasons for choosing the 50 nearest households to a facility as the sample for the survey

- 1 By choosing the nearest 50 households there is no need for paying for transportation—all the households in the survey are close to the health station or health center
- 2 Also, the clinic or zonal/woreda staff can very quickly reach the households. Usually they are located close together. It is easy to know which households are nearest to the clinic
- 3 Since all the households in the sample are near the Clinic you can be sure that distance, cost of transportation, and travel time are not factors in why people don't come to the health center
- 4 The number 50 is large enough to get useful information without being so large as to take a lot of time to carry out

C CLUSTER SURVEYS

Another useful technique for conducting an LRA is to do a cluster survey. Cluster surveys are more complicated and time consuming than doing focus group discussions or “50 nearest household” surveys, but can be very helpful at times. Very briefly, some of the features of cluster surveys are as follows

- A cluster survey is useful for finding out the coverage level for a program (such as immunization, malaria, family planning, etc)
- Cluster surveys are commonly done to find out the immunization coverage for a given population (such as a woreda or zone or region)
- The most common approach is to choose 30 villages within the catchment area (either at random or in a stratified way) and to go to each of these villages. These 30 villages are known as cluster sites or clusters

- Within each village, the survey team chooses one household at random. For an immunization survey, the first question is, “do you have a child between 12-23 months living in the household?” If the answer is “no,” you move to the next nearest household. If the answer is “yes,” you go on with the survey.
- The next questions determine if the child (12-23 months) had been fully immunized on its first birthday or not and if not, why not. Also included are the vaccines the child had received and at what age.
- For the typical EPI coverage survey, 7 households in one cluster site are found with a child 12-23 months old. With 30 clusters, this gives a total of 210 children and a coverage level can be determined.

EPIDEMIOLOGY-BASED PLANNING

Assumptions

- Assume a woreda which is trying to do epidemiology-based planning has an approximate population of 100,000 people (the same approach can be used for zonal planning, except that the approximate population would be about 1,000,000)
- Assume that the best national estimates for Infant Mortality Rate, Under-5 Mortality Rate, Maternal Mortality Rate, etc apply to this woreda or zone

What can we conclude?

- The crude birth rate in Ethiopia is estimated to be about 48 births per 1,000 population This means that in our typical woreda with a population of 100,000 there are about 4,800 births per year (or 48,000 births in a zone with one million people)
- If the estimated IMR for Ethiopia is about 115 per thousand live births, then we can estimate for our woreda that of the 4,800 babies born this year about 550 of them will die, or more than 10 every week (in a zone there would be about 5,500 babies dying before their first birthday, or more than 100 per week)

- We can also estimate that of the 4,800 women giving birth during the year, about 34 of them will die in a woreda (and 340 in a zone) as a result of pregnancy (based on the estimated national MMR of 700 maternal deaths per 100,000 live births)
- Of the approximately 16,000 children <5 living in the woreda, we can estimate that at least half are malnourished, and that about 800 children are severely malnourished, with a 20-fold increased risk of dying compared with children who are not malnourished
- Of the estimated 23,000 reproductive age women living in the woreda, only about 10% or 2,300 of them are using contraception, even though the majority do not want another child soon

So what can we do with all these numbers? For one thing we can see the job of the woreda or zonal health office as trying to change these numbers. For example, if one infant per week can be prevented from dying in a woreda (through such interventions as measles immunization, better breastfeeding and weaning practices, use of ORT, teaching mothers the warning signs of pneumonia, training more TBAs and CHAs, etc), that can reduce the IMR by 10% and have a major impact on health. In a zone, to have the same impact, ten infants per week need to be saved

Another way of looking at it is to ask yourself,

--“Where are those 550 babies who are going to die in my woreda this year, and what are they dying of?”

--What can I do to find their mothers and make sure that their babies are properly weaned, are immunized, and that the mothers know about ORT and pneumonia (and malaria, if it is a problem in the woreda)

A basic strategy of epidemiology-based planning is the “high-risk” approach

- Which villages, which mothers, which pregnant women are at highest risk?
- How can you reach them with the most cost-effective interventions?

These are the kinds of questions the woreda or zonal office staff need to ask themselves (as do the health workers working in the health centers and health stations) How can the data you collect help you answer these questions?

A key feature of epidemiology-based planning is to use these kinds of demographic data to choose priorities and to decide what should be done. Woredas and zones and health facilities alike never have enough resources (people, drugs, vehicles, etc.) to do what they need to do.

Planning is really about choosing—with your very limited resources what is the best way to use what you've got. Instead of just taking last year's plan and adding something here and subtracting something there, why not start over and use local (the best) or regional (next best) or national data to decide where you can have the greatest possible impact.

One question you might be asking yourself is, "Where does the community fit into all this?" There has been lots of good discussion about the role of community involvement and community participation, of community-based planning and community ownership—all of this is right and very important.

But from the perspective of a woreda office, with 100,000 people to think about, or a zonal office, with a million people to be responsible for, and with many of these people living in remote villages or as pastoral nomads, health officials need to make some decisions about priorities and use of resources

Some of these decisions may have to be made without the kind of community input that one would like. The more community input the better, but not every village (out of hundreds in one woreda or even thousands in one zone) can possibly be involved in making a plan

One other important issue in making a health plan—there are more resources in the woreda or zone than provided by the MOH or by the government. There may be NGOs (such as mission hospitals or clinics) as well as traditional practitioners (including rural drug vendors), or even private doctors and nurses providing health care outside the government system. When a planner thinks of resources, he/she should think of ALL the resources that can be used

EPIDEMIOLOGY-BASED PLANNING

- Assumptions for a typical woreda or zone
- Basic rates
- What are the numbers for the woreda or zone
- What does this tell us about the job of the woreda or zonal health office
- How do the numbers help to prioritize and choose interventions
- High-risk approach
- Planning is about choosing
- What about the community
- What about the private sector and NGOs

SESSION GUIDE

Session VIII Planning for Quality Improvement

Purpose

Improving the quality of health services is one of the most important things we can do as health managers and trainers. The purpose of this session is to become familiar with tools and approaches that can be used in health facilities or in zonal and regional offices to improve the quality of services or of management. There are many tools and approaches that have been developed to improve the quality of the work we do, but all of them have in common a focus on the client, teamwork, and improving quality on a continuing basis. This session will enable participants to develop a clear understanding of how quality improvement can be planned for more effective implementation.

Duration 3 hours

Session Questions

By the end of this session, participants should be able to answer the following questions

- What is Continuous Quality Improvement (CQI) and how can it be used to improve quality at health facilities or administrative offices?
- What is an example of an area where quality could be improved in a health facility or in a zonal or regional office and what are the basic steps involved in making the necessary changes to improve quality in that area?
- What is meant by “quality standards,” and what would be an example of a quality standard applied to health centers or health stations?
- What are the major planning steps required for a health facility or zonal/regional office to undertake a CQI initiative?

PLANNING FOR QUALITY

During the 1980's and early 1990's in developing countries there was a boom in construction of primary health care facilities and in training of large numbers of primary health care workers. Over the last 5 years or so the international trend has been a shift from building new health centers and health stations and training more staff to a concern for "quality." Now that access to service delivery has gotten much better in many countries, it is possible to focus on making sure that when providers and clients interact the quality of the interaction is positive.

In Ethiopia, however, due to the war which went on for so many years, there is still a major problem in that there are not enough health facilities for the population and there is also a shortage of primary health care workers. It could be argued that there is no need to worry about quality since the priority needs to be construction, renovation, and training. This attitude would be wrong, since a concern for quality is important regardless what other priorities there might be. If health services are of poor quality, patients (or clients, which is now the preferred term) will not want to come back to the health facility and they will be less likely to do what the health worker advised them to do.

There are several different approaches to improving the quality of services delivered at health facilities. But one of the most effective approaches that has worked in many countries has been that of Continuous Quality Improvement (CQI). CQI can be done in a health facility with the health staff working as a team or it can be done in zonal or woreda offices, with the office staff working as a team. In either case CQI can help improve the quality of services, whether directly in a health center or indirectly through improved supervision and support from a zonal or woreda office.

Planning and Managing Decentralized Health Systems Course—September 7-11, 1998, Addis Ababa

Please answer the following questions and rate each session by circling the appropriate number

Poor Fair Good ^{Very} Good Excel

1 SESSION 1—The Planning Cycle

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like most or least about this session

2 SESSION 2--Regional Experience in Planning and Management Training

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like most or least about this session

3 SESSION 3—Logical Framework

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like most or least about this session

4 SESSION 4—Using Data for Planning and Decision-Making

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like most or least about this session

5 SESSION 5—Monitoring and Evaluation
Experience from the SNNPR

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like most or least about this session

6 SESSION 6—Preparing for Planning and Management
Training

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like most or least about this session

SESSION 7—Proposal and Project Writing

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like most or least about this session

8 SESSION 8—Planning for Quality Improvement

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like best or least about this session

9 SESSION 9—Preparing for Planning and Management
Training Drafting Session Plans

- A) Relevance of the information presented to your job
- B) Overall usefulness of the information presented
- C) Quality of the trainers
- D) Effectiveness of the materials
- E) Overall satisfaction with the session

What did you like best or least about this session

Do you have any overall comments, criticisms, or suggestions about the course with respect to

10 The duration (too long, too short, just right, etc) _____

11 The choice of topics (relevant, varied, etc) _____

12 The pace of the course (too slow, too fast, just right) _____

13 Will this course be useful to you in your work (circle one) Yes No

14 Would you recommend this course to a colleague (circle one) Yes No

15 Other comments

APPENDIX B
LIST OF COURSE PARTICIPANTS

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**Participatory List
For the Planning and Managing Decentralized Heal System
September 7-11, 1998**

Name	Title	Region
Ato Hayelom Tafere	Regional Training Center member	Tigray
Ato Kashu Bekureatsion	Central Zone Health Dept , Health Services and Train Team Leader	“
Ato Awala Equar	Western Zone Health Dept , Health Services and Training Team Leader	“
Dr Abdurahman Abdulahu Abdi	Health Services & Training Department Director	Somali
Ato Ahmed Sheikh Mohamud	TOT from Regional Training Center	“
Dr Bedri Ismael Ahmed	Health Services & Training Dept	Harari
Ato Abdulfetah Mohammed	RTCH Team Member	“
S/r Meliha Aliye	Training and Team Leader	“
Ato Okelo Akuay	Planning and Programming Services Head	Gambella
Ato Samson Oli	Training Team Acting Leader	“
Dr Tilamun Ale Mussien	Head of Health Service Department	Amhara
Dr Dejene Fanta	Head of Regional Training Center for Health	“
Ato Getu Molla	In-service Training Expert	“
Ato Melese Zwdei	Health Service Dept Expert	A A City Gov't Health Bureau
Ato Tesfu Mehari	Pharmacy Head	“
S/r Nigist Afework	Training Expert	“
Ato Kissi Buli	Training Department	Benshangul
Miss Medferiashwork Abebe	Womens Affair Expert	‘
S/r Kribnesh Tefera	Expert	SNNPRG
Getachew Assefa	RTCH Team member	SNNPRG
Asrat W Meskel	Head RTCH	SNNPRG
S/r Momina Abdella	RHB CDC Head	Afar