III MCH Promoters System

(1) Introducing MCH Promoters System

(i) Application of the system

If your township has a problem of geographic disparity in health status, high maternal mortality due to poor access to health service by the community people, and overloaded midwives (MW) due to a scarce human resource, Maternal and Child Health Promoters (MCHP) system might be a solution. The system was designed to bridge community people and quality health service by introducing reproductive health focused community volunteers.

(ii) Preparatory arrangement

[1] Defining the roles and responsibilities of MCHP

The first thing to do for introducing MCHP system is to set tangible goals and define the roles & responsibilities of MCHPs.

The CORH Project set the goal as "to increase access to quality health care," and defined the roles and responsibilities of MCHP as "*bridging* mothers to SBA such as LHV and MW." MCHP help pregnant women to take a series of reproductive health care service: antenatal care; safe delivery; and post natal care including child health care. The roles and responsibilities of MCHP are written in the MCH Promoter Handbook and are taught at the qualification (initial) training.

In order to maintain the system as sustainable and manageable, we recommend that you start the system with **minimum expectation**. One of the lessons learnt from the experience in Northern Shan State was that we expected too much of MCHP to achieve even a minimum expectation: finding a new case of pregnancy and report it to a midwife in time, wherever she is. After three years of system implementation, the trial resulted in a large disparity in performance by MCHP, because we not only asked the MCHP to submit monthly reporting format but also to give health related information to mothers and to work as an assistant to MW on the immunization days. Some are very active referring new cases of pregnant women and helping MW not only on the immunization days, but others would stop working soon after the qualification. We should keep in mind that **MCHPs are volunteers**, not government employees. The capacity of volunteers differs considerably between individuals, because they take only one-day training for qualification. Their priority in MCH activity is not always high, as they have many things to do for their living. You may think about expecting MCHP for further tasks only after your initial minimum expectation has been achieved.

[2] Human Resource Development

Overview

Step 1 **Management Trainings**	Two trainings should be held for those BHS who are expected to be local level managers. • Leadership and Management Training • MCHP Trainers' Training (ToT)
Step 2 **Candidate Nomination**	Developing selection criteria and designing the distribution and the number of MCHP.
Step 3 **Qualification & Appointment**	Candidates are qualified after successful completion of the one-day initial training, which will be held once every two years. With a certificate issued by DMO/TMO, they are officially allowed to start MCHP activities in the community.

Step 1: Management training

Training BHS (i.e. LHV, HA, MW and PHS I/II) on management is necessary because they are expected to play the most important role in the MCHP system: local level managers. Particularly, it is important to train midwives, because they are usually not trained in management. Two kinds of training should be held before starting MCHP system: 1) Leadership and Management Training for BHS; 2) MCHP Trainers' Training (ToT).

Series of management trainings should be started after the official launching of MCHP system, several months before commencement of the MCHP activity, although CORH Project started the trainings only one year after the introduction of MCHP system. Suggested programs and materials for the trainings are attached in the Annex 1 of this chapter.
The Project conducted leadership and management training in August 2008 and August 2009. The first training, focused on teamwork building among MW-AMW-MCHP and leadership by the midwife, and the second

training focused on the effective supervision by BHS towards the improvement in the overall MCH service.

These trainings in the Project were conducted in specially arranged occasions, in which all the BHS were gathered in the township hospital at once, but most of them can be also conducted at monthly meetings, such as CME (Continuing Medical Education) in order to save the cost for the implementation.

Step 2: Candidate MCHP selection

a) Development of selection criteria

Selection criteria for MCHP should be developed several months in advance of the MCHP recruitment process to be in time for the qualification training. The criteria should reflect the local situation such as urban/rural proportion, age and sex distribution, ethnic group distribution, health system sufficiency level, and geographical conditions. Although peer education is one of the most expected roles of the MCHP System, male MCHP may be discussed at villages where very few eligible women are available.

MCHPs need to be selected by BHS and community representatives based on the selection criteria. In the Project, the first selection criteria were developed in 2006. The criteria consisted of gender, marital status, and experience in child rearing.

The initial criteria were reviewed in 2008 based on the recommendation after the practical use for two years. It was relaxed in terms of the experience of giving birth and child rearing. On the other hand, the criteria were tightened in terms of Myanmar language literacy; only those who can read and write were allowed to be a candidate MCHP under the new criteria. By reviewing the selection criteria, we were able to reduce the number of MCHP with no formal education significantly [1].

Box 3-1 Selection Criteria for the Maternal and Child Health (MCH) Promoters

MCH Promoters should be selected based on the following criteria:

1) Is interested in working for the health of women and children of her community;
2) Is a married woman preferably with child rearing experience;
3) Is able to read and write;
4) Is friendly and well trusted by the community people;
5) Has free time to do and participate in the activities of the MCH Promoter;
6) Is willing to cooperate, coordinate and collaborate with the Basic Health Staff (BHS) and local authorities.
7) Has a good manner (i.e. good listener and not to disclose the personal matters and data obtained through the MCH Promoter's work).

[1] MCHP Profile Analysis, 2009

b) Selection process

The selection process takes a few months. Although the Project started the process in September 2008, for the training sessions from December 2008 to January 2009, still10% of the participants list were replaced by someone who had not been in the original candidate list.
BHS participation in the selection process is essential, because they work closely with MCHP and should have direct responsibility of the activity. BHS should take initiatives for the selection process when it is supported by Village Tract Working Group (VTWG).

Step 3: MCHP Qualification (Initial training)

a) Schedule

To minimize the last-minute change of MCHP candidates, and to keep the qualification process well organized, the training should be scheduled to take place during the agricultural off-season. It is also recommended to avoid the rainy season to minimize the participants' absence because of difficulty in traveling. Also December should be avoided as many of midwives are busy for the annual head-count reporting.

b) Program and contents of initial training

One-day training is held for qualifying MCHP. Schedule coordination can be done during ToT (see Annex 2 of this chapter for sample program of ToT) among DMO/TMO and BHS. The Project held 68 training sessions from December 2006 to January 2007 and trained 1,672 MCHP from over 600 villages in the two townships.

Program and contents of initial training are customized by the training batch. In the qualification training for the first batch MCHPs, a lot of role-playing was used. Role-playing is quite effective to describe the images of what are MCHPs, and is considered suitable for the first batch trainees who know little about the system.

On the other hand, in the second or later batch trainings, the proportion for experience sharing and case studies was increased. The purpose of experience sharing is: (1) trainees can learn more practical knowledge and (2) seniors can feel proud of themselves for the contribution, while the purpose of case study is to improve technical skills in activities.

MCH Promoters Trainers' Manual (For the second and later batch training) is attached (Annex 3 of this chapter).

c) Qualification

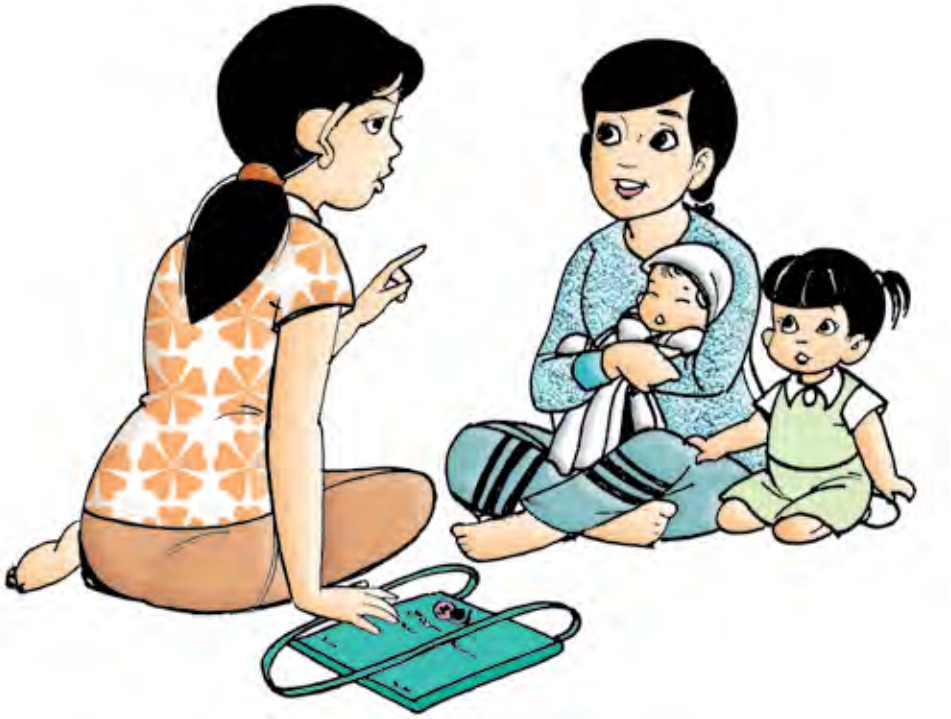
At the end of any qualification training, participants who successfully completed the training will receive certificates issued by DOH (either DMO or TMO). By receiving a certificate, a participant will be officially qualified as an MCHP and will be allowed to start working as MCHP. Those who are absent at the first qualification training are not allowed to work as an MCHP.

The certificate was designed for two years validation, and this needs to be mentioned in the certificate. Those who wanted to continue MCHP activity over two years are expected to take another qualification training after every two years. The second batch qualification trainings were held from December 2008 to January 2009.

No matter how difficult the access is, MCHP qualification training was held only once at a venue, and supplementary training was not available for absentees in the Project. It meant that if one failed to attend the training, she could not be qualified as MCHP.

Recommendation

Midwives should give supplementary training to the absentees of the qualification training.



(2) Keeping the MCHP System on Track

In order to keep the MCHP System on track, there are things to be taken into consideration. System management and supportive supervision are particularly important functions. In this section, you will learn how the CORH Project ran the system with lessons learnt.

(i) Appointment and Tenure

The Project allowed MCHP to start their activity after the initial training for two years. The tenure and starting date needs to be mentioned in the certificate issued by DMO/TMO after the completion of the initial training.

(ii) Working Condition

[1] Workload

The system was designed so that an MCHP takes in charge of around 30 households. The number is such that an MCHP is likely to have 1-2 pregnant mothers in her appointed area at any particular point of time, which is derived from the population size and the average number of deliveries reported in the village per month. The actual number of households in charge in the Project, however, ranged from 5 to 63 [2] when one is considering of the actual workload.

Workload may vary according to geographical condition, age sex distribution, urban-rural difference, presence of midwife and AMW, or individual capacity of MCHP. Workload also varies according to the season and the livelihood of MCHP. When majority of MCHPs are farmers [3] , their activity may be suspended during the busiest season of farming. MCHP with a family who needs special care and attention (e.g. baby, elderly, or sick family), or those who have less support from her families often find it difficult to continue working.

In the Project areas, where there is no formal substitute system, a small number of highly motivated MCHP spontaneously cover up their colleagues, taking care of their responsible household, where for some reason, other MCHPs were no longer active. In those cases, the number of households covered by one MCHP may rise up to 60 households.

[2] Rights & Protection

For the nature of un-paid volunteers, MCHP are currently not covered by any work injury compensation scheme. Since in reality some of the MCHPs are taking risks of health or lives during their activity, the administration should take this responsibility into consideration. In 2009, one MCHP died in a traffic accident during an immunization activity. Although the family did not claim compensation for the loss, many people, including senior level officials, offered condolence to the family of deceased. It will

[2] MCHP Profile Analysis, 2009

[3] In the CORH Project townships, the proportion of farmer was 84.2% in Naungcho, 56.6% in Kyaukme. MCHP profile analysis, 2009

be good if the administration or the community can pool small amount of money in a community welfare account for insurance purposes, as well as to take feasible measures to prevent predictable damage.

Recommendation

To introduce a community level compensation program.

[3] Incentives for MCHP

- Training and learning opportunities

The Project provided MCHPs with four training opportunities within 2 years between December 2006 and January 2009: two qualification trainings (2006 and 2008) and two refresher trainings (2007). The Project also encouraged BHS to hold regular refresher trainings (Continuous Health Education: CHE).

- Exemption from duties

In the Project area, some villages provided MCHPs with exemption from their regular community duties. The duties include regular environmental sanitation activities: cleaning sewage; cutting grass, and other volunteer work: such as night watches. Some MCHPs were also reportedly released from family duties: cooking, cleaning, or taking care of children.

- Awarding

Some are proud to be MCHP, and recognition by local people apparently motivates many MCHPs. Seventy-five percent of MCHP who extended the tenure for another two years answered that they felt proud of being MCHP, when most of villagers give them recognition as MCHP [4]. Awarding outstanding MCHP may also be effective to motivate some MCHPs. However, we should keep in mind that awarding limited number of MCHP will discourage the large number of those who are not awarded. Ideally we should increase the number of MCHPs encouraged, but not to increase the number of MCHPs who feel discouraged.

Certificate given at the end of qualification training and letter of appreciation or recognition given by the local authority also apparently motivate MCHPs to carry out their work.

- In-kind (material) incentives

Project provided working materials which may have been a part of the incentives. Provided materials are an MCHP Handbook (Annex 4 of this chapter), notebook, a ball pen, an MCHP badge, and a carry case for each one of the MCHP.

[4] A result of self-administered questionnaire, conducted by CORH Project in December 2008 to January 2009 (n=1,101)

(iii) Renewal

[1] Facts about renewal

After two years of MCHP system implementation in the Project townships, 66% of the first batch of MCHP showed their interest in renewal and attended renewal training in 2008-2009 [5].

Table 3-1: Number of MCHP by training

No.	Data	Kyaukme	Naungcho	Total
①	MCHP qualified in FY2006 (First Batch)	970	702	1,672
②	Participants in FY08 training	950	704	1,654
③	MCHP qualified in FY2008 (Second Batch)	320	233	553
④	MCHP renewed in FY2008 (First Batch)	630	471	1,101
⑤	Renewal rate (④/①x100)	64.9	67.1	65.8
⑥	Accumulated Number of MCHP '06-'09 (①+②)	1,920	1,406	3,326
⑦	Ever been qualified as MCHP '06-'09 (①+③)	1,290	935	2,225

[2] When and how often?

MCHP will be renewed every two years, because the system is designed for a two-year cycle following the Japanese system. Two-year is an interval not too short for MCHP to get accustomed to the work, and not too long for them to keep their motivation. It also gives enough time for the administration to make necessary arrangement for renewal. The Project started the renewal process in September 2008, from reviewing the selection criteria. It ended up with the last MCHP training session which was held on the 17th January 2009.

[3] Reviewing selection criteria and adjusting the number of MCHP

Member renewal process is a perfect timing for reviewing old selection criteria and adjusting the size and distribution of MCHP recruit to well address the MCH issues in your township. For example, the Project limited the gender of MCHP only to females; the preference of gender may be discussed during the review process in accordance with the condition of your township. It is also important to start the review process well in advance of the next batch nomination.

(iv) Refresher Trainings

[1] Objectives

The Project conducted refresher trainings for MCH Promoters in May and December 2007, 6 months and one year respectively after the initial training, in order to improve and sustain

[5] MCHP profile analysis, 2009

their knowledge and update information necessary for their activities. Refresher trainings featured up-dating knowledge, case studies on referral, and experience sharing. Some BHS also conducted periodical Continuing Health Education (CHE) as refresher training. Refresher training not only helps to overcome challenges in their daily activities, but it also becomes an incentive for MCHPs.

[2] Contents of refresher trainings

In addition to covering the basic topics, it should be also recommended to consider including some additional topics if necessary. The Project added some new components shown below, which are based on the needs assessment and interviews of the MCHPs.

- Exercise for pregnant women: Based on the needs assessment of pregnant women, exercise for pregnant women was introduced to MCH Promoters for enhancing physical condition of pregnant women by doing simple exercises on their own (Annex 5 of this chapter).

- Additional role play: Role play is easy for MCHPs to understand the sociological relationship and role of each stakeholder. Such role plays could be done to stipulate a possible conversation among a pregnant woman, conservative mother-in-law, husband and MCHP. Another role play can be done among a midwife, a husband with traditional idea, a pregnant woman and MCHP. Basic situation needs to be prepared by the trainer. One play on the average takes 5 to 7 minutes.

[3] Utilization of Continuing Health Education (CHE)

At RHC and Sub-RHC level, midwives can also utilize the time of the monthly continuing health education (CHE) for refresher training, even if they cannot conduct refresher training at the same time in the conventional way. The midwife gathers as many MCHPs as possible to conduct their own refresher training sessions by themselves at her center.

If possible, the midwife can provide some of the IEC/BCC materialssuchashealtheducation materials and pamphlets on the subjects, to make them understand effectively.

(v) Performance Monitoring and Supervision

[1] MCHP performance monitoring

The Project introduced a monthly reporting format for monitoring performance of MCHP. Although some MCHPs actually used the format and reported to midwives, in general, the format increased workload of both MCHPs and midwives (also see Part 3, Chapter VI "Skills on Data

Collection by MWs, AMWs and MCH Promoters"). The nature of self administered report, data are subjective and will not give midwives helpful information. For example, although MCHP reports show that she has given some health-related information to pregnant women, it does not reflect the actual number of women who received proper health education.

Some midwives encouraged a form of group reporting to increase the number and frequency of reporting. It seems to work in some part of the villages, but it still has cause for concern and may not be a perfect solution (see Box 3-2 "Information: Group reporting" below).

Box 3-2 Information: Group reporting

Group reporting is a method that an MCHP collects colleagues' reports and submits them to MW. This kind of teamwork apparently improves quality, quantity, and timeliness of data, particularly in hard-to reach areas.

In Narr Khaw village under Loi Khoe Sub-RHC, Kyaukme Township, an MCHP voluntarily collects monthly report of other MCHPs and submit them to the midwife every month. The MCHP who runs a grocery store collects and submits reports monthly, because she has a fixed place, and her colleagues often visit her place for shopping. She also has frequent chance to come downtown for purchase and can see the midwife.

Similar method was observed in other parts of Kyaukme Township and Naungcho Townships. In some cases, MCHPs take turns to collect and submit monthly reports. Some help each other for filling in the monthly report format, in case their colleagues' writing proficiency is not adequate.

One of the concerns of group reporting is, however, disproportion of MCHP workload. If a fixed person takes responsibility of collection and submission of monthly report or takes care of helping someone's report, the workload of this MCHP may become heavier than other MCHPs. It may not be sustainable without any incentive.

Quality assurance of the report is also a concern, because the report submitted by someone else cannot be checked and corrected at the scene. In case the report is helped by an unqualified person, the report may not be filled in correctly.

[2] What data are essential and who is responsible?

The Project collected two kinds of data from MCHP system other than by monthly report format (Table 3-2 "Type of data collected by the Project from MCHP System" on p. III - 12): data for management purpose and data for surveillance purpose. Management data include profiles of MCHPs, reports the number of home visits, which monitor the MCHP performance. Surveillance data

include number of pregnant women and children under 5, emergency referral, and number of immunized children, which reflect community public health status.

Recommendation

To establish a performance monitoring system, introduction of a reliable and light-load monitoring system should be discussed. Utilization of Home-Based Maternal Record (HBMR), verbal reporting may be potential measures.

(vi) Attrition

It is important to keep updating registration record for management purpose, because it affects coverage of the services. Although some MCHPs discontinued the MCHP activity for various reasons, and some MCHPs died during the program [6], it was quite difficult to collect these data, because some MCHP leave the system without telling their midwives.

It was not possible for the Project to know the actual causes of MCHP's drop outs. There is a concern, however, that the vacancies may slow down the progress, if the vacancy can not be filled by somebody soon and we will not take any action to prevent some more drop-outs. These vacancies generated by the attrition were not filled until the second batch appointment in FY2008.

Recommendation

Vacancy should be filled at anytime without waiting until the next renewal and recruitment process. VTWG together with responsible BHS should be encouraged to take every effort to fill in the vacancies immediately, otherwise it may slow down the progress.

There should be a reporting system to know attrition of MCHP as well as ad-hoc recruitment opportunity to fill the vacancies if the attrition rate exceeds to some extent.

[6] A JOICFP assistant field officer recalls three cases of death among MCHPs who were qualified in 2006.

Table 3-2 Type of data collected by the Project from MCHP System

Category	Data	When collect the data?	How often update the data?	Hard/Soft	Use	Who's responsible for data collection?	Who's responsible for record keeping?
MCHP Profile	Full name	Enrollment	If there is a change	Hard/Soft	Management: identification	MW in charge	MW in charge
	Age at enrollment	Enrollment	no	Hard/Soft	Management: Eligibility criteria review etc.	MW in charge	MW in charge & township hospital
	Education background	Enrollment Renewal	Time at renewal, but keep the record at the enrollment	Hard/Soft	Management: Eligibility criteria review etc.	MW in charge	MW in charge & township hospital
	Occupation	Enrollment	Annual	Hard/Soft	Management: Eligibility criteria review, performance monitoring etc.	MW in charge	MW in charge & township hospital
	Training Attendance	Training	at every attendance of training	Hard/Soft			
	Death	Whenreported	irregular		Management: service coverage		
	Resignation	When reported	irregular		Management: service coverage		
	No. of Household	Enrollment					
Monthly Report	Number of pregnant women	As soon as reported	Monthly	Hard	Surveillance	MW in charge	
	Number of U5 children	As soon as reported	Monthly	Hard	Surveillance	MW in charge	

(vii) Support System and Supervision

Supports and supportive supervision from various stakeholders in the community are crucial for MCH Promoters to continue working as non-paid volunteers. The major supports for MCH Promoters are as follows.

By MW

Midwives are responsible for periodical supportive supervision to MCHPs, particularly when they collect data from MCHPs on immunization days. As a local level manager for MCHP system, midwives are also responsible for taking leadership and initiatives for building better teamwork among volunteers, service providers, and community people.

By AMW

Although some AMW are given tasks to supervise MCHP in areas where there is no MW, the overall level of collaboration between MCHP and AMW is not high, compared to MCHP-MW [7]. Ideally, it is recommended to strengthen collaboration of MCHPs with the AMWs.

By Senior BHS

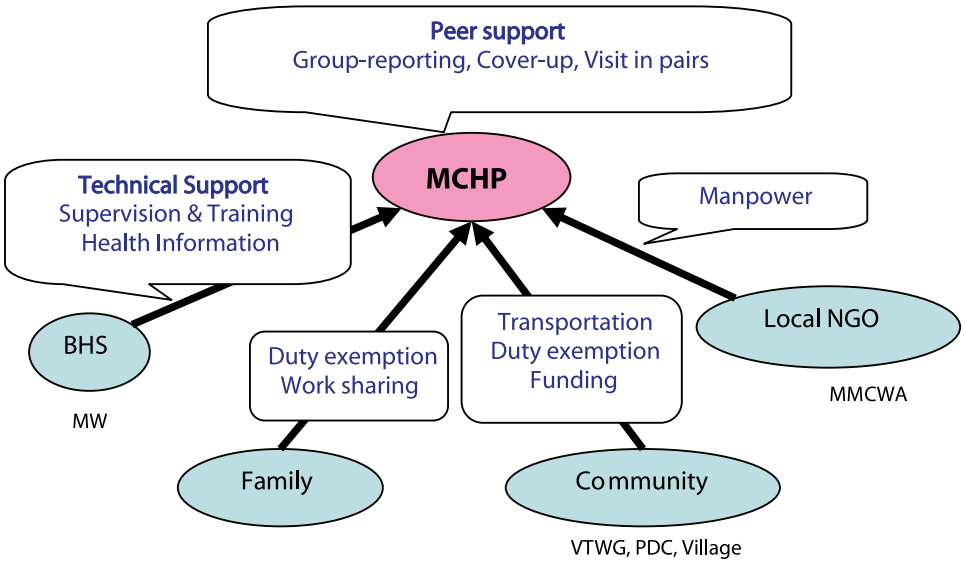
Although some senior level BHS such as LHV directly supervises the MCHPs, they are, by right, supposed to supervise MW primarily. MWs are often waiting for help from their seniors, because they are often too busy to manage the MCHP activities effectively, being given multiple roles and tasks, and responsibilities, from maternal and child health to infectious disease control, and sometimes they need to participate in village level planning. Senior BHS (HA1, LHV, HA, PHS) are expected to provide supportive supervision to MW, for the better management of the MCHP system.

By Colleague MCHP (Peer Support)

Some MCHPs form small groups (usually in pairs) and make home visits together. It is also customary among many MCHPs, to help each other temporary during the farming season. Group reporting has been tentatively started in some of the villages (Box 3-2 "Information: Group reporting" on page III - 10).

[7] M. Kinoshita, Levels of collaboration assessment among MCH service providers, June 2009

Chart 3-1 Major Support for MCH Promoters



Senior and Junior Relationships

A result of the levels of collaboration assessment suggested that the collaboration level between the first batch MCHP and the second batch MCHP was not so high[8]. Improvement of senior-junior relationship may be discussed, because senior MCHP may be more suitable as proximal resource for some junior MCHPs than the MW.

Family

Although some MCHPs are released from family duties when they are engaged in the MCHP activities, many MCHPs who take care of their family (their sick family, children, elderly family, or relatives) find it difficult to continue MCHP activities.

Neighbors

The level of collaboration with neighbors is very high[9]. It suggests that MCHP may likely to get help from neighbors for manpower, communication, transportation, etc.

Community Leaders (PDC Chairpersons, Village Heads)

PDC chairpersons and Ten/hundred household heads are known as reliable supporters for MCHP System. Their support is manifested particularly in emergency referrals. They have the legal authority to organize community people, and can approve disbursement from community funding account (e.g. Community Welfare Fund).

[8] Same as 7.
[9] Same as 7.

(3) Challenge of the MCHP System

Sustainability

Lack of operational cost is the biggest challenge to sustain the MCHP System, because we cannot manage the system properly without budget for training and supervision. It is also difficult to keep attracting volunteers without providing some kind of incentives.

Utilization of local and existing infrastructure is a must to discuss, before seeking support from outside. Community Welfare Fund (CWF) is one of them, which may possibly cover the operational cost, because it has many precedents of application for RH service, particularly in emergency referral. We may explore the application of CWF as a source of some kind of incentives. Expansion of exemption of duties may also be a powerful incentive to attract MCHP.

Box 3-3 Information: Explore inter-sectoral collaboration with school teachers at the township level

Based on the PDC chairperson's initiative for Township Working Group (TWG) members' collaboration[10], an attempt was made to explore inter-sectoral collaboration between health and education in February 2009. A meeting was held at each township, among township health sector representatives (TMO or THO), township education officers (TEO), and representatives from the CORH Project. Future collaboration in reporting and MCHP training were discussed.

Although this idea of inter-sectoral collaboration was not materialized during the Project period, we must admit that it is very powerful tool, and it may enhance the effectiveness of the MCHP system significantly. Training school teachers as MCHP, and asking teachers to participate in the trainings as assistants (e.g. interpreters) may be a possible way of collaboration.

Attached:

Annex 1. Leadership and Management Training for BHS, Facilitator's Guide
Annex 2. Program for MCH Promoters Trainers' Training (TOT)
Annex 3. MCH Promoters Trainers' Manual
Annex 4. MCH Promoter Handbook
Annex 5. Exercises for Pregnant Women

[10] Minutes of TWG meeting (Kyaukme), January 2009

Chapter III - Annex 1

Leadership and Management Training for BHS

Facilitator's Guide

Background:

The Community-Oriented Reproductive Health Project (also known as Healthy Mother Project) provided a series of trainings for midwives (MWs) and auxiliary midwives (AMWs). It was expected to strengthen quality reproductive health services, as well as introduce Maternal and Child Health Promoters (MCHP) System which is expected to enhance MCH promotion at community level by linking community with reproductive health services.

In August-September 2007, JICA mid-term evaluation team recognized considerable achievement of the Project and recommended strengthening the teamwork among Basic Health Staff (BHS), AMWs, MCHPs and local authorities/organizations for further increase in the utilization of quality reproductive health services. The first leadership and management training was held in August 2008 with the aim to enhance collaboration and teamwork among SBAs, AMW and MCHP. With a strong commitment from DOH central, the training completed successfully with tangible results: 1) highly motivated action plans developed in a participatory process, 2) participants' high satisfaction, 3) newly developed manual and 4) improvement in pre/post test scores.

In order to consolidate the gains and enable more comprehensive and realistic approach of the Project, CORH Project organized a second two-day leadership training in August 2009, inviting over one hundred BHS from the two townships. The specific purposes of the second training are: 1) To fix the skills and knowledge on SBA and let them be in practice by repeating the training; 2) To enable more comprehensive approach by expanding training target to all BHS; 3) to build township level capacity for organizing the leadership an management training for sustainability of the MCHP System.

Acknowledgement:

This manual was jointly developed by MCH section, DOH and JICA/JOICFP CORH Project team.

The original version (2008) referred to the following resources:

The Myanmar Township Reproductive Health Management Training Manual, DOH/WHO.

Managers Who Lead, Management Science for Health (MSH).

The revised version (2009) referred to the following resources:

Guidelines for Implementing Supportive Supervision: A step-by-step guide with tools to support immunization, Children's vaccine program at PATH, Seattle: PATH, 2003.

Supportive supervision for quality improvement: Training of trainers guide for health professionals: facilitator's guide, IPPF, 2006.

Table of Contents

DAY 1

Opening Session: (45 min)

1. **Opening speech**
   - Guest speakers

2. **Introducing participants**
   - Introduce yourself to all participants
   - Introduce other trainers
   - Self introduction by individual trainees (Name, Position, Village)

(15 min Break)

Session 1: Introduction (45 min)

1. **Pre-training self-assessment (10 min) (Annex 1)**

2. **Overview of the program (10 min)**

Materials to be Prepared:

☐ Handouts “Time Schedule“ (Annex 2)

☐ Flipchart 1 (Learning Objectives)

Explain about the training

Strengthening the community support system by building teamwork among BHS, AMW and MCHP is important to increase the utilization of quality reproductive health (RH) services. Leadership is an essential element to build a sustainable teamwork. We will learn some of the effective skills for leadership and management at this training, and we will discuss possible application of these skills in our routine work. At the end of the training, we will be able to develop an actual supervision plan.

Explain learning objectives with flipchart 1 “Learning Objectives”.

Learning Objectives

By the end of the training, you will be able to:

1. clarify the roles and responsibilities of each BHS for leading reproductive health activities in the community
2. describe the whole team members and their roles for leading the reproductive health activities in the community
3. tell when you need to take a leadership
4. identify the types of leadership skills needed for your daily practice
5. be motivated to apply some of the supportive supervision skills for routine practice
6. develop a practical and effective supervision plan for improving RH in the community

3. Set up Group Norms (5 min)

Materials to be Prepared:

☐ Plain flip sheets and markers

Ask participants to set up some rules for the training

Write their answers on the plain flip sheets and put on the wall

Example: Do not talk while the facilitator talks

Come on time every day

Be enthusiastic to join the group discussion etc.

Explain about “Recap” before the session starts. From the 2nd day of the training, participants will “recap” the previous day sessions. One person will summarize the key points of the session of the previous day for 5 minutes.

4. Training expectations (10 min)

Ask participants what their own expectations are of this training.
(You may use Guiding questions below, if necessary.)
Write their answers on the flip sheets and put on the wall
Explain that we will review this at the end of the training, and check on how far the expectations are covered.

Guiding questions:

- What do you see as a personal goal of this training?
- What do you see as a goal for your jurisdiction?
- What are the outcomes I would like to have after this training?

Session 2: Situation Analysis (75 min)

In this session, participants will review the current team dynamics for community RH service. Who are the key partners? How each of the partners is linked with each of the others? What are the roles of each BHS at the workplace?

Explain

Session Objectives:

- To share the understanding of who are the essential partners in RH service provision
- To review the duties and responsibilities of BHS in the RH service and the current practice
- To understand how BHS are expected to be taking the supervising roles in the system

Teaching Method:

- Plenary discussion

2-1. Key players in RH service provision and their current practice in supervision (15 min)

Materials to be Prepared:

- ☐ Key health workers cards
- ☐ Plain flip sheets
- ☐ Markers
- ☐ Flipchart 2 “BHS-MCHP-AMW Triad”
- ☐ “Duties and Responsibilities of BHS in RH Service” (Annex 9)

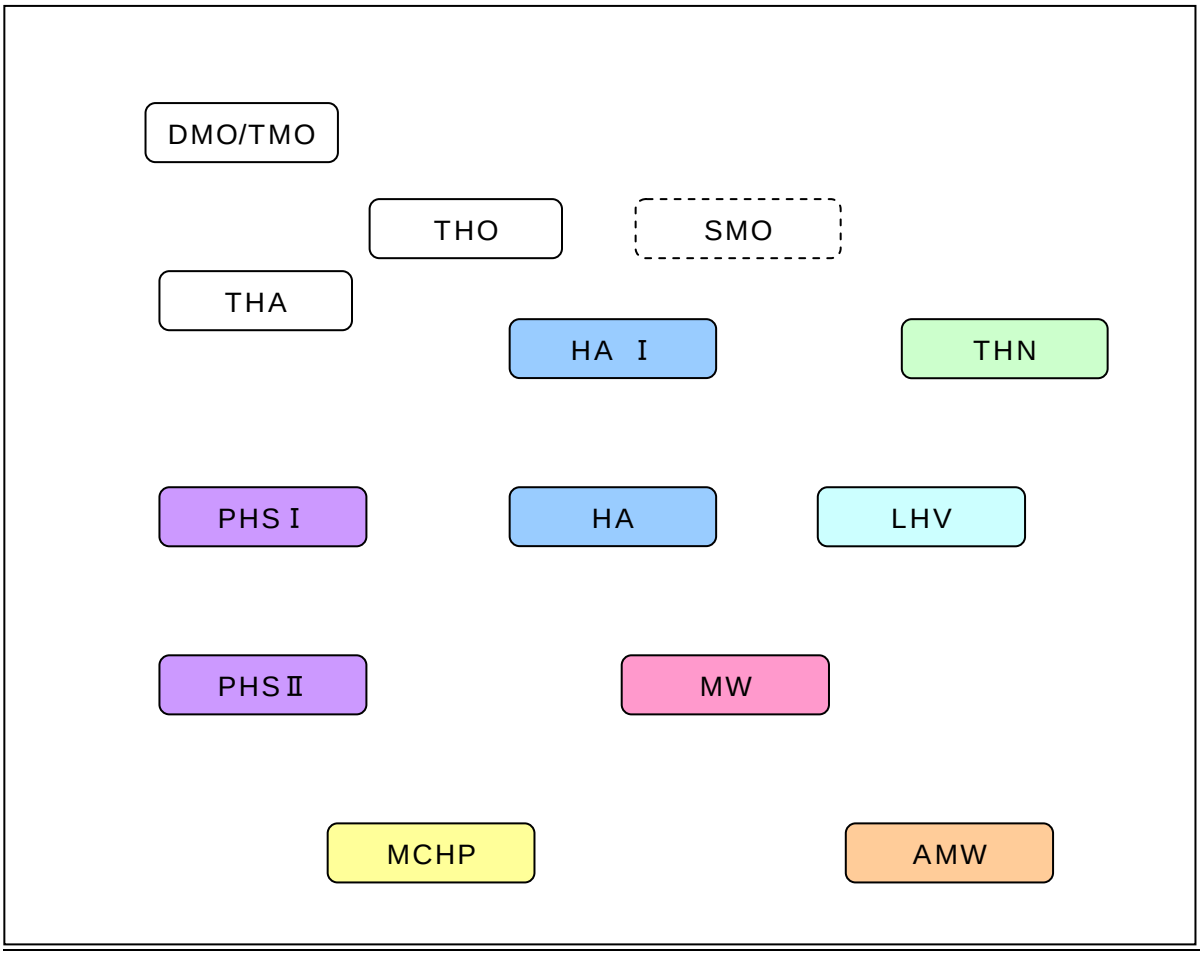
Explain

BHS have lots of duties and responsibilities to work for the communities, as front line health workers in the fields. In order to work effectively, it is important for you to review the necessary duties and responsibilities as BHS. We will start by listing up key health workers in the community RH system, and detect any challenges in their work.

In this session, we will particularly focus on supervision, because it is the most important and common duty and responsibility for all BHS. Every BHS has duties and responsibilities of supervising their juniors, no matter what the type of service is. Without effective supervision, no one can provide quality health service.

Ask participants to name key health workers in community health work, and place those cards on a plain flip sheet. Make sure all workers’ cards are placed on the flip sheet (find the sample placement of cards in next page).

Sample placement of key health workers cards



Ask participants to draw arrows which represent supervisory relationships among the health workers. You may start asking about MCHP; '"who supervises MCHP?", "Who supervises MW?", or "How about AMW?", then, draw **a thin line**. The direction of an arrow should be "**supervisor → supervisee**." You may ask some participants to draw arrows by themselves but they are recommended to use a pencil so that correction may be easy.

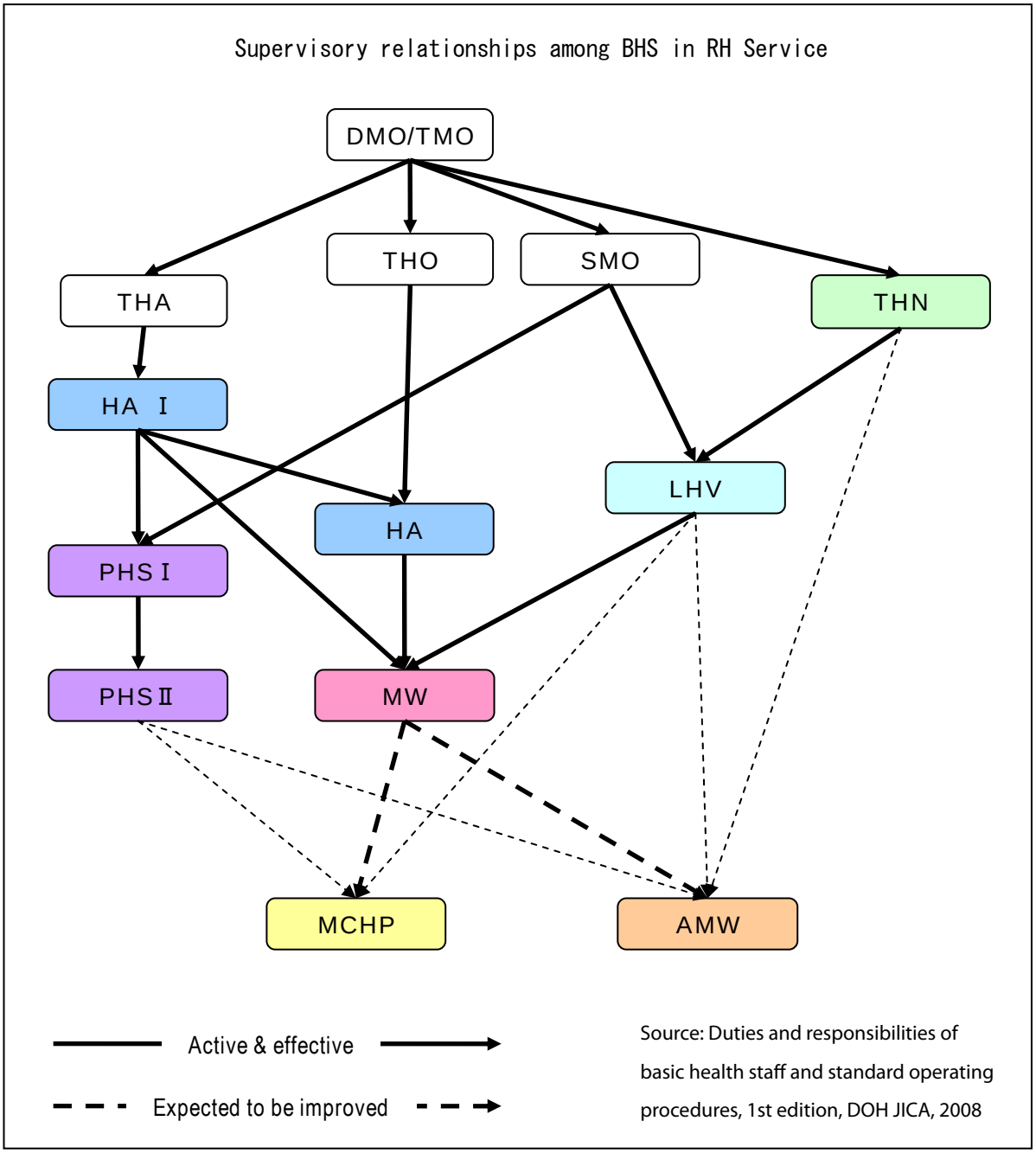
Ask participants how the actual supervision is going: From the point of view of a supervisee (those who are supervised by a supervisor), whether they think they want more supervision to improve their performance. Is it a matter of frequency or matter of content?

For the supervisory relationship (arrow) that few supervisees requested for improvement, trace it with **thick & permanent marker**. For the arrow some supervisee requested for improvement, leave the arrow thin and pencil drawn.

2-2. Reviewing duties and responsibilities of BHS on supervision (30 min)

Review the consistency of the drafted arrows with the "Duties and Responsibilities" (Annex 9). Add arrows for existing supervisory relationship, but not defined as duties and responsibilities, as well as any suggested supervisory relationships currently not defined, but supposed to be effective.

The completed chart may look like this…

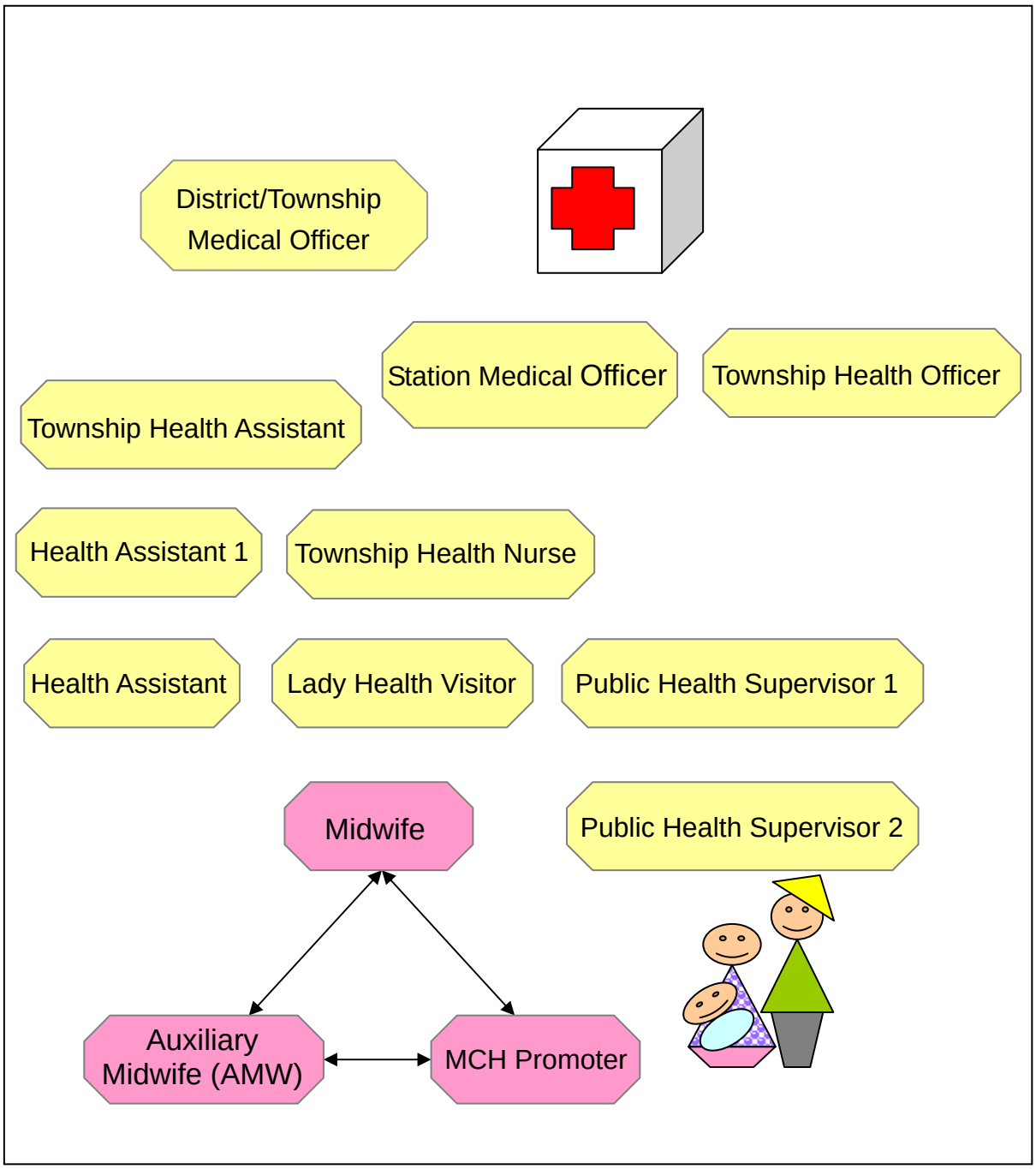


Emphasize that a weak arrow is neither a sign of the supervisor's poor performance nor the supervisor's fault. It is often impossible to improve these problems only by the effort of an individual (e.g. shortage of funding, beyond one's authority and control, etc.)

Ask participants what are the real causes of the weakness. How can we improve the situation?

Explain that one of the possible causes of the weakness in supervision is weakness of support for the supervisor. We should remember that every supervisor needs support from his/her own supervisor, in order to perform effective supervision to their juniors. Necessary supports are often not only financial support, but also support with technical skills for leadership and management. (e.g. Young MW would like to know how to get along with old MCHPs. Her senior BHS will often have useful advice.)

Show Flipchart 2 "BHS-MCHP-AMW Triad"



Explain that if we remember that we are working as in a big team, and if each of us can give good leadership to our juniors by providing effective supervision and support, we can expect improvement in our current practice.

Show Flipchart 3

Take home message 1:

Community RH cannot be improved only with individual effort of MW, MCHP, or AMW. **Team work is essential.**

Picture: Reviewing roles and responsibilities of BHS (Naungcho Township, August 2009)

Session 3: Revisited: The Concept of Leadership and Management (40 min)

The session will provide participants for review of the basics on the concepts of leadership and management.

Explain

Session Objectives:

- To review definitions of leadership, and the characteristics of good leaders through their work experiences
- To remind participants of the skills needed as a leader in the community RH work

Teaching Method:

- Lectures

3-1. What is Leadership? Who is a Leader? (10 min)

Materials to be Prepared:

☐ Flipchart 4 “Leaders”

☐ Plain flip sheets and markers

Show Flipchart and Explain

Leadership is a skill to build teamwork, to optimize it by supervising and motivating members, and to take the team towards an envisaged direction.

Leadership should be built **at every level** and **not just at the top**. Frontline health workers also need to have leadership skills, as they are the ones who come into contact with the community, and will lead the community regarding RH activities.

Show Flipchart 4 “Leaders”

What do leaders do?

- Leaders are committed to realizing a vision
- Leaders assess the gap between vision and reality, by scanning the situation
- Leaders develop mission, goals and strategies, for bridging the vision - reality gap
- Leaders inspire/empower others by aligning their vision to her/his vision.

In other words;

Show Flipchart 5

Take home message 2:

One of the most important functions of leadership is **effective supervision**.

3-2. Importance of work climate & positive work climate (15 min)

Materials to be Prepared:

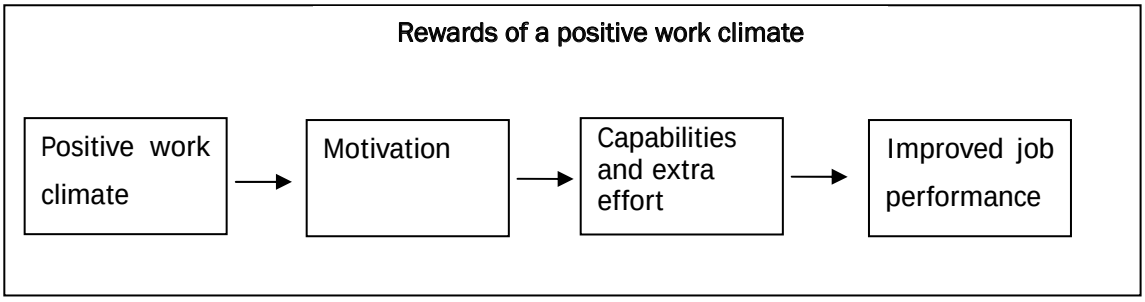
- ☐ Flipchart 6 (Rewards of a positive work climate)
- ☐ Plain flip sheets and markers

Explain

When you are in a work group, it has a work climate. Some climates are positive and productive, while others tend to de-motivate members. To understand the climate of your workplace (community), begin by asking yourself what it feels like to work with your community members, including the MCHP.

Ask the participants to think back over all their experiences as a leader/member of the team.
Is there a team in which you shared a sense of excitement of working together?
Reflecting on your experience, can help you recognize a positive work climate.
What kind of team was it? How did you feel?

Show Flipchart 6 “Rewards of a positive work climate.”



Explain to the participants;

It is important to know how you can influence work climate and distinguish between factors that are within your control and those that are not. You can change a climate that undermines team members’ commitment and performance by managing and leading your team better.

Provide examples of the ways of influencing work climate. You can positively influence work climate by changing the way you assign and manage the workload. Look for ways to;

- Challenge your team members to help them grow;
- Ensure clarity about work roles and responsibilities;
- Support team members by providing resource, making connections, and understanding their needs.

3-3. Improving work climate and team members' motivation (15 min)

Write on the white (black) board and Explain

Three big motivators Power (status, position), affiliation and achievement

Explain People often feel motivated for high performance by one of three primary motivators (or a mix of them) shown above. For example, people who are motivated by power want positions of visible responsibility. People who are motivated by affiliation want to work in a group where the interpersonal relations are pleasant and supportive. **People motivated by achievement want to see results, and to know that their efforts contributed to those results**. You can create a climate that addresses such motivators and allows productivity, results, and sustained performance to flourish.

Explain

People might be motivated to work with the following factors

Show Flipchart 7 "Example of the factors of motivation"

Example of the factors of motivation

- Capacity building (trainings, refresher workshops)
- Accomplishment of visible effects (achieving results)
- Recognition by community members with praise
- Provision of support materials (badge, some in-kind, etc.)
- Connection and feeling of working as a team

Session 4: Communication (60 min)

In this session, participants will practice the skills for “effective communication and supervision.” After learning the skills of “effective communication” for developing a motivated work climate, participants will learn skills for “effective supervision.”

Explain

Session Objectives:

- To learn the variety of methods for communication, and practice one of the most effective communication methods: coaching
- To learn how to make supervision more effective, and discuss possible application of the ideas of supportive supervision

Teaching Methods:

- Lecture
- Individual exercises

Materials to be Prepared:

☐ Plain flip sheets and markers

4-1. What is communication? (5 min)

Explain

Communication is very important to build teamwork. It consists of:

- developing an effective reporting system
- a system of sharing information (immunization day, health education, etc.)
- community resources mobilization

4-2. Barriers of communication (10 min)

Materials to be Prepared:

☐ Flipchart 2 (BHS-MCHP-AMW Triad) (on page 7 of this Facilitator's Guide)

☐ Plain flip sheets and markers

Show the flipchart 2 “BHS-MCHP-AMW Triad”

Explain Communication is the transfer of information from one person or group of people to the other. Communication enables us to share the feelings, thoughts and information, as well as learn from each other, and to work together towards a common goal.

Ask and List on a plain flip sheet, what make communication difficult or impossible in routine community RH activities. If any element of communication barriers is missing, facilitate them to remember by giving a clue.

The list on the flip sheet may become like this…

Barriers of communication
• Language • Age • Social status • Gender • Customs and traditional believes • Transportation

4-3. Practicing leadership skills: Training/coaching (45 min)

Objective: To provide the opportunity to discuss the skills and attitudes of leaders for planning, communicating, coaching and motivating staff

Teaching Method: Individual exercise and plenary discussion

Materials to be Prepared:

☐ Flipchart 8 (Coaching principles)
☐ Plain sheets of papers (as many as participants)

Steps:

1. Read out the "Instructions on making a box" (on the next page) and ask them to make the same box in 5 minutes. Do not provide any further information and guidance, and be very directive with the instructions.
2. While the participants try to perform the task, give negative feedback to participants.
3. After the 5 minutes, lead a discussion on why participants were unable to perform the task effectively.
4. Then, do the opposite. Show a hand made paper box and give participants the correct instructions on how to make the box, and coach them to perform the task correctly. Give positive feedback on their performance and praise their results.

Instructions on making a box

First step:

Fold your piece of paper vertically in three equal parts.

Second step:

Now fold into three equal parts, horizontally. Now you should have nine parts (rectangles) of the same size.

Third step:

You are going to work with the four corner rectangles. Now fold the edge of each corner rectangle diagonally over 2/3 of the opposite side, and make an edge just in that rectangle.

Fourth step:

Fold over all four corners, and then fold the top tabs over each side.

Lead the discussion about "what are the difference in the two different approaches, and effectiveness of each of them."

Show Flipchart 8 "Coaching principles" and summarize the discussion.

Coaching principles

- Coaching is: *enabling another person to reflect on his/her commitment and find new ways to achieve his/her intended results*

A coach **does not:**

- evaluate and judge
- blame, criticize, and scold
- give solutions

An effective coach:

- builds a relationship of trust and support
- cares about the person being coached/has the other's growth in mind
- listens well
- asks questions to clarify and illuminate a goal or challenge.

To be coached, you have to:

- want to learn and change
- be open to feedback from others
- take responsibility for your own actions.

Write and explain key words for coaching.

Observe, Ask, Listen, Feedback, and Agree

To conclude the exercise, reinforce the importance of effective planning, communication and coaching to facilitate the improvement of performance.

Photo: Coaching exercise (Kyaukme Township, August 2009)

Session 5: Effective Supervision (60 + 60 min)

Teaching Methods:

- Individual exercise and plenary discussion
- Group exercise
- Lecture

Materials to be Prepared:

- ☐ Table "Comparison of traditional and supportive supervision" (Annex 3)
- ☐ Table sheet "Current supervision and possible change" (Annex 4)
- ☐ Flipchart 9 (Take home message 3)
- ☐ Flipchart 10 (Training and Follow-up for MCHPs)
- ☐ Plain flip sheets and markers

5-1. Review your current supervision (30 min)

Explain how to read the table "Comparison of traditional and supportive supervision" and what each cell means. Give some examples.

Allow participants to review their current supervision and fill in the cells for "current supervision" of the table sheet "Current supervision and possible change." You may give them 10-15 min. Participants may leave the second column "possible change toward supportive supervision" blank.

Ask HA, MW (MCH, RHC, S/C) and PHS2 for their answers and take notes in the plain flip sheets.

Summarize current supervisions, whether they are generally on the process toward supportive supervision. Which aspect is nearly close to supportive supervision, and which aspect is far from supportive supervision?

5-2. Key elements of supportive supervision (30 min)

Group exercise 1: Review what you know about Supportive Supervision (20 min)

1) Divide into groups (grouping A – following the "Instructions for group exercise" (Annex 10))

2) Discuss among members

- What supportive supervision is?
- Why is it recommended?
- How can we do it?
- What is difficult to do?

3) Ask members to write down their answers on the plain flip sheet

4) Ask participants to present their answers

5) Lead discussion to cover all the elements of supportive supervision

Show Flipchart 9

Take home message 3:

The elements of supportive supervision

- Communication
- Planning and organization
- Motivation
- Training and coaching
- Team building/group dynamics/working with groups

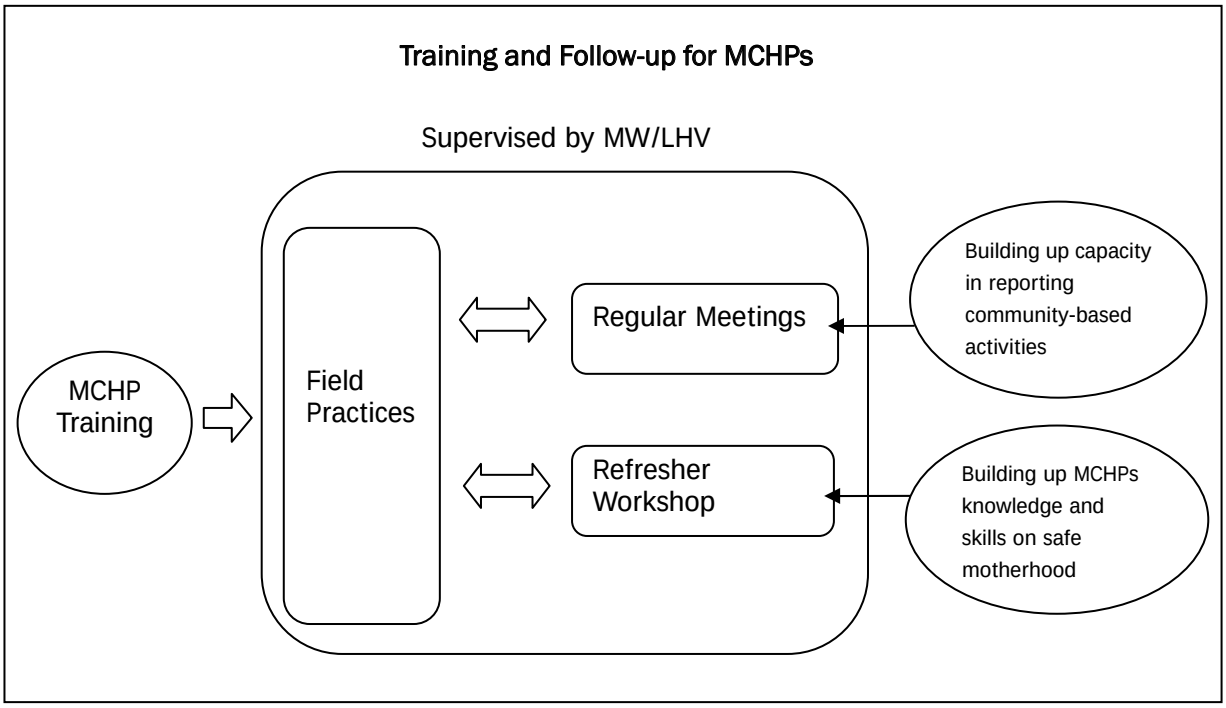
(Supportive supervision for quality improvement)

Explain the importance of post-training follow-up. For example, once MCHP are trained and have started working, MW/LHV continuously train the MCHP and follow-up their activities.

Follow-up training may not always be a formal training. BHS can develop their own way of training, using any occasion available, such as: regular monitoring visits; immunization visits; or seasonal health education.

Remember, juniors will be motivated by gaining up-date knowledge and skills which contribute to their own jurisdiction.

Show Flipchart 10 “Training and Follow-up for MCHPs”



Exercise: review current supervision and possible change

Before starting the session, discuss the form for the individual exercise of the "review current supervision and possible changes" among the trainers, and set up a guideline for the exercise. Make sure that you have included the following points in the guidelines:

1) deadline for the exercise;

2) who is going to collect, summarize, and facilitate the plenary discussion; and

3) how? (is it a homework, or an additional exercise for the tomorrow's session)?

Explain to the participants how to read the table "current supervision and possible change". Then, introduce the guideline for the individual work.

Take questions from the participants.

Wrap up for the Day 1

Ask participants what they have learnt today

Review three "take home" messages

Introduce the following documents, which will give the participants more idea of "supportive supervision," and will help them catch up on the second day's training program.

- Five Steps for Supportive Supervision Implementation (Annex 7)
- Leadership styles and skills in supportive supervision (Annex 8)

(…End of DAY 1 program…)

DAY 2

5-3. Applying leadership and management skills into practice (60 min)

Materials to be Prepared:

- ☐ "Five steps for supportive supervision implementation" (Annex 7)
- ☐ Flipchart 11 (Five Steps for Supportive Supervision)
- ☐ Plain flip sheets and markers

Explain and summarize what is in the document "Five Steps for Supportive Supervision Implementation." Also, which part have we already put into our routine supervision, and which part have not?

Show Flipchart 11 "Five Steps for Supportive Supervision"

Five Steps for Supportive Supervision

1. Prepare in advance for supervisory visits
2. Set expectations for performance
3. Monitor and assess performance of the target facility/worker
4. Identify gaps and solve problems in positive ways
5. Provide support and strengthen capacity of health care providers to meet performance goals

Group exercise 2: possible application of the ideas of supportive supervision –what can we apply? (40 min)

1. Divide into groups (grouping A)
2. Discuss
   - Which element or concept of supportive supervision are you interested in?
   - How will it improve current supervision?
   - Do you have any idea how to apply the concepts in our current supervision?
   - What will be necessary for applying the idea?
   - What will be an obstacle when we try to apply the idea?
3. Write down the answers in the plain flip sheets and make a presentation
4. Discuss and summarize what we can at least do.

In order to make the discussion constructive, try focusing on giving supportive feedbacks. Also encourage participants to use coaching skills for the discussion.

To conclude the discussion, find at least one thing that we can try to introduce in the current supervision activity.

Session 6: Development of Actual Supervision Plan (90 min)

In this session, participants will learn how to apply all the useful ideas learnt from the previous sessions and how to develop an effective supervision plan.

Teaching Methods:

- Plenary discussion
- Individual/group work

6-1. General instruction (10 min)

Explain the session objectives

Session Objectives:

- To learn how to apply the ideas of “supportive supervision” into the current practices of community RH work
- To develop actual supervision plans with the coordination with concerned partners

Materials to be Prepared:

☐ Supervision Planning Sheet (Annex 6)

☐ Plain flip sheets and markers

Explain

In this session, each participant will develop a supervision plan for a different target. The topic of supervision will depend on the position and workplace, but is exclusively on (community) reproductive health. After this plenary discussion, participants will be divided into groups (grouping A by position) and develop actual supervision plans for the coming month-quarter-year. Participants will also have time to work individually during group work.

Participants are also recommended to take this opportunity to coordinate with other BHS: BHS of different position, or BHS in neighboring villages.

- Most BHS will develop more than one plan depending on their duties and responsibilities.
- Participants may use the “Supervision Planning Sheet” (Annex 6) and check with ”Check sheet for actual supervision plan” (Annex 5)
- Supervision plan should include the response for various area-specific conditions which are likely to happen (e.g. How to perform supervision in rainy season, how to perform supervision of MCHP or AMW, where MW post is temporarily vacant, etc.)

Answer to the questions raised by participants.

6-2. Group and individual work (80 min)

Explain

Participants will be divided into the groups (grouping A -by position). A facilitator/tutor will be assigned to each group and he/she will give them their instructions.

At the beginning of group work, participants should discuss:

- Time allocation for group work and individual work, each?
- What time they will start their individual work?
- Who is going to make the presentation in the next session?

Follow the “Instructions for supervision planning” (Annex 11) and
Explain how to work on “supervision planning” within the allocated time.
Answer questions raised by participants.

Participants may take a 15 min. break.

Session 7: Presentation and Discussion (165 min including a 15 min break in between the presentations)

Explain

In this session, participants will present their actual supervision plans and share them with other participants. Then, we will review the coverage, efficiency, feasibility, purpose orientation, and effectiveness of each supervising plan, so that we will have practical and comprehensive supervision plans as a whole, by the end of the session.

Session Objectives:

- To share supervision plans with other BHS, so that every BHS will know which of the group's supervision she/he is responsible for.
- To develop feasible and comprehensive supervision plans by reviewing coverage, efficiency, feasibility, purpose orientation, and effectiveness of each presented plan.

Materials to be Prepared:

☐ Flipcharts of each presentation
☐ Flipchart of supervisory relationship completed in the session 2.
☐ Markers

Explain

Representative from each group (by position) will present their own supervision plans (10 min for the presentations, 5 minutes for Q&A and comments).
Each presentation may cover:

1) Supervision on what? (e.g. "performance of MCHP")
2) What are the points of supervision? (e.g. "frequency of reporting")
3) Schedule of the supervision cycle (e.g. "Supervisory visit in the 1st week of the month and return visit in the 1st week of the following month")
4) When the earliest possible cycle would start? (e.g. "tomorrow")
5) Response to an area-specific-condition (e.g. "Delegate AMW for the supervision in a hard-to-reach village and where MW post is temporarily vacant.)

After each presentation, start from Q&As for clarification, and then proceed to comments on the contents and substantial discussion.

Check with the flipchart of supervisory relationship, whether all necessary supervisory plans are presented by each designated supervisors. Also use "Check sheet for actual supervision plan" (Annex 5) to assess effectiveness, feasibility, and purpose orientation of each plan.

Ask the presenter these questions.

- What kind of ideas for “supportive supervision” is applied in this plan?
- What kind of “communication skills” is applied in this plan?
- What consideration will you give the person being supervised in order to keep their motivation?

Share experience with others

Ask participants if there are any other good ideas or suggestions for responding difficulties for effective supervision.

In order to make the discussion constructive, try focusing on giving positive feedbacks. Encourage participants to use coaching skill for the discussion.

To conclude the session, make sure that every RH partner is covered by each of the presented plans.

Closing Session (45 min)

Materials to be Prepared:

- ☐ Plain flip sheets and markers
- ☐ Post-training self-assessment form (Annex 1)

Teaching Methods:

- Lecture
- Discussion
- Questionnaire

1. **How do we evaluate effectiveness of leadership?**

   Explain

   Good leadership and management practices are harder to assess than other aspects of high-performing health systems, but are nonetheless equally important.
   How do we effectively measure leadership outcomes?

   Leadership outcomes range from intermediate outcomes, such as changes in work climate or in management systems and processes (for example, improving the recruitment, development, and productivity of health professionals by strengthening the human resource management system), to long-term outcomes such as service delivery results (for example, improved quality of care, increased utilization of services, or better client satisfaction).

   Leadership outcomes are measured at two levels:

   - the behavior changes in participating teams and
   - the results these teams produce.

   Ask participants to discuss with their neighbors, what kind of changes they can expect according to their action plan

   Ask some of voluntary participants to present their discussion
   Share the comments and concerns with other participants

2. **Questions and Answers for the whole sessions (10 min)**

3. **Plenary evaluation of the training (10 min)**

   Review the expectations set up by the participants on the first day of the training.

4. **Closing remarks (5 min)**

5. **Post-training self-assessment (10 min)**

Annex 1:

Pre/post-training self-assessment form

Please read all the statements listed at column 1 and complete column 2 using the rating scale below.

Rating Scale:

5: Strongly agree	4: Agree	3: No opinion	2: Disagree	1: Strongly Disagree

No.	Statements	Rating
1	I can identify who is the right person to take leadership at every level of RH service provision.	
2	I can tell in which circumstance I should take a leadership.	
3	I can define supervision.	
4	I can explain supportive supervision.	
5	I can list all the elements of a supportive supervision process.	
6	I can describe the knowledge, skills and attitudes for an effective supervisor.	
7	I can explain what coaching is in the context of supportive supervision.	
8	I am very clear about the roles and responsibilities of the supervisor at each level.	
9	I am very knowledgeable about how to work with teams.	
10	I feel confident I could implement a supportive supervision process to improve RH service provision.	

Annex 2:

Time Schedule

Time	Min.	Sessions/Activities	Presenters/Facilitators
Day 1			
08:30- 09:00	30	Registration	
09:00- 09:45	45	**Opening Session** - Opening speech - Introduction of trainers - Introduction of participants	PDC Chairperson DOH Representative Rep. State Health Dept. DMO/TMO
09:45-10:00	15	Break	
10:00-10:45	45	**Session 1: Introduction** - Pre-training assessment - Overview of the program - Group norm - Expectation	FPP SMO
10:45-12:00	75	**Session 2: Situation Analysis** - Key players in RH service and current practice - Review duties and responsibilities of BHS in community RH supervision	DoH, FPP
12:00-13:00	60	Lunch	
13:00-13:40	40	**Session 3: Revisited: The Concept of Leadership and Management** - What is Leadership? Who is the leader? - Importance of team motivation and positive work climate - Improving work climate and team members' motivation	DMO/TMO
13:40-14:40	60	**Session 4: communication** - What is communication? - Communication Barrier - Exercise <Coaching>	SMO
14:40-14:55	20	Break	

Time	Min.	Sessions/Activities	Presenters/Facilitators
14:55-16:15	80	**Session 5: Effective Supervision** - Key elements of supportive supervision	SMO
16:15-16:30	15	Home work: Review your current supervision and think about possible change Wrap up & Take home messages	
Day 2			
09:00-9:15	15	Recap for the previous day	
9:15-10:15	60	**Session 5: Effective supervision (Cont'd from the previous day)** Review your current supervision and think about possible change Applying leadership and management skills into practice - ideas from supportive supervision	SMO
10:15-12:00 (10:30-10:45)	105 (15)	**Session 6: Development of Actual Supervision Plan** (Tea Break)	DOH, SHD, DMO/TMO, FPP, SMO
12:00-13:00	60	Lunch	
13:00-15:45 (14:45-15:00)	165 (15)	**Session 7: Presentations and Discussion** - Presentation and feedback from trainers and participants 1. HA I 2. THN 3. HA 4. LHV 5. MW (MCH) 6. MW (RHC) 7. MW (Sub-RHC) 8. PHS I (Tea Break)	DOH, SHD, DMO/TMO, FPP and SMO
15:45-16:30	45	**Closing Session** - How do we evaluate effectiveness of leadership? - Q &A, plenary evaluation of the training - Closing remarks - Post-training assessment	DMO/TMO

Annex 3:

Comparison of traditional and supportive supervision

Action	Traditional Supervision	Supportive supervision
Who performs supervision	External supervisors designated by service delivery organization	➢ External supervisors designated by the service delivery organization ➢ Staff from other facilities; colleagues from the same facility (internal supervision) ➢ Community health committees ➢ Staff themselves through self-assessment
When supervision happens	During periodic visits by external supervisors	Continuously: during routine work; team meetings; and visits by external supervisors
What happens during supervision encounters	➢ Inspection of facility; review of records and supplies ➢ Supervisor makes most of the decisions ➢ Reactive problem-solving by supervisor ➢ Little feedback or discussion of supervisor observations	➢ Observation of performance and comparison to standards ➢ Provision of corrective feedback on performance ➢ Discussion with clients; provision of technical updates or guidelines ➢ Onsite training ➢ Use of data and client input to identify opportunities for improvement ➢ Joint problem-solving ➢ Follow-up on previously identified problems
What happens after supervision encounters	No or irregular follow-up	➢ Actions and decisions recorded ➢ Ongoing monitoring of weak areas and improvements ➢ follow-up on prior visits and problems

(Original source: Marquez and Kean, 2002)

Annex 4:

Current supervision and possible change

Action	Current Supervision	Possible change toward supportive supervision
Who performs supervision		
When supervision happens		
What happens during supervision encounters		
What happens after supervision encounters		

Annex 5:

Check sheet for actual supervision plan

Category	Question	HA1	THN	HA	LHV	MW(MCH)	MW(RHC)	MW(S/C)	PHS1
Coverage	Does it cover all the necessary monitoring?								
Efficiency	Schedule is efficient?								
Efficiency	Does it overlap with other supervision plan?								
Feasibility	Is it detailed enough to be implemented?								
Feasibility	Schedule is feasible?								
Purpose oriented	Is it on reproductive health?								
Effectiveness	Does it use effective communication skills?								
(From the view point of person being supervised)									
Effectiveness	Will you be motivated no matter how the result of evaluation is?								
Effectiveness	Point of supervision is fair?								
(From the general viewpoint)									
Effectiveness	Does it care about keeping motivation of person being supervised?								
Supportive supervision	Does it apply any ideas for supportive supervision?								
Supportive supervision	Does it focus on performance?								
Supportive supervision	The plan synchronizes with management cycle?								
Supportive supervision	Does it include return visit?								

Annex 6:

Supervision Planning Sheet <<Sample>>

Topic for supervision: MCHP performance

Item to Observe	Duties and responsibilities	Method	Date	Assessment (*)				Comments
				Yes	N/I	No	N/A	
MCHP Reporting	MCHP report the number of pregnant mothers to MW without fail and delay	MW journal, ANC records checking	25/08/09					
		Individual interview	1st week 09/09					
	MCHP submit reporting sheet monthly	Report sheet checking	28/08/09					
		Individual interview of MCHP	1st week 09/09					
MCHP give necessary information to pregnant mothers	MCHP inform mothers of the Number of immunization that their children should take.	Accompanying MCHP home visit	Mid 09/09					
		Interview with mothers	Mid 09/09					
	MCHP inform mothers of danger signs to which they should pay attention.	Accompanying MCHP home visit	Mid 09/09					
		Interview with mothers	Mid 09/09					
	MCHP give practical information about recommended food during/after pregnancy.	Accompanying MCHP home visit	Mid 09/09					
		Interview with mothers	Mid 09/09					

(*) N/I: Need Improvement, N/A: Not Applicable, Not Available

Annex 6:

Supervision Planning Sheet

Topic for supervision:

Item to Observe	Duties and responsibilities	Method	Date	Assessment (*)				Comments
				Yes	N/I	No	N/A	

(*)N/I: Need Improvement, N/A: Not Applicable, Not Available

Annex 7:
Five steps for supportive supervision implementation

1. Prepare in advance for supervisory visits
2. Set expectations for performance
3. Monitor and assess performance of the target facility/worker
4. Identify gaps and solve problems in positive ways
5. Provide support and strengthen capacity of health care providers to meet performance goals

1. Prepare in advance for supervisory visits

- Plan to conduct **regular** supervisory visits. When supervisory visits are made routinely, supervisors are better able to monitor performance, and can identify and address problems before they have negative impact on service delivery.
- Arrange visits when supervisors can observe an immunization session, interview clients, and arrange for staff meetings (e.g. CME, CHE) **without** adding extra burden on the staff. Some institutions recommend monthly supervisory visits, others quarterly. Lesser performing health facilities should receive more frequent visits.
- Organize the supervisory visit by:
  - reviewing objectives of annual and multi-year plans.
  - developing clear objectives for the visits.
  - following up on recommendations made during previous visits.
  - collecting helpful publications, materials, and supplies for the staff to be supervised.
  - preparing updates and/or refresher training to present during the visit.
- Plan to spend sufficient time (from several hours, to a full day or more) to conduct the supervisory visit. The amount of time of a supervisory visit varies depending on the needs of the staff to be supervised. For example, in some cases a two-day visit would be more effective than just one day. It allows the supervisor enough time for meeting with the health worker to discuss performance goals, meeting with the community, assessing traveling time of the staff.
- Stick to the schedule and respect the health workers' time. Always schedule a return visit before leaving the site.

2. Set expectations for performance

- Develop job descriptions, expectations, and standards of performance. Supervisors should prepare these together with the staff being supervised.
- Determine measurable performance goals together with staff. Make sure that the goals are realistic and attainable.
- Develop measurable indicators, milestones, and tools, so that staff can monitor their own progress toward the goals. (*See Annex 6 for a "Sample Supervision Planning Sheet."*)
- Develop a supervisory team if possible, within the health facility that can provide day-to-day support and supervision.
- Introduce a self-assessment/feedback system.

3. Monitor and assess performance of the target facility/worker

- Observe activity and note the strengths and weaknesses.
- Talk to clients (e.g. mothers) about the quality of services, preferably away from the health facility – you are more likely to receive honest answers.
- Involve the community in the evaluation process. Ask community members how they are

treated when they visit the facility, or when they received service. Do they know about danger signs? Do they know what to do about them? Do they know when to return? Meet with designated community leaders during the visit to get their feedback.

- Check the availability of stocks (materials/consumables) and condition of equipment.
- Review health facility records, including ANC registration, immunization coverage and other RH records.
- Meet with the supervision team within the facility and ask for additional feedback on service delivery.
- Use information gathered during the visit to discuss progress with the health facility team.
- Always start out by presenting positive attributes of the health staff and the person being supervised.
- Review indicators, milestones, and performance with the staff.
- Assess performance goals and make adjustments as needed.
- Both the supervisor and the person supervised should keep a written log/record of items discussed, including strengths and weaknesses, and actions to be taken (by whom and by when).

4. Identify gaps and solve problems in positive ways

- Praise health workers in public for good performance and for practices that meet quality standards. **Correct negative performance only in private**.
- Provide staff with informational updates on policies or new recommended practices.
- Discuss findings and recommendations with the health facility team:
  - Ask the staff to identify areas of strength and weakness. A supervisor can serve as a facilitator and help the staff develop strategies for solving problems.
  - Give constructive feedback.
  - Find causes and reasons for poor performance. Is it a capacity issue? An equipment or supply issue? Or a question of motivation?
  - Discuss, listen, give feedback, and solve problems together.
  - Review ANC service coverage data and drop-out rates. Work with the team to identify reasons for drop-out rates and strategies for improvement.
  - Set target ANC/PNC coverage rates for improvement.

5. Provide support and strengthen capacity of health care providers to meet performance goals

- Identify information/training needs together with the staff.
- Work with health facility and township-, district- or central-level authorities to set priorities.
- Provide on-site updates and training.
- Develop job aids according to priorities. Be prepared to leave job aids at the health facility, but consider leaving behind only the job aids related to priorities.
- Follow up on equipment and supply problems in a timely manner with the district or central level authorities.
- Work on ways to improve the delivery system with the district- or central-level authorities.

(Derived and modified from: Children's Vaccine Program at PATH. *Guidelines for Implementing Supportive Supervision: A step-by-step guide with tools to support immunization.* Seattle: PATH, 2003, pp. 4-7)

Annex 8:
Leadership styles and skills in supportive supervision

The role of the supportive supervisor is to address the needs of the providers as well as to teach and support staff members to undertake the quality control process and maintain quality of care standards. There are different styles of leadership which can be used to support staff and teams in this process. The supervisor needs to know which style to use in different situations.

Telling:
The telling style of leadership could be applied to staff and teams who are still unable to tackle the task to implement and maintain quality of care. The approach can be useful with new staff or in emergency situations. This style is needed when staff needs a lot of direction and support.

Skills:
- Be clear about standards
- Be clear what is expected
- Instruct extensively
- Develop individual's technical skills
- Check performance
- Point out errors
- Develop pride in good performance
- Be considerate but firm
- Help the person supervised to learn, by showing interest in their learning problems

Coaching:
The coaching leadership style is used with a more established team and staff members who have certain basic skills, but still have much to learn. The style is well suited to teams who need support in solving the quality gaps at the RHC or S/C level. In this style the supportive supervisor takes the initiative in directing and monitoring the quality control process. They also give rapport a high priority and invest energy in developing it with all staff members as well as getting acquainted with all their needs.

Skills:
- Spend time with each staff member
- Identify topics of common interest
- Assess individual characters and needs
- Communicate intensively
- Develop pride in output
- Be directive when necessary
- Reward positive behavior
- Be strict to maintain standards

Supporting:
The supporting leadership style in supportive supervision can be used with staff members and teams who have all the basic skills and competences to handle most of the tasks related to the job as well as a common understanding of the quality of care standards. Further development of the team, and increasing the motivation of the staff members to maintain quality of care standards, requires that they take more responsibility for their work, the quality of care process, and keep their own morale high. Staff members are encouraged to tackle and solve the problems at the RHC or S/C.
In exceptional circumstances, issues may need to be clarified and decided by the supervisor or manager. Important decisions should be explained, and staff members encouraged to make a contribution to the wider organization.

Skills:
- Limit direction and control
- Set up self-monitoring systems
- Counsel on problems

• Develop people by giving them tasks and assignments
• Communicate widely
• Encourage feedback and comment

Delegating:
The delegating leadership style in supportive supervision is used with staff members and teams who have achieved a level of skills and want to devote all their energy into doing a good job. This style is appropriate for a supportive supervisor with people who have responsible and positive attitudes toward the RHC or S/C. The supervisor acts as a resource and leaves much of the work to the staff and the team. The day-to-day monitoring of the quality of care process is administered by the staff members.

Skills:
• Clarify and agree on objectives
• Give support when requested
• Represent the group to others if necessary
• Avoid interfering
• Respond to requests seriously

(Derived and modified from: Supportive supervision for quality improvement, training of trainers guide for health professionals, facilitator's guide, IPPF, 2006, pp. 40-41)

Annex 9:

Duties and Responsibilities of BHS in RH Service

(Excerpts from "Duties and Responsibilities of Basic Health Staff and Standard Operation Process" 1st edition, DOH, JICA, 2008)

TMO

- Supervises the performance of Station Hospital, RHCs and sub-RHCs through SMO[1].
- Supervises all activities included in RH care packages[2].

THO

- Giving priority to public health and disease control activities, supervision and monitoring of basic health services performed by basic health staff at RHC, sub-RHCs and other health centers[3]
- Monitoring and supportive supervision of urban health centers, station hospital, station health unit, rural health centers, school health and MCH centers, and reporting to the TMO and providing feedback[4].
- Supervisory field visits from township health department to station and rural health centers at least twice a month[5].

SMO

- Guiding, supervising and monitoring LHV to take responsibility for maternal and child health, nutrition promotion and reproductive health services[6].

THA

- Monitoring and supervision of functions of urban health centers, station and rural health centers, MCH centers…[7]

THN

- Public health and disease control activities
  - Training to LHV and MW for public health activities[8]
  - Training of AMW[9]

1 P9 (3) 2nd bullet
2 P11: (5) 2nd bullet.
3 P34: (2)-(2)
4 P34: (3)-(1)
5 P34: (3)-(2)
6 P37: Public health and disease control functions (3)
7 P40: (4)
8 P42: 2-(2)
9 P42: 2-(7)

HA Ⅰ

- Maternal and child health care and reproductive health care.
  - Supervising urban health center, station health unit and rural health center in implementation of MCH and Reproductive Health Care activities[10].

HA

- Supervision and monitoring of BHS and voluntary health workers' performance during field visit[11]
- Inspecting, checking and taking necessary action over the monthly report submitted by the staff, on a specified date at the end of the month. PHS Ⅱ, MW, LHV are assigned to collect data and compile together with the team of BHS at the regular basis. Volunteer health workers (Community health workers and auxiliary midwives) must participate in this meeting.[12]

LHV

- Supervision, training and support to MW, AMWs and CHWs[13].

MW

- Supervision and monitoring of VHWs and AMWs[14].

PHS Ⅰ

- Screening of reports of RH and MCH activities. As MCH activities are the duties of LHV and MW, the role of PHS Ⅰ is only organizing and helping in their activities and health education[15].

PHS Ⅱ

- Participating in family health care.
  - Working together with MW and AMW in MCH services.

10 P46: (1) and 1st bullet point
11 P53: (1) 7th bullet point
12 P54: (4) 4th bullet point
13 P83: "Supervision, training and support to MW, AMWs and CHWs"
14 P92: 11
15 P97: Field visits Public health activities (1)

Annex 10:

Instructions for group exercise

Suggested grouping for the group works

<For group exercise>

Grouping A (by position)

Group	Sub-group No.	Member	No.	Facilitator
	1	MW(MCH)		
	2	MW(RHC)		
	3	MW(S/C)		
	4	MW(S/C)		
	5	LHV		
	6	THN&HA Ⅰ		
	7	HA		
	8	PHS Ⅰ/Ⅱ		
Total				

<For presentation>

1) HA Ⅰ
2) THN
3) HA
4) LHV
5) MW (MCH center)
6) MW (RHC)
7) MW (Sub-RHC)
8) PHS Ⅰ

Annex 11:

Instructions for supervision planning

Instructions for HA Ⅰ

You are expected to develop actual supervision plans for:

- **LHV**
- **MW**
- **PHS Ⅰ**
- **PHS Ⅱ**

You may use existing supervision plans and guidelines, but should seek possibility of improvement in current supervision by applying some of the ideas you learned during this training.

Instructions for THN

You are expected to develop actual supervision plans for:

- **LHV**
- **MW**

You may use existing supervision plans and guidelines, but should seek possibility of improvement in current supervision by applying some of the ideas you learned during this training.

Instructions for HA

You are expected to develop actual supervision plans for:

- **LHV**
- **MW**
- **PHS Ⅰ**
- **PHS Ⅱ**

You may use existing supervision plans and guidelines, but should seek possibility of improvement in current supervision by applying some of the ideas you learned during this training.

Instructions for LHV

You are expected to develop an actual supervision plan for:

- **RH related activities' performance by MW**

You may use existing supervision plans and guidelines, but should seek possibility of improvement in current supervision by applying some of the ideas you learned during this training.

Instructions for MW

You are expected to develop actual supervision plans for:

- **AMW**
- **MCHP**

You may use existing supervision plans and guidelines, but should seek possibility of improvement in current supervision by applying some of the ideas you learned during this training.

- Discuss how to improve supervision in hard-to-reach areas in your jurisdiction and reflect the discussion result in your supervision plan.

Instructions for PHS Ⅰ

You are expected to develop actual supervision plans for:

- **RH related activities' performance by PHS Ⅱ**

You may use existing supervision plans and guidelines, but should seek possibility of improvement in current supervision by applying some of the ideas you learned during this training.

Instructions for PHS Ⅱ

You are expected to join the group of PHS Ⅰ and simulate development of supervision plans for:

- **RH related activities' performance by PHS Ⅱ**:

You may use existing supervision plans and guidelines, but should seek possibility of improvement in current supervision by applying some of the ideas you learned during this training.

Chapter III - Annex 2

Program for MCH Promoters Trainers' Training (TOT)

Day 1

Time	Program	Trainer/Facilitator
08:30-09:00	Registration	
09:00-09:30	**Opening Remarks** ➢ PDC Chairperson ➢ DMO/TMO	HA1
09:30-10:00	Tea Break	
10:00-11:15	**Opening Session** ➢ Introduction, Trainers, Facilitators ➢ Participants ☞ Each participants will present **Name, Post, Years of Experience, Episodes with MCHP** for 3-5 min. per participant. ➢ Training Overview ➢ Pre-training Questionnaire	DMO/TMO
11:15-12:30	**Session 1. Overview of the MCH Promoters System** ☞ Chapter 2. Maternal Child Health Promoters (MCHP) System ➢ Public Health Challenges, including MCH, in our Township ☞ Major causes of death, maternal mortality, infant mortality, and the prevalence of seasonal diseases will be covered. ➢ Challenges/hindering factors in BHSs' Routine Work ➢ MCH Promoters System as one of the Solutions ➢ MCH Promoters in the Health System ☞ Diagram of partnership/teamwork among BHS, AMW and M CHP will be covered. ➢ Strategic Plan through MCH Promoters ➢ Up-Date of the Program ☞ *Monthly Reporting Format of MCH Promoter and MCHP Activity Summary* will be explained. ➢ Roles and Responsibilities of MCHP ➢ Do's and Don'ts ➢ Challenges of the Program ☞ The program sustainability will be covered. ➢ Q&A	DMO/TMO

Program for MCH Promoters Trainers' Training (TOT)

Day 1 (continued)

Time	Program	Instructor/Facilitator
12:30-13:30	Lunch Break	
13:30-14:30	**Session 2. Normal Pregnancy and Delivery** ☞ Training Manual Chapter 3. Learn Normal Course of Pregnancy and Delivery ➢ Normal Course of Pregnancy ➢ Antenatal Care ➢ Nutrition ➢ Infectious Diseases and Immunization	Focal Point Person
14:30-15:30	**Session 3. Emergency Referral** ☞ Training Manual: Chapter 4. Emergency Referral ➢ When and How to Refer: During Pregnancy ➢ When and How to Refer: Upon Delivery ➢ When and How to Refer: Newborn Baby ➢ When and How to Refer: Other Emergencies ➢ Case Study and Discussion	DMO/TMO
15:30-15:45	Tea Break	
15:45-16:15	**Session 4. Planning an MCHP Training** ➢ Suggested MCHP Training Program ☞ Trainers' manual will be covered. ➢ Preparation ☞ Personnel, administrative part including accounting, reporting and procurement of the training materials will be covered. ➢ Q&A	DMO/TMO Focal Point Person
16:15-16:30	**Wrap-up** ➢ Today's Take Home Messages ➢ Assignment: Micro plan ➢ Announcement	DMO/TMO

Program for MCH Promoters Trainers' Training (TOT)

Day 2

Time	Program	Instructor/Facilitator
09:00-09:30	**Opening** ➢ Announcement ➢ Review of the Yesterday's Program ➢ Today's Program	DMO/TMO
09:30-11:00	**Session 5. Teaching Methods** ➢ Effective Teaching/Learning Methods ➢ Basic Presentation Skills ➢ Skills of an Trainer and a Facilitator ➢ Voice of Experience ☞ How effective to have an experience sharing session in a training. ➢ Q&A	DMO/TMO/ Focal Point Person
11:00-11:15	Tea Break	
11:15-12:30	**Session 6. How to Use Training Materials** ➢ MCH Promoters Handbook ☞ We will go through the handbook emphasizing the points. ➢ Trainers' Manual ➢ Educational and Training Materials (to be decided) ➢ Exercise: Teaching Practice ☞ model training by RHC, Sub-RHC, MCH Center	Focal Point Person
12:30-13:30	Lunch Break	
13:30-14:30	**Session 7. Leadership Management** ☞ Training Manual: Chapter 5: Experience Sharing ➢ Discussion of Effective Teamwork Building with MCHP/AMWs based on the action plans made in the Leadership Training	DMO/TMO
14:30-15:00	**Session 8. Micro Plan (on Training Date, Venue and Trainers) Coordination** by Each RHC/Sub-RHC/MCH Center Jurisdiction	DMO/TMO
15:00-15:15	Tea Break	
15:15-16:00	**Review and Wrap Up Session** ➢ Take Home Messages ➢ Q&A ➢ Post-Training Questionnaire	DMO/TMO
16:00-16:30	**Closing Session** ➢ Closing Remarks ➢ Announcement	DMO/TMO

Chapter III - Annex 3

MCH Promoters Trainers' Manual

Contents

Chapter 1. Opening

Suggested Time Frame: 08:30 – 9:00 (30 min.)

Materials	Quantity
Flipchart 1	1
Tripod for the flipchart	1
Handouts: Time-Table	No. of trainees
Pre-Test Answer Sheets	No. of trainees
Pens	No. of trainees

1.1. Opening Ceremony

Opening Remarks: TMO, Village Head

1.2. Introduction

(1) Introduce yourself

(2) Introduce participants

(3) Introduce other lecturers and staff

(4) Today's Schedule (☞ See Annex: Flipchart 1)

(5) Qs and As

1.3. Pre-Test (15 min.) (☞ See Annex: MCH Promoters Training Pre-/Post Test (sample))

Chapter 2. Maternal and Child Health Promoters (MCHP) System

Suggested time frame: 09:00 – 10:15 (75 min.)

Materials	Quantity
Flipchart 2 – 4	1
Tripod for the flipchart	1
Handbooks	No. of trainees

2.1. Know Your Community (15 min.)

2.2.1. Public Health Challenges in Your Community

- Explain the public health situation in your community, such as population, three major diseases, endemic diseases, RH/MCH situation, etc.
- Explain the challenges to address those public health issues, e.g. type and number of BHS &AMW, geographical difficulties, language barrier, accessibility to the health services, unhealthy traditional believes, poverty, etc.

2.2.2. How Public Health Problems affect Our Daily Life

- Explain how public health problems affect participants' daily lives:
  - Where there is no health facility in village, they have to pay for transportation to go to the nearest health facility when necessary.
  - MW may not be able to come to your village as often as necessary, because she also needs to travel to other villages in her responsible area..

2.2. Maternal and Child Health Promoters (MCHP) System (30 min.)

- Use Flipchart 2 (☞ See Annex: Flipchart 2)

2.2.1 Overview: Objectives and Expected Outcomes of the System

- Emphasize that **'MCH Promoters work as a bridge between the BHS and community people**,' and can be the part of the solutions for the public health issues.
- Objectives To support pregnant women, under 5 children and their mothers in the area so that they can maintain better health.
  - To recognize all pregnant women, under 5 children and their mothers.
  - To assist MCH activities with Basic Health Staff (BHS) and community people related with their health matters.
  - To disseminate Reproductive Health (RH) messages and information (especially safe motherhood) to the community.

2.2.2 Dos and Don'ts

- Use the MCHP Handbook

2.2.3 Reporting –

- Explain that all MCHPs are requested to report the MW at least once per month following information in their responsible area.
  - Name of pregnant women
  - Name of postnatal women
  - Name of children 5 years old or younger

- MCH activities performed by the MCHP during the month

➢ There are two types of reporting. MCHP may choose either one at their convenience.
- MCHP Monthly Report Form (Preferred)
- Oral Report

➢ Distribute and explain MCHP Monthly Reporting Format (☞ See Annex: Monthly Reporting Format of MCH Promoters (sample))

➢ Let them fill the form in a exercise for better understanding

➢ Introduce 'Group Reporting'; Some MCHPs may form a group and one of them submits their colleagues' monthly report to their MW.

➢ Report using written form is recommended, because it is more reliable. But it increases MCHP burden for filling and submission.

2.2.4 Effective Communication

➢ Use the MCHP Handbook and Flipchart 3 (☞ See Annex: Flipchart 3)

➢ Read the text out loud. Role playing is not a 'must', but optional.

➢ Emphasize that **'if a MCH Promoter has good communication with the pregnant woman, it is more likely that the MCHP can know health conditions of the pregnant woman better. Thus MCHP will be able to help the pregnant woman take necessary action before any problem becomes serious.'**

2.2.5 Team work

➢ Use Flipchart 4 (☞ See Annex: Flipchart 4)

➢ Emphasize that **'MCH Promoters need to work in close collaboration with the midwife and AMWs in their area, so that they can work effectively to ensure that pregnant woman/baby can receive proper RH services, such as, AN care, delivery and PN care by skilled health personnel.**

➢ Where there is no **MW, AMW could provide necessary RH services.**

➢ **When any danger sign is found in the pregnant woman/baby, MCHPs are expected to facilitate the timely referral to higher level health facility with strong teamwork between MW, AMW and also community members.'**

Coffee Break

Suggested time frame: 10:15 – 10:30 (15 min.)

Chapter 3. Normal Pregnancy and Delivery

Suggested time frame: 10:30 -12:00

Materials	Quantity
Flipchart 5	1
Tripod for the flipchart	1
Handbooks	No. of trainees

3.1 Normal Course of Pregnancy

- Explain the changes to be observed in a woman in a normal course of pregnancy

3.2 Antenatal Care

- Use flipchart 5 (☞ See Annex: Flipchart 5)
- Emphasize that **'every pregnant woman needs to take AN care at least 4 times before delivery, so that the midwife can know whether the fetus is growing without problem, and she can also provide necessary advice to the pregnant woman to make the pregnancy and delivery safer.'**
- Emphasize that **'every pregnant woman should receive a Home-Based Maternal Record so that all the necessary information on the pregnant woman can be written in the Record. It is useful for both the pregnant women and BHS.'**

3.3 Nutrition

- Use chart in the MCHP Handbook. Give some examples of suggested foods available in the market.
- Emphasize the importance of exclusive breastfeeding upto 6 months for the baby.

3.4 Infectious Diseases and Immunization

- Emphasize on the following points for each of the infectious diseases:
  - **Malaria** If a pregnant woman gets malaria, she should take proper treatment in time. If not, she will get severe complications eg. anaemia, cerebral malaria and unconsciousness, still birth, etc.
  - **Tuberculosis** A pregnant woman needs to consult BHS if she is coughing for 3 consecutive weeks. Tuberculosis may be cured after proper treatment, and examination and treatment will be provided at RHC or hospital, free of charge.
  - **HIV/AIDS** If a pregnant woman has HIV, it can be transmitted to the baby. Therefore all the pregnant women need to be tested for HIV before delivery, so that the possibility of the transmission can be reduced by treatment.
  - **Tetanus** is a life threatening disease often passed by unsafe delivery or abortion. To prevent this, every pregnant woman should take TT immunization 2 times before delivery.

Chapter 4. Emergency Referral

Suggested time frame: 13:00 – 14:30

Materials	Quantity
Flipchart 6 and 7	1
Tripod for the flipchart	1
Handbooks	No. of trainees

☞ Assisting in referring clients to the appropriate health professionals timely is one of the most important work of MCHPs. Use the MCHP Handbook and Flipchart 6 (☞ See Annex: Flipchart 6)

4.1. When and How to Refer: During Pregnancy

- ✓ Hemorrhage (bleeding per vagina)
- ✓ Convulsions, unconsciousness
- ✓ Severe headache, blurred vision
- ✓ General weakness due to high fever
- ✓ Severe abdominal pain
- ✓ Fast breathing, difficulty in breathing

4.2. When and How to Refer: Upon Delivery

- ✓ No progress in labor after six hours of ruptured membrane
- ✓ Continuous labor pain for more than 12 hours
- ✓ Massive bleeding at the onset of labor
- ✓ Excessive bleeding soon after delivery, as much as to soak all the pads and clothes within 5 minutes
- ✓ No sign of placenta separation up until one hour after delivery of the baby

4.3. When and How to Refer: Newborn Baby

- ✓ Too small (low birth weight)
- ✓ Difficulty in breathing
- ✓ Convulsions
- ✓ Fever
- ✓ Cold and clammy
- ✓ Bleeding
- ✓ Unable to suck milk

4.4. When and How to Refer: Other Emergencies

- ➢ Remind them that some emergency cases are post abortion complications (hemorrhage, infection, etc.).

4.5. Case Study and Discussion

- ➢ Use Flipchart 7 (☞ See Annex: Flipchart 7)

- Let them think and discuss; when, what, and how they could have prevented the maternity related problems, if they were the MCHP in that village. You may give participants 10-15 minutes for a small group discussion, followed by a whole class discussion.

Coffee Break

Suggested time frame: 14:30 – 14:45 (15 min.)

Chapter 5. Experience Sharing
Suggested time frame: 14:45 – 16:00 (75 min.)

5.1. Panel Discussion: Practical Advice from Experienced MCHPs (45 min.)
Ask, in advance, 4-5 MCHPs who renewed their term to be the panels in the session 4. A member of the panel will make a brief presentation (5 min. per each panel) on;

- What was the most difficult work as a MCHP?
- What was the greatest experience as a MCHP?
- Why did you decide to renew your contract?
- Why some of their co-workers did not renew the contract?
- What encouraged them to work as a MCHP?
- What discouraged them to work as a MCHP?

Q&A or discussion will follow the panel presentation.

5.2. Questions and Answers, Discussion (30 min.)
- Overall questions and answers, discussion

Chapter 6. Evaluation

6.1. Pre/Post Test

- Objectives

  To evaluate the participants' understanding of the objectives of the training.
  To find weaknesses of the way and contents of the training for improving future program.

  - Pre Test will show the pre-training knowledge about the training contents.
  - It will be the baseline for the comparison of the results.
  - Post Test will show the knowledge which should have been corrected or newly acquired through the training.
  - The difference of the grade will show the level of achievement.

- How to conduct

  Questionnaire is distributed from an officer of township level.
  Make sure that every trainee takes both Pre and Post Test.
  Make sure that every trainee takes Pre/Post Test under the equal condition.

- After the test

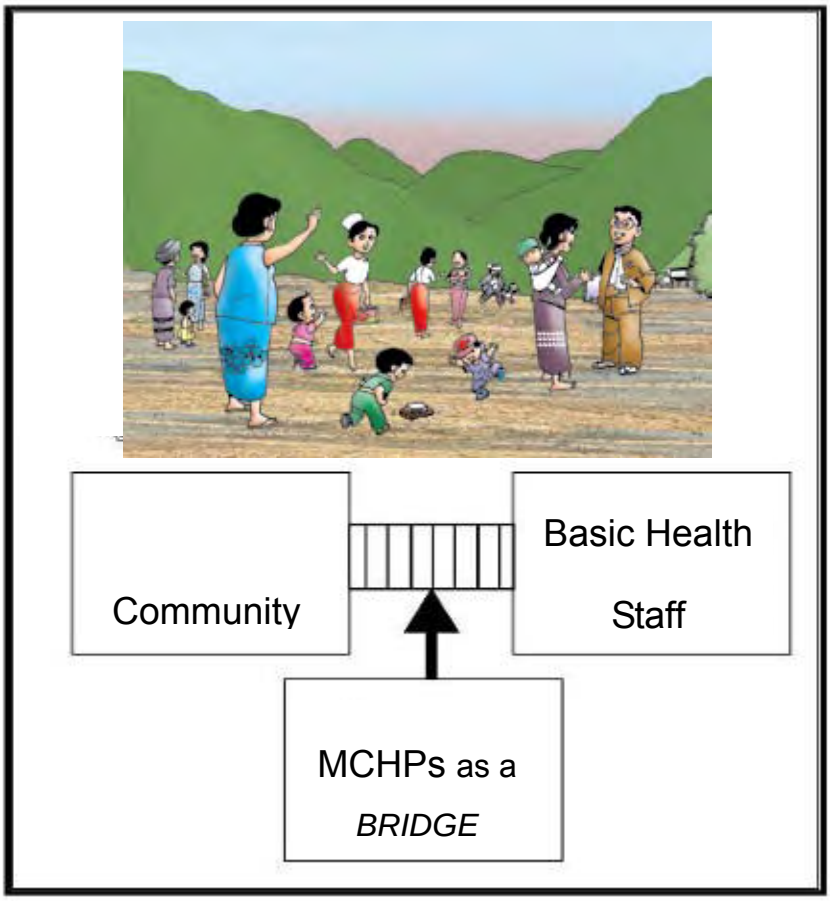
  Collect all the answer sheets and send them to the township hospital.
  Collected answer sheets will be graded and evaluated at the township level.
  Results of Pre-/Post- test will be shared with the supervisors of the MCHP System.

Flipchart 1

Today's Program

8:30 – 8:45	**Opening**
	1. Opening Remarks
	2. Introduction
8:45 – 9:00	**Pre-Test**
9:00 – 10:15	**Session 1: Maternal and Child Health Promoters (MCHP) System**
10:15 – 10:30	**Coffee Break**
10:30 -12:00	**Session 2: Normal Pregnancy and Delivery**
	1. Normal Course of Pregnancy
	2. Antenatal Care
	3. Nutrition
	4. Infectious Diseases and Immunization
12:00 – 13:00	**Lunch**
13:00 – 14:30	**Session 3: Emergency Referral**
	1. During Pregnancy
	2. Upon Delivery
	3. Newborn Baby
	4. Other Emergencies
	5. Case study and Discussion
14:30 – 14:45	**Coffee Break**
14:45 – 16:00	**Session 4: Experience Sharing**
	1. Practical Advice from Experienced MCHPs
	2. Questions and Answers, Discussion
16:00 – 16:30	**Closing**
	1. Wrap up of the program
	2. Post-Test
	3. Certificate
	4. Closing Remarks

Flipchart 2

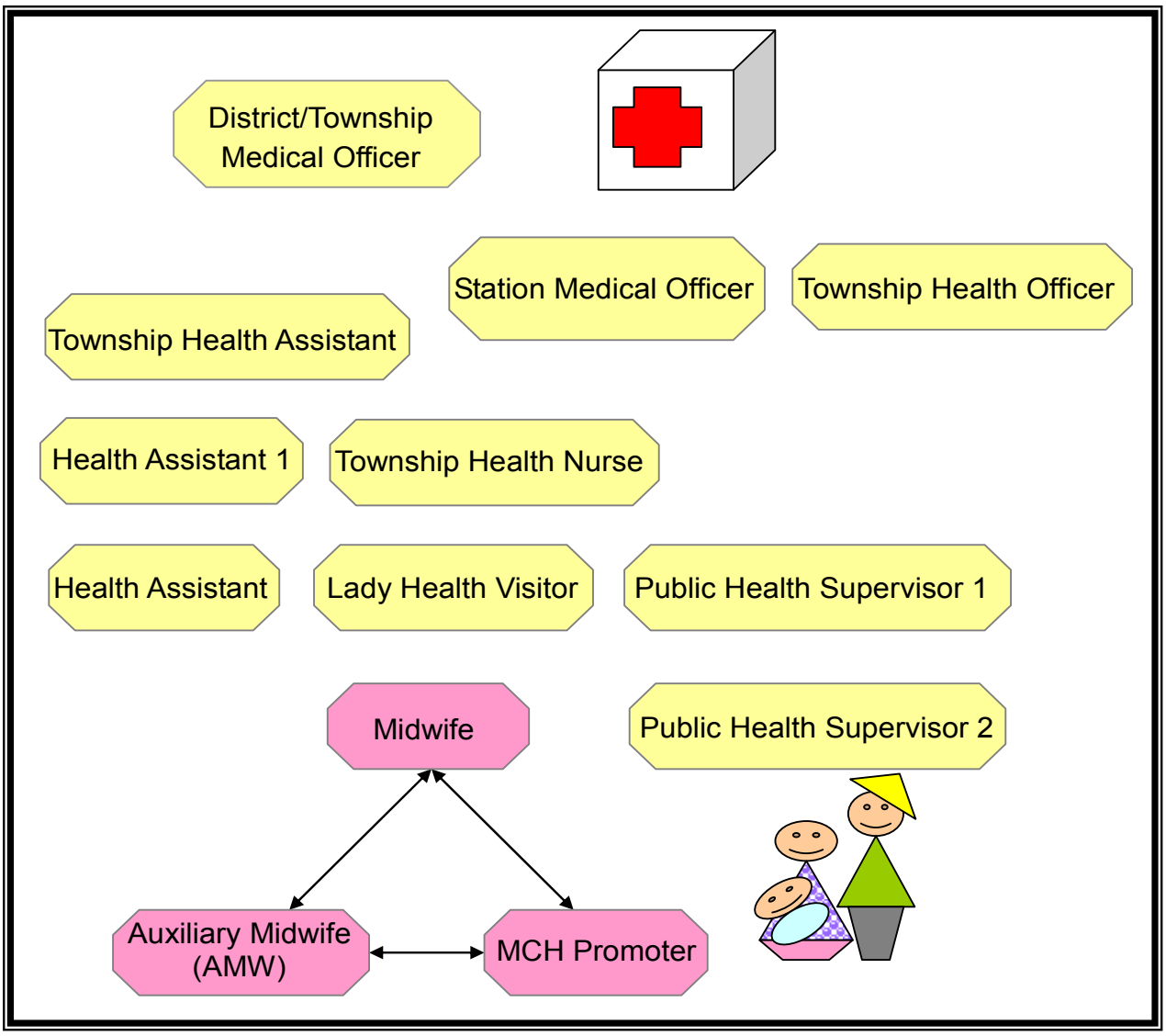


Flipchart 3

Good communications for MCH Promoters are:

1. Greetings
2. Be a good listener
3. Talk with easy and polite words
4. Have suitable behaviors

Flipchart 4



Flipchart 5

To get ante natal (AN) care at least four (4) times.

First Visit	➡	Within first 3 months (as soon as possible)
Second Visit	➡	Within 6 and 7 months of pregnancy
Third Visit	➡	at 8 month of gestation
Forth Visit	➡	at 9 month of gestation

Flipchart 6

Referral

1. If a pregnant woman, a mother or a baby needs to be referred to the hospital, MCH Promoters will take a part in the team for the referral.
2. Contact the nearest BHS in the responsible community and assist them. Ask the community authority and community people to provide their help. (Especially for transportation and money)
3. Encourage the person and the family.
4. To help in packing all the necessary things that the person will need. (HBMR, medical record, clothes)

Flipchart 7
Case Study for MCHPs

Case1: Anaemia

- A woman gave birth to her 5th child last month
- She still has bleeding 2 days after delivery
- One week later she started working in the field
- She had to work for several hours, and does not have enough time to rest or take nutritious food
- Her bleeding continued till one month

Now she has complained of tiredness and weakness.

Case 2: Mastitis

- A woman gave birth to her 2nd child
- There were no complications during delivery and she breast-fed her baby
- One week later, she had fever, her breasts were tender and inflamed

MCH Promoters Training Pre-Test/Post-Post (sample)

Date _____

Township _____

Village _____

Name _____

Fresher _____ Refresher _____

Please tick (✔) if the sentence is true and put a cross mark (✗) if it is false.

No	Question	Answer
1	MCHP should visit every household whenever she wants.	✗
2	MCHP should not do any medical interventions.	✔
3	Three times of AN care is enough for the pregnant mother.	✗
4	MCHP can tell personal information of mother to other MCHP.	✗
5	New born baby with difficult in breathing should be referred immediately.	✔
6	Mother should stop giving Breast milk after 6 months of the delivery.	✗
7	Severe abdominal pain of pregnant woman is a danger sign of pregnancy.	✔
8	MCHP should recommend PN care after delivery.	✔
9	If MW is not available for delivery, MCHP must attend the delivery.	✗
10	Pregnant woman should take medicine only given by health institutions.	✔

Monthly Reporting Format of MCH Promoter (sample)

Name of Village: _____

Name of MCHP: _____

Date (D/M/Y)	Name of Pregnant Woman/Mother with child under 5	Age of Pregnant Woman/ Mother with child under 5	Subject you have referred to MW (√)							
			ANC (1.2.3.4)	TT (1.2)	Delivery	Emergency Referral	PNC	NBC	Immunization under 5	Other subjects, specify
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
			( )	( )						
(Sample)										
			√ (4)	√ (2)						*Nutrition*

Received by: _____

Date: _____

**** This format has been used as a tool for monitoring MCH Promoters activities in the Project. You can modify this format according to your needs in your area.***