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ACCELERATING THE ACHIEVEMENT OF HFA/2000 THROUGH ACTIVITIES AT THE LOCAL LEVEL

1. This document presents a conceptual framework for accelerating the achievement of HFA/2000. It emphasizes action at the local, district or peripheral level. A three-tier health development programme of activities was approved by RC35 (September 1985) as follows:

- 1986: Operational support activities for PHC (peripheral level);
- 1987: Technical support activities for PHC (intermediate level);
- 1988: Strategic support activities for PHC (central level).

2. Emphasis is on the need to establish at the local level a health management cycle (planning, implementation, monitoring and evaluation), as well as a systematic approach to the organization of community health activities applying simultaneously key PHC strategies. There would be coordination of the inputs from the health sector, other related sectors and the participating communities. Indicators are proposed for the assessment of progress towards HFA/2000.

3. This document should be regarded as a short reference guide from which member countries can review their strategies and plans of action for PHC implementation at the local level.

CONTENTS

ANNEXES

INTRODUCTION

1. As countries implement their primary health programmes, it is becoming increasingly clear that considerable decision-making and support structures must be brought as close as possible to the operational/implementation level. While it was relatively easy to direct basic health service units from the centre and to implement disease control programmes separately or "vertically", the demands and challenges of the PHC approach cannot be met through central planning and management alone. An appropriate level would have the responsibility of harmonizing the policy decision of central authority with local initiatives and resources through community involvement and intersectoral collaboration.

2. Focus on district level (or another appropriate level) health planning and management permits relatively more concise analysis of managerial needs and adaptation of organizational structures to a geographically defined area and population of relatively easily manageable size, which is replicable in all parts of a country. It would be more accountable to community health needs and demands and would harness the creative potential of communities and utilize their skills and resources. The motivation and productivity of local health and other related staff and officials would increase because of their involvement in planning and management decisions. The credibility of front-line health workers as well as community health workers, health/development committees and similar groups depends upon their ability to assure referral service when needed and upon the amount and type of technical supervisory support they receive.

3. Almost all countries that conducted Joint PHC Reviews in 1984/1985 noted the crucial importance of district level planning and management. The two intercountry workshops (Banjul, June 1985 and Mbabane, October 1985) that conducted such reviews recommended joint action by WHO and countries in the development and strengthening of district planning and management capabilities in Member States.

OPERATIONAL SUPPORT FOR HFA/2000 ACTIVITIES

OBJECTIVE

4. The objective is to assist local authorities in promoting the following:

- establish (and or adapt) operational plans for HFA/2000; including activities that would promote physical, mental and social well-being of people leading to individual, family and community self-care;

- organize health-related activities for HFA/2000 in established comprehensive infrastructures (health centres, etc.), with the assistance of community health teams, front-line workers from other social and economic sectors, and community health aides selected and (possibly) supported by the client communities;

- monitor implementation of these activities and evaluate their impact on health and well-being status, expansion of health care coverage and satisfaction of health-related social needs.

METHODOLOGY

5. The goals of HFA/2000 have been subdivided into goals related to individuals, families and communities, the implementation of which would include the eight components (suggested as the minimum at Alma-Ata), as well as others generally accepted as major determinants of health (Annex 4).

6. All countries, whatever their size, are organized into administrative units of varying size. National health authorities, it is suggested, would define or redefine "health districts" which would correspond ideally with the smallest administrative units for which public services are provided. These are the smallest urban or rural communities for whom primary health care programmes can be organized. The population size and its

composition would vary in different countries and in different areas of any given country. It is important however to define minimal viable "health districts" for the delivery of "essential health care", which should be consistent with economic and geographical realities and recognized political subdivisions of the country. Operational support for PHC, including community participation and intersectoral coordination, would be organized for these health/administrative districts as an integral part of the development process.

7. The Regional Director made suggestions to the Regional Committee meeting in Lusaka (September 1985) for accelerating the implementation of primary health care in order to achieve the objective of Health for All by the Year 2000. Those suggestions consisted in preparing a plan of work for each country that would specify clearly the activities and support required at the operational (peripheral) technical (intermediate) and strategic (central) levels so as to implement primary health care. In order to focus the Regional Committee's efforts on the Region's top priorities, the Regional Director proposed a three-year overlapping plan for supporting primary health care as from 1986. The following would be reviewed by Member countries as follows (Annex 1):

1986: Operational support for primary health care (peripheral level).

1987: Technical support for primary health care (intermediate level).

1988: Strategic support for primary health care (central level).

8. The Regional Director was requested to prepare a framework for each subject with certain details that the countries might use in organizing the required support at each level for implementing PHC. The Regional Office and the subregional multidisciplinary teams will be available to each country to support that activity. The experience thus accumulated will be the subject of a document that will be used as a basis for the technical discussions in 1987, 1988 and 1989 respectively.

9. The following schemas (Annex 2 and 3) illustrate the typical administrative structure observed in African countries and the manner in which accelerated PHC implementation can be achieved through local (district) level planning, management and evaluation of individual, family and community health initiatives.

10. In a given health district, community representatives, health staff and front-line workers from other sectors will attempt to set priorities, within the framework of essential health care goals. They will thus determine a district health programme which they will jointly plan, programme, implement and monitor, applying simple management skills.

11. Health districts may also be organized around local/district hospitals; if they do not overlap with administrative districts, articulation with other sectors may be difficult while community mobilization falls out of step with local, political and social forces. Health districts organized in this way may provide health care, but inputs of health into development would not be easy.

12. To ensure "health for all" it is suggested that each administrative district should have an HFA/2000 implementation committee. These are sometimes called District Management Committees. These implementation committees will have as their role, the three objectives listed above. These are reproduced in the form of a two-dimensional matrix (Annex 5).

13. The Community Health Team (CHT) has a key role. It is the most peripheral outpost of the health system, the first point of contact with its clients. The CHT would work in close collaboration with community health workers (CHW) on the one hand, and community based workers of health-related sectors, on the other. The community health team participates in the training and supervision of community health workers, as well as in the orientation of other community based workers (CBWs) to health development goals. The CHT would assist CHWs in helping to achieve personal self-care and in monitoring and evaluating health and well-being status, using simple indicators. The CHT would assist other CBWs in achieving community self-care, and in monitoring and evaluating the satisfaction of the health-related needs of the people. The CHT usually comprises health team members capable of promoting family self-care goals and the monitoring/evaluation of health care coverage within the administrative unit.

IMPLEMENTATION

14. National authorities will continually review their implementation policies. The major components (or subgoals) of the goal of HFA/2000 can be redefined in client-oriented terms. There would be targets for individuals (especially those at special risk like infants, the youth and the elderly), families and communities respectively.

15. "Health for all" would be viewed as:

- the attainment by the vast majority of individuals of certain measurable indices of health and their capability to take responsibility for their own health; the same would be true for families and community groups;

- extension of health care coverage over the entire country, all the "health districts" within the country, including coverage by a range of defined activities, e.g. immunization, water, family planning, diarrhoeal disease control, etc.;

- satisfaction of community groups as far as a specified range of health-related social needs are concerned, including literacy, housing, water and food supplies, sanitation, etc.

16. Annex 6 shows how district HFA/2000 implementation committees can use the operational management cycle, during a fiscal year, to plan, organize and evaluate activities in support of HFA/2000.

17. Annex 7 shows a suggested model for the composition of district/local HFA/2000 implementation committees that will collaborate with operational support teams (example in Annex 8).

18. Annexes 9, 10 and 11, show in outline the possible starting points for operational planning of activities in support of HFA/2000. Annexes 12-15 summarize a range of possible community based activities that can be implemented by community health workers and other community based workers with health-related duties.

19. Annexes 16, 17 and 18 show in outline how the district implementation (management) committee and the operational support team may proceed with monitoring and evaluation.

DISCUSSION

20. Health-related activities at the local/district level in many countries of the Region remain uncoordinated. This can be demonstrated by direct observation in the field, and by the witness of the many individuals, institutions and agencies - local, national and international, government and nongovernmental - that contribute to health development at the local level. A much greater impact can be assured and the achievement of HFA/2000 goals would be accelerated if resources can be pooled (even partially) and the efforts of many disciplines and sectors coordinated (Annexes 1, 2 and 3).

21. This document seeks to promote an accelerated thrust in health development through coordinated planning, organization and evaluation of all health-related activities at the local level - in well-defined "health districts" - under the overall leadership of the administrative/political head of the "district" - District Officer/Commissioner, "Sous-Prefect", etc. The approach presented here can, we believe, be applied to a varying degree in different countries, according to the extent to which the national administration has been effectively decentralized. Failure to strengthen the "district" or other appropriate level would diminish the chances of implementing the primary health care approach (Annexes 3 and 4).

22. Multidisciplinary, multisectoral health-related activities can be planned, organized and evaluated by appropriately constituted district/local/HFA/2000 implementation committees, which should be well briefed on how to carry out their responsibilities.

23. These are sometimes referred to as District Management Committees, but the term "implementation" is preferred because their role would be "operational planning" - "strategic" and "technical" planning would have been done at the higher echelons. They would implement nationally agreed policies and strategies, decide what can be done with locally available resources (with help from higher levels), assist with the organization of health-related activities at the community/grassroots level, and in monitoring and evaluation (Annexes 5 and 6).

24. These "implementation committees" (Annex 7) would be assisted by "Operational Support Teams (OST), the composition of which can be determined by Member countries, bearing in mind the principal activities they are expected to perform (Annex 8). A small country might utilize one such team but as a general rule it is expected that many countries would have one OST per province/region, serving all the districts within the "intermediate level" of the hierarchy. Ideally however, each district would have its own "OST" - at which stage of development the fully staffed district health team becomes synonymous with the operational support team, combining responsibility for the "health care package" of the district with assisting the District Implementation Committee in coordinating and canalizing the efforts of the many actors in district health development. It will also participate in the implementation in the district, of health development activities organized from higher levels of the hierarchy, e.g. training and supervision, monitoring and evaluation, research and development.

25. A framework for operational planning at the district level (Annexes 9, 10 and 11) would be prepared by the central and intermediate levels so that these are in keeping with national resources and objectives. Operational plans would, however, vary according to local circumstances, including the findings of an initial situational analysis or the results of monitoring/evaluation after each year's activities.

26. The framework adopted should be such that health-related goals for "individuals", "families" and "communities" would be easily understood and the lead role played respectively by:

- community health workers;
- community health team members;
- community-based workers from other sectors.

This division of labour is important because it places responsibility squarely on the client communities, the Ministry of Health, and other health-related ministries and agencies, government or nongovernmental. It is understood, however, that in the field collaboration would be so close that all community-based staff would be involved in all three areas.

27. As with the framework for operational planning, the organization of health-related activities for individuals, families and communities will reflect the capabilities of community health workers, community health teams and other community-based health-related personnel respectively, in spite of the fact that implementation would be a joint effort (Annexes 12-15).

28. As far as individual health is concerned, child survival, adolescent health and geriatric welfare activities are emphasized (Annexes 12 and 13). The needs of children between 5 and 14 years, of working adults between 25 and 64 years and of pregnant and lactating women are incorporated in family health activities; the latter would be carried out in the context of community health care. Health-related activities for individuals would depend a great deal on community participation and are defined in such a manner that lay individuals, family heads, and community health committee members would have little difficulty in organizing them since this requires little biomedical knowledge. They would however have the backing of front-line (community-based) health and other workers.

29. In the majority of countries of the Region, child survival activities would be a "hollow victory" if adolescents are unable to "make it" to responsible adulthood. Furthermore, investment in geriatric welfare will contribute to child survival and adolescent health because of traditional involvement of the elderly in the care of the young

30. Family health activities presented include - reproductive health, diet and nutrition, family life education, primary medical care and special health care needs. They are complementary to "individual" and "community" health activities. They cover traditional areas of expertise of "health team" members (Annex 14).

31. Community health activities cover a wide range of expertise (Annex 15). Health team staff can contribute to many of them, but by and large the required skills belong to front-line (community-based) workers under the control of other ministries and agencies of government, and, in some cases, workers belonging to nongovernmental organizations. Since the health sector normally has no control over their activities, the cooperation of their

supervisors at higher levels of the hierarchy must be sought, and at the local level coordination of all development activities including health must, of necessity, be the responsibility of the local politico-administrative authority. Health-related activities would then be implemented as part of development, the leader of the health team (and members of the team) would then have "secretariat" responsibility which includes follow-up of all the decisions and recommendations of the local authority as they relate to health, and of the district HFA/2000 implementation committee - if one exists.

32. Monitoring of activities and evaluation of impact (Annexes 16, 17 and 18) complete the operational management cycle, leading to further operational planning, and "reprogramming" of activities. As with the other parts of the cycle "health status indicators", "health care coverage" and "health-related basic needs" would be put in a framework that would allow for the participation/involvement of community health workers, health care teams and front-line workers of other sectors respectively. The higher echelons of the hierarchy would play an important role in ensuring reliability; and comparability of findings in different parts of the country, and with other countries in the Region and the world.

33. Emphasis on evaluation will be on "positive" information or data, including primarily the type of information the significance of which intelligent educated members of the community can evaluate. The instruments and methods of evaluation will clearly relate to the goals of "operational plans", and the extent to which these goals have been attained. Monitoring, on the other hand, will ensure that the activities are proceeding as planned and that "corrections" and "improvements" can be made in the course of implementation of planned activities.

34. Three types of indicators are proposed for children under five years. Birth weights which have a prognostic value in relation to survival in the neonatal period and later, and could be a measure of the effectiveness of "intra-uterine care" during the antenatal period. "Milestones" - widely used in clinical medicine, paediatrics and public health - provide an indication of a child's progress especially in the first year, whilst growth monitoring, used effectively, will in addition provide warning signals of danger. These simple indicators for under-fives, and similar ones for adolescents and the elderly can be used as instruments for management especially for "self-care".

35. On the other hand, well-known "negative indicators" like infant mortality rate are more a measure of the hostility of the environment to which a child is born and failure of organization on the part of the community to protect its offspring. The infant mortality rate can properly be presented as a child survival rate - as a health indicator applied to human population groups. Similarly, maternal mortality is a reflexion of the biological quality (health status) of the women before pregnancy, the extent to which antenatal care succeeded in correcting health defects, and last (but not least) the effectiveness of arrangements to deal with pathological, anatomical and pathophysiological problems/complications related during birth. Maternal mortality or survival is also a health-related population issue.

36. In summary, the achievement of HFA/2000 would be accelerated through action at the district/local level. Countries having received PHC implementation in health districts during 1986 will extend their experiences from "pilot" districts progressively so that by the year 2000, all districts in the country would have been covered. It is expected that each district would be able to achieve the following:

- a well organized functioning and sustained managerial process for health development;

- effective and efficient implementation of health-related activities for individuals, families and communities;

- attainment of selected health development targets related to health status, health care coverage, and health-related basic needs.

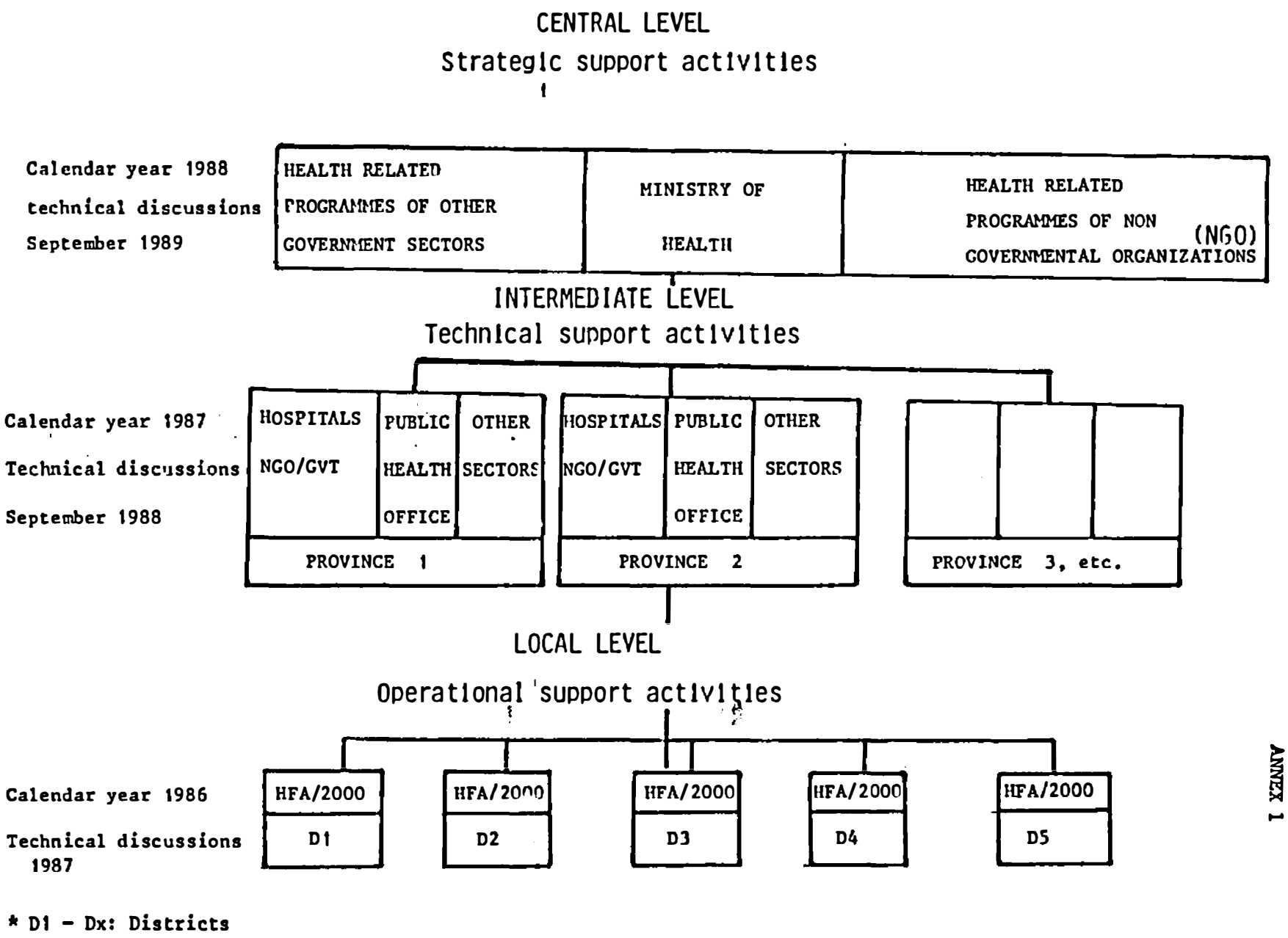
WHO and the international community will assist member countries in providing support as follows:

- operational support including helping to get the work done, at the local and community/village level;

- technical support, especially the selection and adaptation of affordable technologies, for programme implementation at the intermediate level;

- strategic support including the use of appropriate strategies to translate policies into action plans, at the central/ministerial level.

THREE YEAR "SCENARIO" OF HEALTH DEVELOPMENT ACTIVITIES

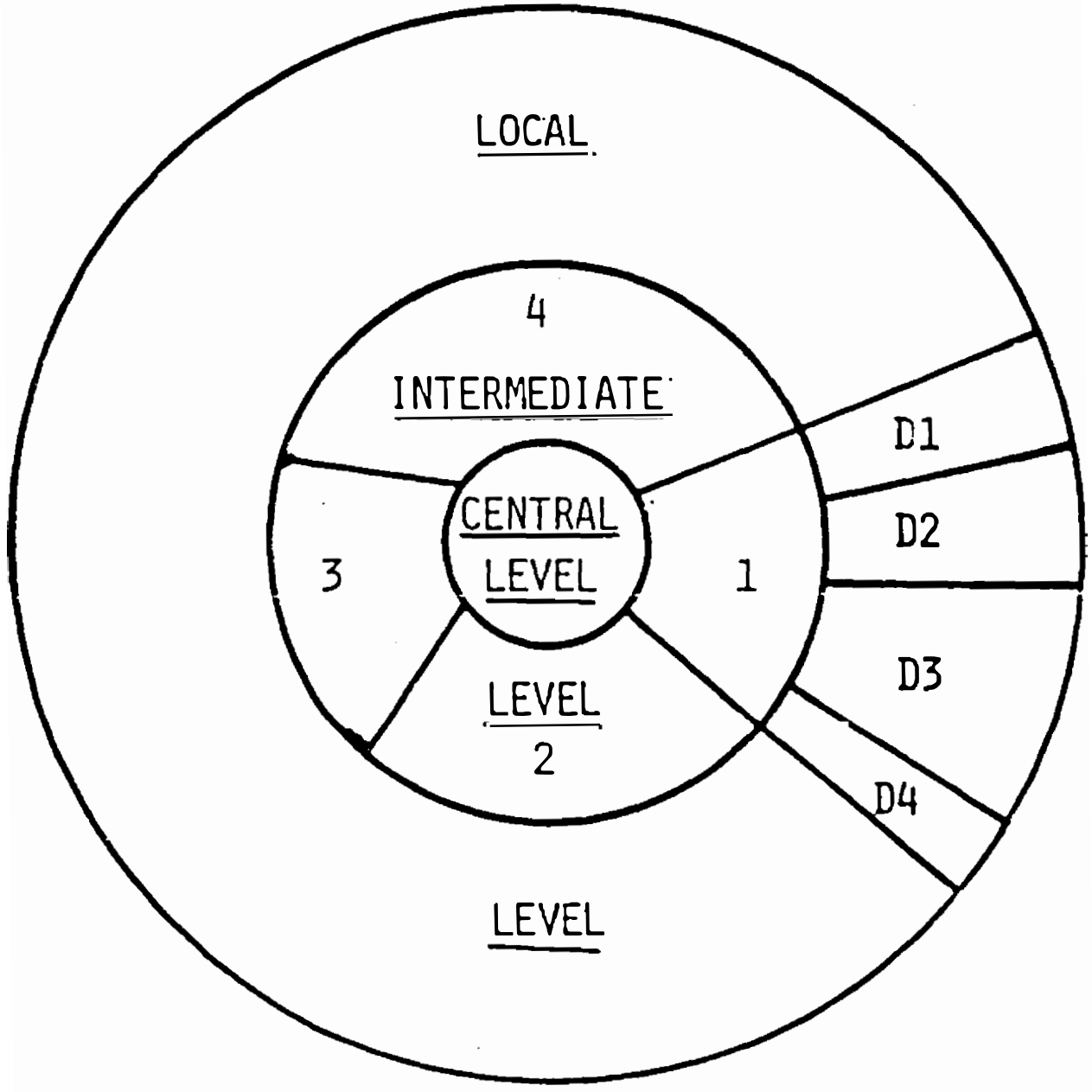


* D1 - Dx: Districts

ANNEX 2

SCHEMA OF HYPOTHETICAL COUNTRY

(AFRO-LAND)

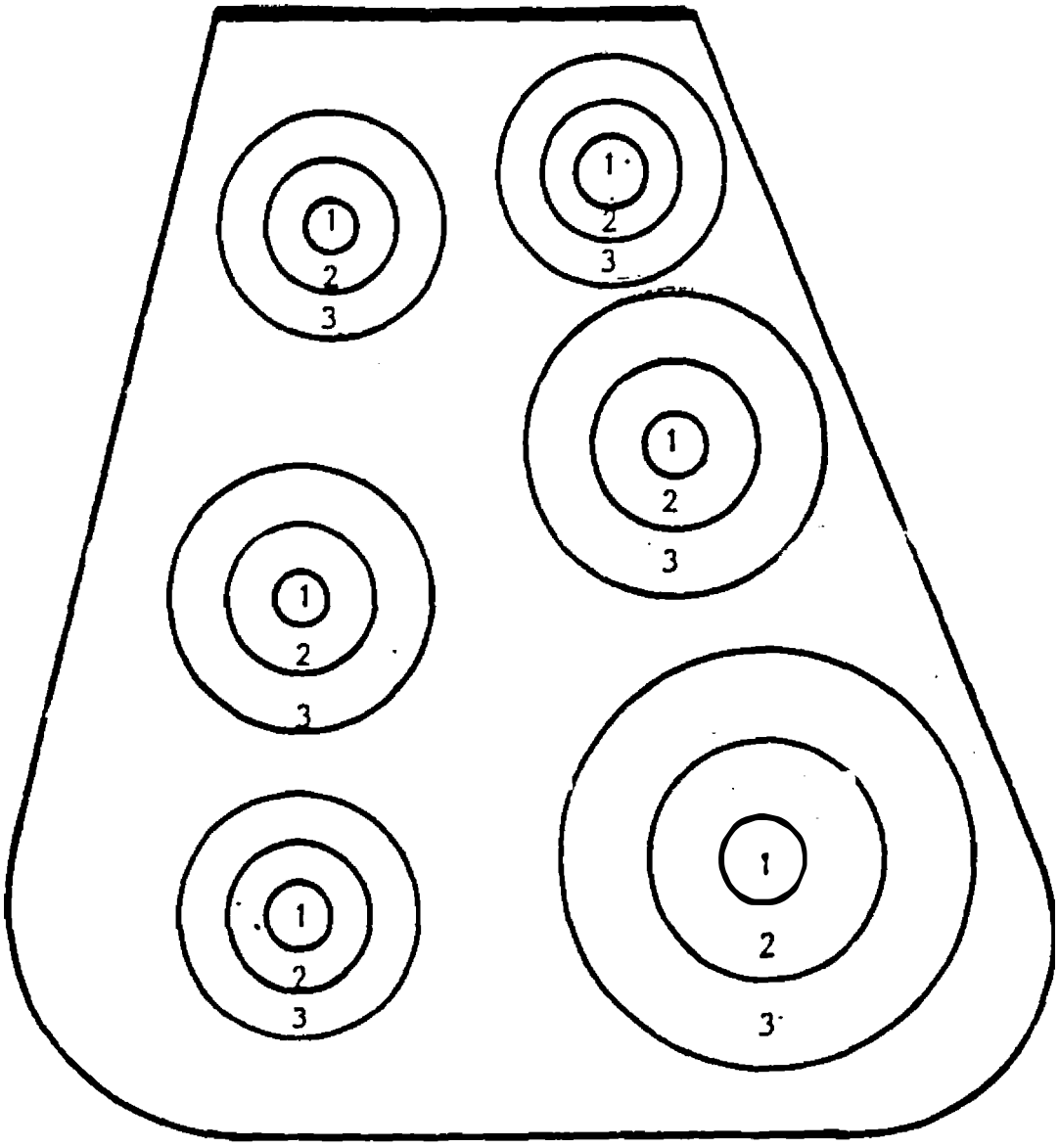


Note central level (unique), intermediate level (four provinces or regions) and the local level (four districts in one province shown).

Strengthening of operational support at the local level is scheduled for 1986, technical support at the intermediate level in 1987, and strategic support at the central level in 1988.

ANNEX 3

SCHEMA OF A HYPOTHETICAL DISTRICT IN AFRO-LAND

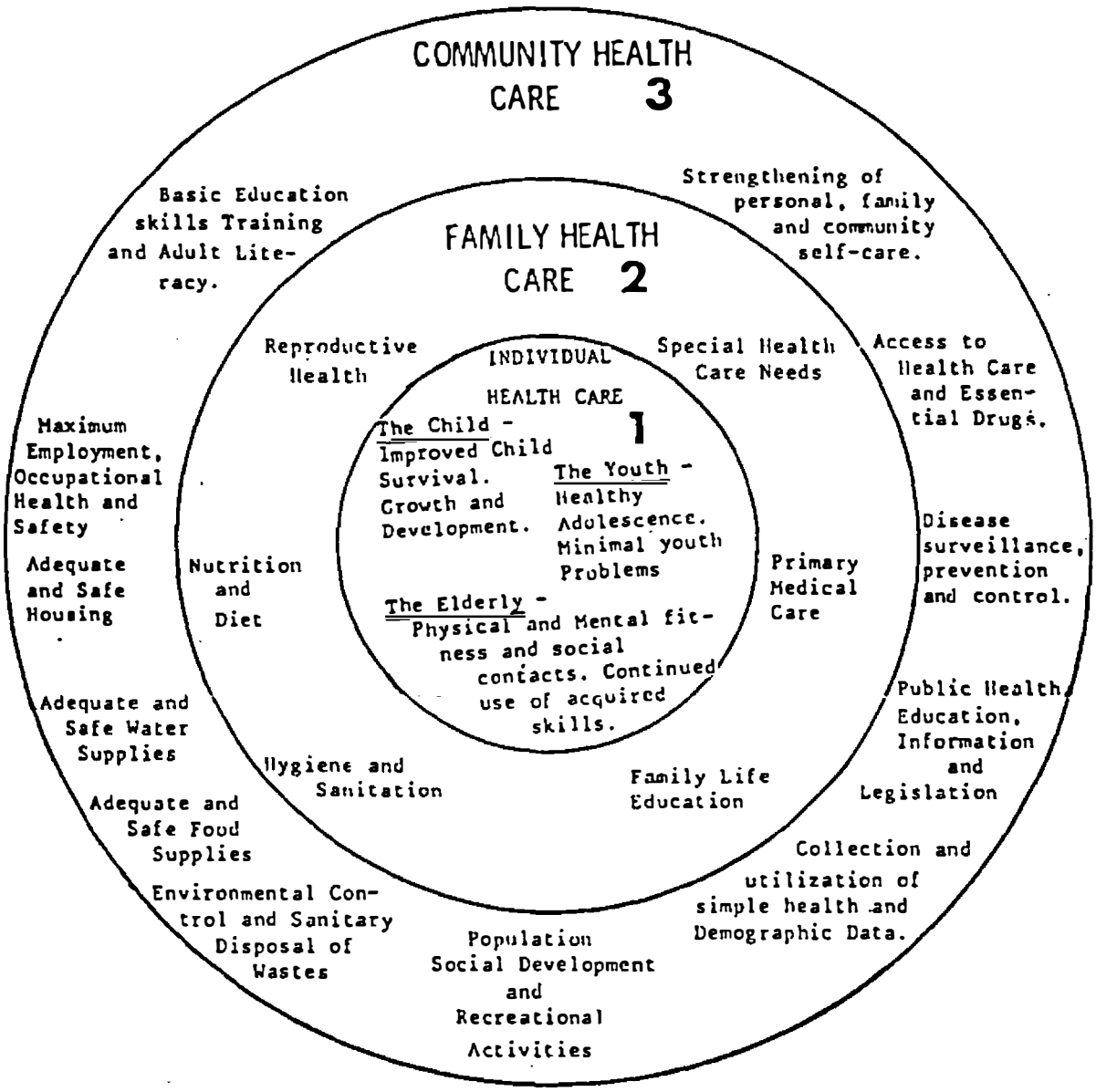


District comprises six villages (or population agglomerations) of varying size. With the guidance of District HFA/2000 implementation committees[1], and the assistance of the district's operational support team, each village would organize activities related to individual (1), family (2) and community (3) health; (1) being a subset of (2) and both subsets of (3). These activities (1), (2) and (3) include the minimum eight components of PHC.

[1] or District Development Committees.

ANNEX 4

A FUNCTIONAL BREAKDOWN OF THE GOAL OF HEALTH FOR ALL BY THE YEAR 2000

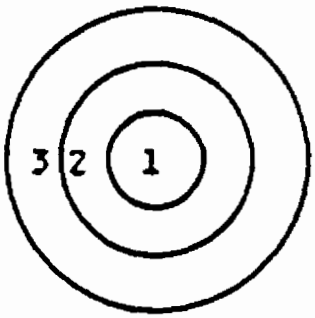
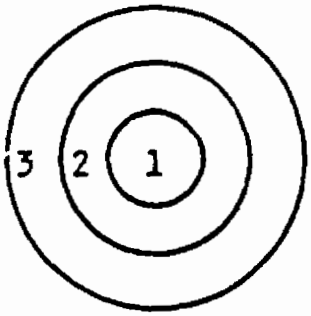
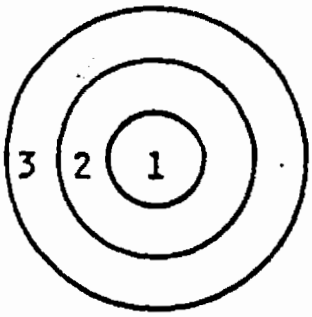


A checklist for selecting priorities and setting specific targets for individuals, families and communities; for operational planning and organization of health-related activities as well as monitoring and evaluation.

ANNEX 5

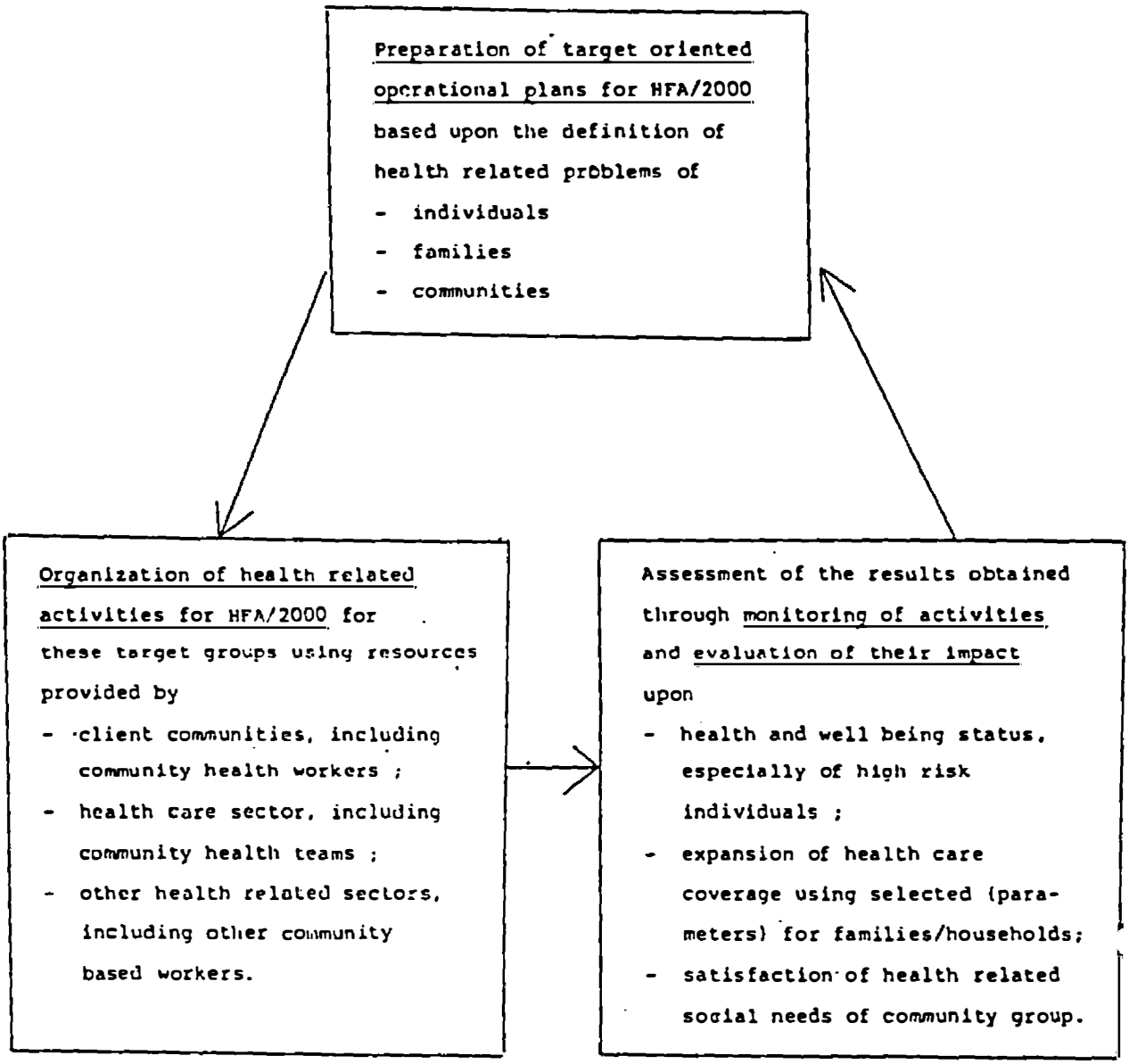
OPERATIONAL LEVEL

PRINCIPAL CONCERNS OF HFA/2000 IMPLEMENTATION COMMITTEES

ESTABLISHMENT OF OPERATIONAL PLANS FOR HFA/2000	ORGANIZATION OF HEALTH RELATED ACTIVITIES	MONITORING AND EVALUATION FOR HFA/2000
A	B	C
		
SELECTION OF PRIORITY HFA/2000 GOALS FOR PROMOTING:	IMPLEMENTATION OF MULTIDISCIPLINARY, MULTISECTORAL ACTIVITIES BY:	MONITORING OF PROGRESS AND MEASUREMENT OF IMPACT USING THE FOLLOWING PARAMETERS:
A1 - INDIVIDUAL SELF CARE	B1 - COMMUNITY HEALTH WORKERS	C1 - HEALTH AND WELL-BEING STATUS
A2 - FAMILY SELF CARE	B2 - COMMUNITY HEALTH TEAMS	C2 - EXPANSION OF HEALTH CARE COVERAGE
A3 - COMMUNITY SELF CARE	B3 - COMMUNITY BASED WORKERS FROM HEALTH RELATED SECTORS	C3 - SATISFACTION OF HEALTH RELATED SOCIAL NEEDS

ANNEX 6

A MANAGEMENT CYCLE FOR ENSURING OPERATIONAL SUPPORT FOR HFA/2000 ACTIVITIES IN HEALTH DISTRICT*



* This is a responsibility of District HFA/2000 implementation committees, assisted by the district operational support team

ANNEX 7

SUGGESTED COMPOSITION OF DISTRICT (LOCAL) HFA/2000 IMPLEMENTATION COMMITTEES

Chairman

Head of the local/district administration, or similar politico-administrative authority, e.g. "District Officer", "Sous-prefect", local Party Chairman, etc.

Secretary[1]

Team leader of the District Health Team, e.g. District Health/Medical Officer, Public Health Officer, etc.

Members

- Representatives of major governmental agencies, especially those responsible for water, education, agriculture and animal husbandry, community development.

- Representatives of major nongovernmental agencies with significant health-related activities; representatives of health committees from villages within the district.[2]

- Representatives (political, religious and professional leaders) of the major communities, villages or other human agglomerations (including underserved urban areas) within the administrative/health district.

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[1] Secretariat, liaison and follow-up functions will be the responsibility of the District Health Officer/Health Centre.

[2] In addition to the District HFA/2000 IMPLEMENTATION COMMITTEE there would be VILLAGE HEALTH COMMITTEES helping in the organization of health-related activities.

ANNEX 8

ACTIVITIES OF MEMBERS OF OPERATIONAL SUPPORT TEAMS

A. - Health team leadership, coordination and referral support.

B. - Health care support activities

- For individuals: simple diagnosis, prevention and treatment
- For families: maternal and child health and family planning
- For communities: epidemiology and control of prevalent diseases.

C. - Infrastructure support activities

- Health education and community mobilization
- Health records and statistics
- Maintenance, logistics and supplies.

D. - Technological support activities

- Field health laboratory examinations
- Environmental sanitation and community water supplies
- Pharmaceutical techniques and essential drugs.

E. - Administrative and general services support

Ideally every health district would have a team, based at the District Health Office, that will provide operational support for community-based health-related activities. Members of the team will work closely with District HFA/2000 implementation committees (district PHC - management committees) in providing support for community health workers, community health teams, and other community based workers.

ANNEX 9

OPERATIONAL PLANNING OF ACTIVITIES IN SUPPORT OF HFA/2000 GOALS

(A) Health-related goals for individuals

Objective would be to improve the health status of individuals within the community, giving priority to the needs of those with special risks.

For under fives

Undertake a clearly defined range of child survival activities that would decrease infant morbidity and mortality and promote healthy child development.

For youths/adolescents

To facilitate the transition from childhood to a physically, mentally and socially fit adult, including promotion of physical fitness, intellectual potential, and social integration.

For elderly persons

To promote physical and mental fitness and social contacts, whilst ensuring disability prevention/management, continued use of acquired skills and attachments to friends and relatives.

ANNEX 10

OPERATIONAL PLANNING OF ACTIVITIES IN SUPPORT OF HFA/2000 GOALS

(B) Health-related goals for families

The final aim is to ensure healthy, stable and economical viable families. Health inputs would include emphasis on the following:

- health reproductive practices: including programmes in maternal and child health and family planning;

- healthy domestic living: including family life education, nutrition and diet, hygiene and sanitation, and water supplies;

- health medico-social behaviour: healthy habits (personal hygiene and self-care) of family members and utilization of accessible, affordable, primary medical services, especially diagnosis, prevention, treatment of common illnesses and injuries, and rehabilitation.

ANNEX 11

OPERATIONAL PLANNING OF ACTIVITIES IN SUPPORT OF HFA/2000 GOALS

(C) Health-related goals for communities

Emphasis would be placed on several important areas (see functional breakdown of the goals of health for all) with a view to contributing to equity through the satisfaction of health-related basic needs.

Goals related to human development

Attempt to ensure that every individual achieves his/her full potential, by ensuring adult literacy (through basic education of children, and special programmes for adults); that everyone acquires useful marketable skills and there are maximum possibilities for self-fulfilment through gainful employment.

Goals related to human settlements

Ensure that minimal healthy standards are defined for urban and rural areas, that families are properly housed, that there is adequate disposal of human and domestic wastes, and access to water in the home or within 15 minutes walking distance.

Goals related to human populations

Ensure optimal quality of life of communities by ensuring a rational balance between the expectations of populations and their medical and social needs e.g. health centres, hospital beds, physicians, nurses, etc., as well as the need for balanced population growth (child survival, fertility, mortality, life expectancy); better quality of life (economic and cultural wealth, food security), and community participation in health development.

ANNEX 12

HEALTH-RELATED ACTIVITIES FOR HIGH-RISK INDIVIDUALS

Child survival activities

- Promote healthy pregnancies (including family planning)
- Provide optimal conditions for delivery
- Ensure health and welfare during the first year (Annex 13)
- Monitor growth and development during the first three years
- Provide skilled day nursery care
- Provide "play groups" education and early childhood stimulation.

Adolescent health activities

- Promote participation in physical culture and sports
- Promote socialization in youth clubs and schools
- Organize activities that will prevent accidents and violent behaviour
- Organize activities that will prevent teenage pregnancy and promote responsible parenthood
- Organize activities that will assist in prevention and control of sexually transmissible diseases
- Organize activities that will reduce abuse of tobacco, alcohol and drugs.

Annex 12

Geriatric welfare activities

- Provide facilities for management of chronic disabling disorders, e.g. diabetes, hypertension, arthritis.

- Promote socialization in senior citizen's clubs, etc.

- Promote continued integration of the elderly within their families or with relatives.

- Organize community rehabilitation programmes.

- Promote continued use of acquired skills.

- Promote participation in community services especially child survival and youth health.

ANNEX 13

HEALTH AND WELFARE ACTIVITIES RELATED TO CHILD SURVIVAL DURING THE FIRST YEAR

- Promotion of optimal infant nutrition especially breast feeding; discourage use of infant formulas, encourage development of local weaning foods

- Immunization of children following the locally agreed scnedule, in appropriate health centres, etc., against preventable childhood infections

- Prevention and control of diarrhoeal diseases, including preparation (locally if possible) and prompt utilization of oral rehydration salts

- Prevention, control and treatment of malaria, in the home using an approved multi-pronged strategy, applied by parents themselves

- Surveillance of the child, especially following severe infections, to detect early symptoms and signs of protein-energy malnutrition (kwashiokor/marasmus).

- Surveillance of the child to ensure early detection of potentially disabling conditions (e.g. keratomalacia) that may occur locally.

ANNEX 14

HEALTH-RELATED ACTIVITIES FOR FAMILIES ESPECIALLY IN UNDERSERVED RURAL AND PERIURBAN AREAS

Reproductive health

Antenatal care for all pregnant women, using a predetermined schedule of visits, with provision for high-risk pregnancies, and special laboratory tests; provision for adequate obstetric care by trained traditional birth attendants or qualified health personnel at home in health centres, maternity centres or hospitals; adequate neonatal care, infant care and child survival activities; advice and proper use of family planning methods for fertility control.

Diet and nutrition

Promote cultivation of vegetables and foodcrops, and animal husbandry (where possible) within easy reach of the house; promote selection, preparation and consumption of locally available foodstuffs that will ensure optimal nutrition of family members. Promote monitoring of food prices (local and imported) in relation to minimum wages. Promote healthy infant feeding practices especially breast feeding and local weaning foods.

Domestic hygiene and sanitation

Promote cleanliness of home and surroundings; adequate disposal of human and domestic liquid and solid wastes; construction and use of culturally acceptable and technologically sound "latrines". Ensure that there is access to safe drinking water, including in drought proven areas technologically sound methods of water conservation. Promote methods for the prevention and control of mosquitos, cockroaches, flies, rats, etc.

Annex 14

Family life education

Organize family life education through direct contact of family members with health care personnel, school teachers, social welfare workers, etc. This would be done if need be through adult literacy classes. Some of the main components would include personal hygiene and dental care for children, sex education and responsible parenthood for adolescents, pre-marital education, family planning and child spacing practices, personal interrelationships and family solidarity, family life economics, first aid in emergencies.

Primary medical care

Access to first aid and primary medical care, including diagnosis, prevention and treatment of common illnesses and injuries by health professionals and appropriate health team members, including traditional health practitioners, as appropriate. This would be carried out in dispensaries, health centres and hospital outpatient departments, equipped to perform simple laboratory tests and X-rays, and adequately supplied with essential drugs and vaccines. Financial arrangements would in general be that no money or a minimum sum, is payable at the point of delivery.

Special health care needs

In addition to primary medical care, there would be ambulatory dental health services (especially for school children) and community based mental health and rehabilitation services organized by health professionals and community health workers. There would also be a need for long-term management of family-related chronic diseases, e.g. highblood pressure, diabetes, asthma, epilepsy and sickle cell disease.

ANNEX 15

HEALTH-RELATED ACTIVITIES FOR COMMUNITIES IN DEVELOPING COUNTRIES

Basic education and adult literacy

Arrangements should be made to ensure maximum primary school attendance; making sure that children are literate, numerate on leaving, including instruction in hygiene, first aid and economically useful skills. Adult literacy programmes, including health matters (PHC) should also be organized to ensure that a high proportion of adults are functionally literate.

Skills training, maximum employment and safety

There should be training in a wide range of skills (especially those related to agriculture and water supplies, and rural living). Rural or community based institutions should be created to absorb young school leavers, adults (and their families) requiring deployment or employment. There should should be a special emphasis on the health of workers (especially agricultural workers/farmers).

Adequate and safe housing

Arrangements that encourage individuals, families and groups to be "adequately" housed; building regulations in urban areas take account of safety, including protection from natural and artificial hazards. Model housing units for rural areas should be developed taking account of critical health matters (e.g. location of domestic animals, latrines, ventilation, mosquito/insect/pest "proofing", fire hazards, etc.).

Adequate and safe food supplies

Permanent and continuing efforts to ensure that people grow most of the food they need and that local foodstuffs consumption is encouraged. That community members and farmers are aware of the nutritive value of foodstuffs (local and imported) as a basis for choice; that transportation, distribution and marketing are skilfully organized; that appropriate incentives exist for food growing farmers.

Annex 15

Adequate and safe water supplies

Arrangements for ensuring adequate and safe water supplies for drinking and domestic purposes and for agriculture and industry. Especially ensuring that drinking water is available within "15 minutes" walking distance. Provision of technical, maternal and financial support for small community water supplies (ponds, wells, springs, etc.), and for the conservation of water (at domestic and community level). Monitoring of chemical and microbiological safety of community water supplies, as well as of "hygienic" surroundings of water sources.

Adequate sanitary disposal of wastes

Arrangements for the sanitary disposal of human, domestic and industrial solid and liquid wastes. Especially the construction of culturally acceptable and technically sound latrines; collection and disposal of solid water from households, markets and other public places, especially with community participation.

Cultural and recreational activities

In the spirit of self-reliance and with government and nongovernmental support community groups would organize cultural, sporting and other recreational activities to promote social and mental well being.

Collection and utilization of simple health and demographic data

Community representatives (e.g. health committees) will collaborate with district health teams and other community based workers in the collection/recording of information about births, deaths, significant health-related events (e.g. local epidemics), health and nutritional status (as part of organized field surveys). They would participate in review and utilization of the data collected in the operational planning, and evaluation of community based health-related activities, health and well-being status and satisfaction of health-related social needs.

Annex 15

Public health education, information and legislation

Information on health matters, including prevailing health legislation will reinforce public health education, so that people will understand public health matters, play an active role in prevention of ill-health, in the organization of health care, and comply with health-related legislation in their own interest.

Disease surveillance, prevention and control

This would be done by recording of common illnesses seen in dispensaries and health centres, and in outpatient clinics of hospitals, "sentinel" observation posts in district hospitals from where specific clinical observations and laboratory tests are performed; and by periodic community field surveys for detecting common illnesses as well as endemo-epidemic disorders. These arrangements for the surveillance of infections and other community-wide diseases will include strategies for their early detection, prevention, treatment and control (with community participation).

Access to and financing of health care and essential drugs

Community participation would include ensuring safety of officially built premises and their maintenance; participation in the construction of health posts and health centres; participation in the organization of a revolving fund for the acquisition of essential drugs, vaccines and medical supplies; the provision of transport for the evacuation of the sick; the organization of community based health insurance, and in the management (as committee members) of the local district management committee.

Promotion of individual, family and community self-care

This would be the final aim of all health-related activities, and would be attained by participation of individuals, families and community groups in these activities. It can be promoted by transfer of technology/knowledge from the highest level of the health system (central level ministries, univerisites, research institutes) through the intermediate (provincial level institutions) to the local level.

ANNEX 16

MONITORING AND EVALUATION FOR HFA/2000 AT THE LOCAL LEVEL

(A) Health status indicators

For under fives

Birth weights	- % children born over 2.5 kg. (by birth attendant/midwife).
Child survival	- % children developing normally at end of the first year (mother).
Growth monitoring	- % height/weight at end of third year (health centre).

For youths/adolescents

Physical fitness	- % individuals physically fit and able to run (self-assessment).
Intellectual aptitude	- % individuals (15 years old) literate and numerate (school teachers).
Social integration	- % individuals fully integrated socially without alcohol, tobacco and drug abuse (parents, teachers, counsellors).

For elderly persons

Physical status	- % able to walk free of crippling deformities and blindness (self-assessment).

Annex 16

Mental status	- % able to look after himself/herself and continuing to use acquired skills (relatives, friends).
Social status	- % with high degree of attachments to friends and relatives, and participating in community/social activities health/social workers).

ANNEX 17

MONITORING AND EVALUATION FOR HFA/2000 AT THE LOCAL LEVEL

(B) Health care coverage

For individual health care

- child survival activities
  e.g. % children - aged 12 months - fully vaccinated.

- youth guidance activities
  e.g. % youths participating in recreation and sporting activities.

- geriatric welfare activities
  e.g. % elderly persons participating in social, cultural and/or economic activities.

For family health care

- maternal and child health and family planning
  e.g. number of children per mother, and interval between births.

- family life education, nutrition and diet
  e.g. % families enjoying food security - self-grown or purchased foodstuffs - providing adequate diets for family members.

- diagnosis and treatment of common illness and injuries.
  e.g. % episodes illness/injury in family members fully resolved at the local level.

For community health care

- disease surveillance, prevention and control
  e.g. % families with acceptable morbidity/mortality from major illnesses - malnutrition, diarrhoeal disease, malaria, etc.

Annex 17

- access to medical care and essential drugs supplies
  e.g. % homes/families able to secure medical attention and essential drugs within one hour walking from a fully staffed health care or hospital

- community involvement in health care
  e.g. % homes/families actively participating in self-care - health committees, mobilizing health care resources, health care activities.

ANNEX 18

MONITORING AND EVALUATION FOR HFA/2000 AT THE LOCAL LEVEL

(c) Health-related basic needs

Related to human development

- literacy
  % of adults (male/female) over 20 years able to read/write in any language.

- skills training
  % of youths/adolescents (male/female) with marketable skills.
- employment
  % of youths/adults (male/female) in gainful employment/self-employment.

Related to human settlements

- housing
  % of families living in sanitarily acceptable houses.
- sanitation
  % of families utilizing proper facilities for disposal of human and domestic waste.
- water supplies
  % of families with access to clean drinking water in the home or within fifteen minutes walking distance.

Related to human populations

- population balance
  % villages/communities with acceptable life expectancy, growth, fertility and child survival rates.
- quality of life
  % villages/communites with estimated per capita income above US $500 and with an acceptable percentage of families enjoying "food security" and participating in socio-cultural activities.

Annex 18

- expert medical care

  % villages/communities whose members have access (financial and geographical - within 24 hours road travel) to "expert" medical care in well equipped general or specialized hospitals, etc.

WORLD HEALTH ORGANIZATION
Regional Office
for the Eastern Mediterranean
'ORGANISATION MONDIALE DE LA SANTE
Bureau régional de la Méditerranée orientale

منظمة الصحة العالمية
المكتب الإقليمي
لشرق البحر المتوسط

INTERREGIONAL WORKSHOP ON STRENGTHENING TEACHING HEALTH EDUCATION/COMMUNICATION SCIENCES AT THE PROFESSIONAL LEVEL, FACULTY OF MEDICINE, SUDAN

IEH/WP/04
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ORIGINAL: FRENCH

6 - 11 December, 1986

MODULE EVALUATION SHEET

Module No. _____

Please evaluate the module as it appeared to you in relation to the eight points listed below. Place an X on the scale over the point between the two evaluations so that it indicates where your opinion lies. A + indicates the optimum point on the scale.

1. OBJECTIVE EXPLAINED:

Poorly |---|---|---|---+---| Clearly

2. OBJECTIVE ACHIEVED:

No |---|---|---|---+---| Fully

3. SELECTION OF METHOD OF INSTRUCTION:

Poor |---|---|---|---+---| Full appropriate

4. CONTENT:

Over-simplified |---|---|---+---|---| Too sophisticated Too complicated

5. PARTICIPANTS' ACTIVE INVOLVEMENT:

Too little |---|---|---+---|---| Too much

6. LEADERSHIP PROVIDED BY GROUP FACILITATOR:

Weak |---|---|---+---|---| Overdone

7. DOCUMENTATION:

Over-simplified |---|---|---+---|---| Too complicated

8. TIME ALLOTTED:

Too short |---|---|---+---|---| Too long

Suggestions for improvement not covered by the above.

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