Community Mobilization to improve MCHN outcomes in the West Bank

Report of the PMRS-Hanan Community Mobilization training Workshop June 12-15th 2006, Ramallah

Abbreviations

CM	Community mobilization
CCM	Cluster Community Mobilizer
CBO	Community Based Organization
CHW	Community Health Worker
PMRS	Palestinian Medical Relief Society
MCHN	Maternal Child Health Nutrition
NGO	Non-governmental Organization
CMAC	Community Mobilization Action Cycle
oPT	occupied Palestinian Territories
WBG	West Bank and Gaza Strip

Introduction

This report documents the first formal training workshop in Community Mobilization (CM) to be held in the Palestinian Territories. The course participants were community mobilizers who would be putting the skills learned during the workshop into practice straightaway in West Bank communities, with the overall aim of improving the health of mothers and children. Long term, the practical benefits of the training will remain and allow communities to address other issues of concern to them.

Background information

In the occupied Palestinian Territories (oPT) maternal child health indicators have been steadily worsening and the population is increasingly vulnerable due to political instability and economic deterioration. Within this context the Hanan project is working to improve key maternal and child health and nutrition (MCHN) indicators through activities within communities and at the clinic level. The community mobilization based approach aims to reach a diverse and wide geographical coverage and deliver sustained improvements.

The Community Mobilization Project Partnership

Key to the success of any community based activity is that it is generated and developed from within the community itself. The PMRS-Hanan partnership makes the CM approach a realizable one. Hanan can develop its overall aims for improving maternal child health but, as an external body and a project with a finite lifespan it cannot achieve profound nor lasting health improvements by itself. The implementation and long term effects can only be achieved by local partners who understand and work within communities. PMRS are a long established, highly respected organization with numerous, existing, wide-reaching community activities. Their recruitment, management, ongoing support and training of the CM teams, as PMRS staff members, ensure that the organization and the oPT will retain the experience from the activity after the Hanan project has ended.

Hanan

The Hanan project is a USAID-funded initiative designed to promote the health and well-being of Palestinian women and children through improved access to quality MCHN services and information. The community element of Hanan is working with pregnant and post partum women, children under 5, and their families particularly husbands/fathers and mothers-in-law/grandmothers living in the West Bank and Gaza Strip (WBG). The project has 18 months remaining, until the end of 2007.

Palestinian Medical Relief Society (PMRS)

PMRS is a grassroots, community-based Palestinian health organization. Founded in 1979, the society is one of the largest health NGOs in the oPT. it is a non-profit, voluntary organization. PMRS professional staff include physicians, community health workers, nurses, midwives, and other health professionals who work to supplement the existing national health infrastructure.

PMRS operate services at 26 permanent community health centers and at outreach locations that serve over 400 communities throughout the oPT including deprived and remote areas and with a focus on vulnerable members of Palestinian society including women and children. PMRS activities include a woman's health program, well baby and child program, health education, community mobilization and professional training within their school of community health. PMRS has become part of the social structure of many local communities – through their long term investment in services and health education and via established networks of community health workers and health promoters.

At the national level, PMRS advocates to influence health policy decisions. They contribute expertise to the development of nationally adopted protocols and guidelines for health care and focus on information dissemination, coordination and cooperation among stakeholders and civil society.

Further information about the PMRS can be found at *http://www.upmrc.org/*

Community Mobilization experience in the oPT

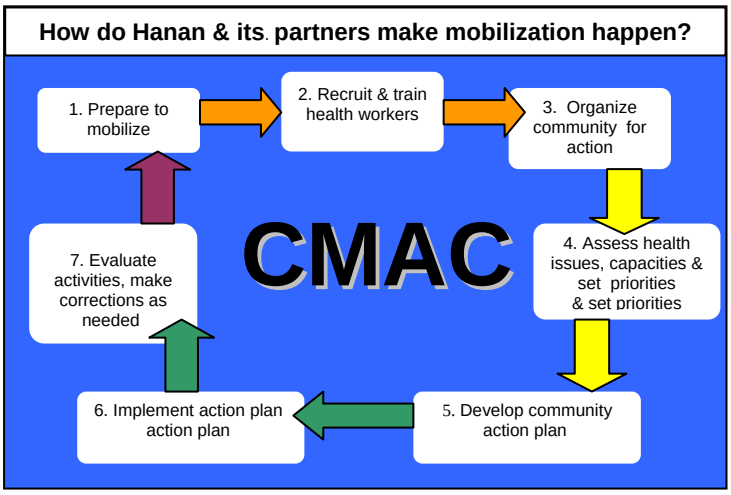
While health education activities in the oPT are widespread and expert, consolidating these within CM is not usual. A review of community mobilization experiences in the WBG [1] identified several short term projects or quite localized longer term efforts where community mobilization had led to successful outcomes. Examples include the rehabilitation of primary health care centers or supporting women to prepare iron-rich food to reduce childhood anemia. However, the review found that for the most part, community mobilization is not seen as an integral part of project designs. Furthermore, poor documentation made it difficult to identify which factors contributed to the success or otherwise of community interventions.

The Community Mobilization Approach (the community action cycle)

Community mobilization involves working with the whole community. It is a systematic process that involves identifying and using available resources locally. The community mobilizer has to be a local person themselves, in order to really know and understand how the community works, thinks and feels and what the norms and traditions are. Without this local insight – any externally generated solutions or inputs are unlikely to be sustainable. The CM approach recognizes that health is not a standalone issue and health decisions, particularly those related to household behaviors and practices are intertwined with many other lifestyle factors and choices.

The challenge for CM is to identify the barriers to "better health behavior" and then to find ways to influence a community so that an activity that may be considered inconvenient, unnecessary or expensive (for example attending for early antenatal care) becomes desirable enough to most people so that the perceived obstacles are overcome and the norms of behavior are shifted.

The model of community mobilization that has been adopted for use by the project and modified for use in the Palestinian context is the Community Mobilization action cycle (CMAC), the steps of which are illustrated in the figure below.



There are three major elements to CM using the CMAC theoretical framework:

1. **Strengthening collective action at the community level**, resulting in improved reliance on community resources, greater awareness by the communities of their health needs and service options and improved health seeking behavior. In practice this means creating viable structures for mobilization by helping to organize community coalitions which can liaise between the community and the clinic and supporting local NGOs and CBOs to improve their ability to negotiate and to plan. An important part of the process is the documentation and followup of activities. It helps to keep issues "live" and moving forward.

2. **Promoting key family practices that are critical for MCHN** by completing a community capacity assessment with each community coalition to discuss, review and agree upon local priority health needs. And then ensuring that all education, motivation and skills activities at the community level are in line with and integrated with clinic based activities and any wider communications marketing and health education interventions.

3. **Partnering where feasible with health facilities** to match service delivery practices with the community's needs. In practice this involves informing clients of the range of services they have access to and the conditions of that access (location, travel time, opening hours, cost etc) and the quality of care that they should expect and developing formal mechanisms for clients to provide feedback to providers (eg suggestion boxes, exit interviews)

This training course was designed to work through each step of the community mobilization action plan. Each topic was covered thoroughly in order to build the appropriate local action plan. It was the first of three three formal training events scheduled in 2006. Together they contribute to "step two" of the Community Mobilization Action Cycle (to recruit and train health workers). These courses are designed to equip the CM teams with the knowledge and skills need to implement community mobilization in the field. In the three months following the first course the teams will be putting newly learned skills into practice following the CMAC approach. The CM project and activities are structured to provide the teams with a supportive environment. Ongoing training and coaching is essential to guide them through the practicalities of putting together local community coalitions, keeping them together and working with and through them towards the end goals - improved mother and child health.

Project area, communities and scope

An initial assessment by Hanan used an objective approach to identify vulnerable[1] non-refugee communities in the oPT. These communities, grouped into local

[1] Vulnerable communities were defined as non-refugee communities who were vulnerable in terms of access to health care. Access issues included both financial and physical hindrances to access.

geographical “clusters”, are the target locations for the Hanan project and community mobilization activities will be focused there.

Key Maternal Child Health and Nutrution (MCHN) indicators specifically relevant to the oPT have been defined. It is evident that there is very high coverage of some MCHN indicators but that others fall short of internationally recommended standards for best practice. For example almost all women in oPT go to the laboratory to get a pregnancy confirmation test but most do not attend an antenatal service until the 4th or 5th month of pregnancy. WHO recommends an initial visit in the first trimester to optimize antenatal care. In addition, many women in the oPT do not receive any post natal care at all, and of those that do, most are not seen at the WHO recommended times (6 hours, 6 days and 6 weeks after delivery). A household survey in the target communities during 2005 [2] found that less than 5% of mothers in West Bank project clusters received such “timely postnatal care”. Similarly, less than 60% of mothers surveyed breastfed their babies within the first hour of birth and less than half exclusively breastfed their babies for the first six months. These examples illustrate some of the MCHN indicators where improvements are desirable. Table 1 lists the key messages promoted through the community program which are aimed at improving these MCHN indicators by promoting positive behaviors and knowledge.

Table 1: PMRS-Hanan Community Program - CM&M Key Messages

Topic	Key Messages
Ante-Natal Care	Importance of early antenatal visit (within 1st trimester) for fetus and mother, and barriers to early registratio
	Understanding danger signs and potential complications during pregnancy, and the early identification of risks and emergency response
	Importance of preventing anemia for fetus and mother, and what to do about it – iron and folic acid supplementation for at least 6 months during pregnancy and for 3 months postpartum
	Signs of labor, planning for delivery, importance of physical and psychological support by husband and family (m-in-l, mother) during pregnancy and postpartum
Breast Feeding	Importance and benefits of early initiation of breast feeding – from ½- 1 hour after delivery, night feeding, and feeding on-demand
	Correct technique for breastfeeding
	Importance of breast feeding exclusively for 6 months, and overcoming barriers
	Importance of breast feeding for 2 years, and overcoming barriers
Post Natal Care	Importance of postnatal care (for baby and mother) within 6 hours, 6 days and 6 weeks of delivery, and barriers to seeking early postnatal care
	Understanding danger signs during 1st 6 days of delivery for the neonate and mother, early identification of risks and complications during this period, and emergency response
	Importance of appropriate care for neonates (wrapping, warming, eye care, care of umbilical cord)
Child Health U2	Timing and type of liquids/solids in baby's diet after 6 months
	Importance of healthy weaning practices at 2 years
	Importance of anemia prevention – iron supplementation, and Vit A&D drops
Child Health U5	Prevention, early detection, home management, referral of children with ARI
	Prevention, early detection, home management, referral of children with DD
	Prevention of anemia – iron supplementation, nutrition
	Importance of growth monitoring and promotion

The Community Mobilization training plan

The community program has defined three lifecycles through pregnancy and early childhood. The initial training schedule involves three training workshops, the first session, the subject of this report, laid down the basics and principles of a community mobilization approach and the two subsequent events will cover the elements of the MCHN pregnancy-childhood lifecycles in detail. The lifecycles and the training schedules for the next workshops are included in Annex 1.

Pre-training preparation

Before the first training workshop all of the Hanan household baseline survey results [2] and information from local focus groups were analyzed to identify, for each community, the MCHN indicators of most concern locally. These local profiles were used to focus the training course activities towards the health issues that the field workers would be addressing in reality. In addition PMRS mapped the health resources available to each community (such as midwives, labs, physicians, clinics etc) and the obstacles to access in order to equip each community with information to prepare for emergencies.

Some MCHN indicators, such as timely postnatal care were a priority for all communities. Other indicators were important in some but not other clusters. For example anemia was an important problem in some clusters but was not an issue at all for grape growing areas (Hebron district) where locally made iron-rich grape-concentrate "dibs" is commonly eaten by pregnant women.

The first training workshop: Introduction to Community Mobilization Concepts and Approaches

On June 12th the project managers from PMRS and Hanan, Atef Shubita and Anne Scott welcomed the project community health workers and mobilizers to the training workshop. The introductory session was an opportunity to set the scene for the work that the CM teams would be doing in the oPT and outline the overall course objectives. These were to:

- Understand how the PMRS-Hanan partnership will work, and the PMRS Community Structure and reporting relationship
- Learn to differentiate between the role of health educators and community mobilizers
- Learn ways to think critically about the needs of communities and engaging all stakeholders in an active dialogue
- Learn to present and actively exchange ideas and experiences in working with communities.

The first training sessions covered general themes. During this period the participants got to know each other, the project technical team and trainers It gave the organizers the opportunity to emphasize the significant role of the community program within the overall Hanan goal of improving maternal child health; the

importance of the PMRS-Hanan partnership in achieving this; and the key role of the trainees as the crucial link between the project and the communities.

Training methods:
Several training methods were used during the workshop. Emphasis was on group work and practical sessions. Most of the exercises were conducted within cluster, or district based groups focusing each day on indicators that were the MCHN priorities relevant locally. The training methods included:

- **Group exercises**: Trainees worked in small groups on specific problems and challenges that may arise in the field. Solutions and conclusions were presented and discussed within the whole group for overall discussion and analysis.

- **Role playing** enabled trainees to practice for real-life events they are likely to encounter during their field work. The sessions concentrated on the key MCHN messages and indicators specific for each community. Trainers and other participants carefully monitored the role play sessions and provided feedback. Group discussions afterwards reviewed the objective of the session.

- **Interactive group discussions** were facilitated by the trainers to guide participants through theoretical concepts and how to apply them to common challenges that they might encounter at work or in the field and including appropriate action steps. Again the focus of these sessions was on issues relevant to the key messages of the program.

- **Lectures:** structured teaching sessions to take participants through the theories and concepts behind community mobilization and relevant to their field work. The sessions used a variety of audiovisual aids (powerpoint presentations, manuals, brochures, flip charts etc)

- **Reviewing and previewing:** Each training day ended with a wrap-up and evaluation session and began with a rapporteur, from among the trainees, recapping and summarizing the previous day's training. Before key sessions the trainers used various techniques to engage the audience in the topic, to make them think about the area and to gauge areas where more detail or time might be needed on a particular topic. Typically this would involve a short question and answer session.

Course materials and handouts:
Each participant was given a document pack at the outset containing the training schedule, program key messages, and empty files to contain the course handouts. Handouts were available for every lecture so participants did not need to take notes. Presentations and detailed manuals were distributed as were health education materials and resources for further reading. Handouts were an essential part of the

training as they can be kept as reference materials for revision and recall of the acquired knowledge and skills. Their quality, clarity, and usefulness were continuously evaluated.

Trainers and facilitators:
The workshop trainers come from a variety of public health backgrounds with each bringing a particular area of expertise and experience. Every person who worked on this course (trainers, facilitators and administrators) contributed some distinctive feature from their own experience, background or personality adding to the overall effectiveness of the training course. A short profile of all the trainers and facilitators is given in Annex 2.

Course participants:
The trainees included all those recruited to implement the MCHN community mobilization project in the West Bank (Hebron and Jenin). The team members had been recruited on the basis of qualifications and experience and included both existing PMRS members and new recruits from the register of PMRS prospective applicants. Many are graduates of the PMRS community health college. Most have a health or social work background. The short listing and interview process identified individuals with the skills and personalities to be effective community mobilizers. Candidates were required to demonstrate communication skills, judgement and problem solving abilities as well as knowledge of their local community based organizations and services. The make up of each CM team is shown in table 2. Females were recruited for the CCM and CHW posts. Other positions could be male or female. In addition to the PMRS CM teams, the Hanan satellite office team leaders for Hebron and Jenin also attended the training course. There were 29 trainees in total.

Table 2: Structure of the Community Mobilization teams

Hebron	Jenin
1 Team leader	1 Team leader
1 Community mobilization officer	1 Community mobilization officer
5 Cluster community mobilizers	4 Cluster community mobilizers
7 Community Health Workers	7 Community Health workers

A list of the participants is attached at Annex 3

Summary of the training course topics

1. **PMRS-Hanan community program overall framework**: the two components of the program (the CM and C&M) were introduced and the way they are linked was explained. The focus on prevention, home management, and when to seek

medical care were emphasized. The objectives of the training and the link with work in communities was explained and clarified.

2. **PMRS-Hanan community program organizational structure**: The organizational hierarchy, chain of command and reporting relationship were explained. The linkage between PMRS and Hanan at all levels was clarified, in addition to the roles and responsibilities of the staff. The evaluation process of the activities and daily work was explained.

3. **An overview of key MCHN indicators:** the key MCHN indicators were presented. The implications of these indicators for work in the communities were explained and discussed in detail.

4. **Target beneficiaries of the program**: the key interventions and target beneficiaries were explained along with the reasons for choosing these targets. Challenges and resources in implementing the program and how health workers can access these resources at the community level to meet these challenges were also discussed.

5. **Community mobilization**: community mobilization was defined and the difference between health education and community mobilization was clarified An overview of the basic framework of the CMAC (Community Mobilization Action Cycle) model was given. Key concepts in community mobilization and the CMAC model were explained. The mechanism of preparing communities for mobilization, approaches used to organize communities and the role of participants in the implementation of the plan were discussed in detail.

6. **Gathering data systematically from communities**: the reasons why we need to collect data, the main methods used and the advantages and disadvantages of each were discussed. through theoretical and practical methods.

7. **Report writing and time management:** types of reports, the elements of good reports and how to write efficient and clear reports were presented. How to allocate tasks, set priorities, determine the time for each task and implementation were discussed and analyzed through explanation and group discussion.

Closing

The PMRS director general, Dr Jihad Mash'al and Hanan's director of community mobilization and marketing, Dr Kumkum Amin brought the training workshop to a close with an interactive session. The aim was to gather views from the trainees on how what they had learned during the workshop related to their field work in practice and how they envisaged translating the training theories into day to day activities. Most participants spoke during the session.

The link between this CM field work and PMRS previous and ongoing activities and relationships in the communities was clarified and the PMRS and Hanan support

structures for the CM teams at both district and headquarter level were explained and identified. Special thanks were extended to the trainees for their commitment and attendance, and at the end words of thanks were also extended to all those who participated and contributed to the success of the training module: facilitators, administrators and trainers.

Training evaluation
A high priority was given to evaluating and monitoring the progress of the training course. Where possible remedial action steps were taken to solve any immediate problems and suggestions were considered to improve the quality of training. Two main means of assessment were used:

- **Daily verbal feedback**: two trainees collected feedback from the group and presented the results to the course administrators. Conclusions and action steps were presented to the group first thing the next day. Following the feedback there was usually a group discussion with the trainers, facilitators and course administrators to discuss the evaluation of the day, provide feedback, and agree on any action steps.

- **Written evaluation**: evaluation forms were distributed at the end of each day for participants to write their comments, suggestions and their evaluation of the lectures, trainers, logistics, content and other aspects of the course. Trainees gave this feedback anonymously. The evaluation forms had a quantitative scoring section and a area for writing comments.

All participants filled in and returned feedback forms for each session. The results are tabulated in Annex 4. Overall the level of satisfaction was very high. Most people felt that the topics covered were important, useful and relevant. Feedback was very positive for all sessions with the level of scoring increasing as the workshop continued. In every session there were reports that not enough time had been spent on the topic. This was apparent in both the quantitative evaluation and in the written comments. Trainees were complimentary about the training style and content. There were also requests for followup and continued communication including to be informed of any new data and studies relevant to the districts.

Location and facilities:
The course was held at the Best Eastern hotel, which also provided accommodation for the trainees. The venue offered training rooms including a large training hall, which was fully organized and equipped to host a training event. The hall easily seated all the trainees and had enough room for the smaller working groups to hold separate discussions. Hospitality was provided inside the hall, which saved time at breaks helping the workshop keep to schedule. The hall was air conditioned and the environment was very comfortable. Hotel staff were helpful and the accommodation clean and tidy.

Course administration:
Two people managed the logistics of the course including provision of all handouts, course materials and feedback documents. They were also responsible for all arrangements with the hotel management regarding the training hall, breaks and lunch arrangements. The course administrators also took a direct role in implementing the action steps recommended by the course steering committee based on feedback from the participants. For example if trainees talking-aside were causing a distraction the course administrators worked with them to solve the problem.

Specific recommendations for future training workshops

1. Allow more time for the training topics
2. Ask about accommodation preferences – some trainees prefer to share.
3. Add in-service practical training for some topics
4. Maintain and improve the level of coordination and communication between the technical teams of both projects. Especially during the build up to the next training module(s).

Next steps:
Cluster level 3 month action plan
Each cluster team will put into action a 3 month plan: to enter the community; form a coalition; begin community based surveys to register pregnant women and build a community action plan – according to the key health priorities that are important locally. In practice the 3 month plans break down into weekly and daily activities. It also forms the first block in a longer 9 month plan after which in-field evaluation will be carried out to test for a difference in behaviors and any improvements in the key health areas for the community.

Ongoing, support, supervision and training
Within each district there will be intensive and direct supervision and followup during the first weeks when the CM teams begin converting theory to practice. There will be continued active support for the teams through weekly meetings at the district level where each cluster team will feedback the week's progress, discuss arising issues and be provided with in-service training as well as planning for the next week's CM activity. The teams will be able to support each other and be supported by the district management and the technical teams from PMRS and Hanan. The technical teams will meet with the CM teams weekly.

The entire CM team will attend and participate in the two following formal training courses scheduled for 2006, brief details of which are listed in Annex 1.

References

1 Review of Community Mobilization Experiences in the West Bank and Gaza Strip – unpublished report on behalf of the Hanan Project, M. Shaheen, April 2005

2 The Hanan household baseline survey – technical paper number 7 (unpublished)

PMRS website: *http://www.upmrc.org/*

Annex 1: Overview of the training schedule for workshop 1

Introduction to Community Mobilization Concepts and Approaches

Day 1 – **June 12th**
Arrival, registration,
Welcome and introductions (Atef Shubita, Anne Scott)

1. Overview of the PMRS-Hanan community program (Kumkum Amin)
2. Overview: the community program organizational structure (Atef Shubita)
3. Overview of key MCHN indicators (Rand Salman)
4. Who is the program targeting and why? (Randa Bani Odeh)
5. What is community mobilization (Randa Bani Odeh)

Day 2 – **June 13th**

(Randa Bani Odeh)

1. Key Concepts in Community Mobilization
2. The CMAC model – steps 1 & 3
    - Preparing to mobilize
    - Organizing communities for action
3. The CMAC model – steps 4 & 5
    - Assessing health issues, capacities & priorities
    - Developing community action plans

Day 3 – June 14th

1. The CMAC model – step 6 (Randa Bani Odeh)
    - Implementing the plan
2. How to gather data from communities? (Adel Takrouri)
3. The CMAC model – step 7
    - Evaluating performance and making mid-term corrections

Day 4 – June 15th

1. Developing a 3 month action plan (Randa Bani Odeh & Maysa Antabil)
2. Reporting requirements for the community program (Maysa Antabil)
3. Time Management (Maysa Antabil)

Closing Session (Atef Shubita, Kumkum Amin, Dr Jihad Mash'al)

The structure of the formal training plan

Workshop 1: Introduction to Community Mobilization Concepts & Approaches

- Introduction of newly recruited community health workers and community mobilizers to the PMRS-Hanan partnership
- The role of the recruits within the PMRS organizational structure
- Key concepts in community mobilization
- The model that will be applied in implementing the program in the communities
- Basic data gathering techniques (how to apply these to assess the on the ground impact of the program)
- Reporting requirements
- Time management
- **Work within the community teams to develop a draft plan for the first three months of the programs implementation**

During the first month in the field

CM teams begin to build community coalitions; start community based surveys to register pregnant women; develop a community action plan – stating health problems according to the key messages and priorities locally for the community

Training: In service training for new topics arising and to spend more time on some of the topics from the training course

Structure and contents of the next training workshops – Summer/Autumn 2006

lifecycle 1

- Establishing pregnancy and seeking immediate antenatal care
- Understanding and acting on pregnancy danger signs
- Knowing appropriate and healthy eating during pregnancy
- Understanding the necessity for iron/folate supplementation
- Understanding the importance of early postpartum care
- Understanding the importance of immediate and exclusive breastfeeding and right bf techniques
- Learning how to prepare for birth and neonatal care

Lifecycle 2

- Ensuring mothers breastfeed immediately
- Encouraging exclusive breastfeeding for six months
- Knowing how to introduce appropriate complementary liquids/foods
- Understanding the importance of breastfeeding for two years

Training session 2 – July 2006

- Knowing the importance of appropriate weaning
- Understanding the importance of growth monitoring

Lifecycle 3

- Promoting the importance of early and appropriate care for
  - Childhood diarrhea and
  - Respiratory tract infections
- Recognizing danger signs of these and other serious childhood illnesses
- Ensuring children with danger signs are seen by a health provider
- Adopting good practices in the home including basic hygiene and sanitation

Training session 3 – Sept 2006

Annex 2: Trainers and Facilitators

Trainers

Randa Bani Odeh (Hanan) is a qualified Public and community health nurse (BSN, MPH). She has worked in community programmes across the oPT for twelve years and has gained wide national recognition during this time. Her expertise is in community capacity assessment. She initiated the adoption and modification of the community mobilization action cycle (CMAC) for use in the Palestinian context. She has extensive experience training community based project workers. She is a technical expert for the Hanan project.

Maysa Antabil (PMRS) is a qualified nurse with a public health background including a Masters degree in Public Health. She has a long experience in community work and maternal child health in the oPT including writing numerous project reports. She is a member of the PMRS technical team with a remit to provide regular support and expert advice to trainees.

Adel Takruri (PMRS) is a medical doctor with a public health background. He is an experienced teacher at the PMRS community health college, where among other subjects he has taught topics on child health and quantitative methods for many years. He has extensive experience in large projects requiring data collection and analysis and interpretation. He is a member of the PMRS technical team for the MCHN project.

Rand Salman (Hanan) is a medical doctor with a Masters degree in community medicine and a subspeciality in epidemiology. She is an expert in maternal and child health and nutrition and has worked in the field for more than ten years. She had a key role in the development and definition of the main MCHN indicators for the project. She is the deputy director of public health at the Hanan Project.

Facilitators

Atef Shubita (PMRS): is the overall project manager for the PMRS team. He has a background in business economics and a Masters in Public Health. He is an expert in institutional management. During many years with PMRS he has managed several community projects working with local and international agencies. He has an extensive knowledge of the social and economic structure of Palestinan communities and maintains excellent liaison with most national civil society organizations and many international institutions. He is responsible for the strategic direction of the project.

Kumkum Amin (Hanan): is responsible for the Hanan inputs to and the strategic direction of the project. She is an established communication and marketing expert with extensive training experience. She is the director of community mobilization and marketing at the Hanan project.

Nadira Sansour (Hanan): is a training specialist. She was present throughout the workshop as a independent observer and facilitator. Her role during the event was to

control the timing and flow of the sessions and to communicate with participants and facilitate feedback. As a neutral party she was able to provide objective unbiased advice and communicate with both organizers and participants easily.

Rania Abu Shaweesh (PMRS): the training course administrator: She is the co-ordinator of all major PMRS events and activities. She managed all the course logistics, accommodation and administration and was present throughout to deal with any matters arising.

Annex 3: Training course participants

Hebron - trainees

Name	Location	Qualifications & Experience
Team Leader (PMRS)		
	Hebron district	
CMO (PMRS)		
Suhil Aqapna	Hebron district	Physician in general medicine *6 yrs experience*
CCMs (PMRS)		
Amal Modya	Al Thahereya	Health worker *20 yrs experience*
Janat Al zaro	Hebron	Registered midwife (3 yrs). *7 yrs experience*
Fatina Al Baltaji	Hebron	BSN nutrition. *11 yrs experience*.
Ranya Abu Omar	As Samu`	
Buthayna Ayoub	Al Aroub camp	Diploma of nursing. *8 yrs experience*.
CHWs (PMRS)		
Nadia Abu Ayash	Yatta	School of community health *6 yrs child health clinic*
Arwa Abu As`ad	Ethna	School of community health *2 ½ yrs child health clinic*
Manal Jawabra	Al Faware camp	Diploma of nursing. *6 yrs experience*.
Maha Al Tel	Al Thaherya	BSN of nursing. *2 ½ yrs experience*
Lina Jubran	As Samu`	School of community health *2 1/2 yrs child health clinic*
Mariyam Nassar	Dora	BA Social work.
Hanan District Team Leader		
Diane Ibrahim	Hebron district	

Note: Although 7 CHWs attended the training course, one has subsequently discontinued working the project.

Jenin - trainees

Name	Location	Qualifications & Experience
Team Leader (PMRS)		
	Jenin district	
CMO (PMRS)		
Omar Mansour (PMRS)	Jenin district	BA of Sociology *16 yrs experience*.
CCMs (PMRS)		
Najat Ne'rat	Maythalon	Diploma in Primary health care. *20 yrs experience*.
Abeer Al Jamal	Jenin	Community health worker (PMRS). *11 yrs experience*
Ruwaida Salah	Kfer Dan	Diploma of community rehabilitation *14 yrs experience.*
Hayfa' De'bis (PMRS)	Zababdeh	BA of nursing. *20 yrs experience*
CHWs (PMRS)		
Rawda Jalghom	Faqoa`,	Community health *18 yrs experience*
Tahani Ne'rat	Maythalon	BA Social work *2 yrs experience*
Fatema Abed	Kfer Dan	Diploma Community health development. *14 yrs experience*
Feryal Barakat	Faqoa`	Diplomas primary health care & primary education - *17 yrs experience*.
Susan Ne'arat (PMRS)	Maythalon	BA primary education. *One yr experience*.
Mays Subuh (PMRS)	Al Fara camp	Diploma in community health. *One yr experience*
Faten Badawi	Aqaba	*4 yrs experience.*
Hanan District Team Leader		
Raja' Zyoud	Jenin district	

Annex 4: Course feedback results

Table A: Mean and standard deviation values to summarize the quantitative "scored" feedback from the training sessions, by topic, date and feedback area being assessed.

Date	Topic	Score	The topic was			Time was enough
			Important	Useful	Relevant to my work	
Day 2	**Community mobilization**	Mean	4.76	4.69	4.72	4.48
		SD	0.58	0.60	0.59	0.74
Day 4	**Community mobilization (continued)**	Mean	4.90	4.90	4.90	4.45
		SD	0.31	0.31	0.31	0.87
	Report writing	Mean	4.93	4.90	4.90	4.45
		SD	0.26	0.31	0.31	0.99

Note: all 29 trainees completed feedback scores for each topic

Interpreting the quantitative evaluation scores:
Each element of feedback concerning the importance, usefulness and relevance of the topic and the amount of time allocated was ranked from 1 to 5: 1=weak, 2=acceptable, 3=good, 4=very good, 5=excellent
Table 2 presents the mean scores and the standard deviation for each topic where this type of feedback was collected.

The mean indicates the average/general opinion of the group. The nearer the average is to 5 (excellent) the more the group was satisfied. For example - the general opinion was that report writing was a very important topic (scoring an average of 4.93). The standard deviation indicates the range of opinions around the scoring. A larger standard deviation indicates a bigger spread of opinions. Again, for report writing, the standard deviation is small (0.26) reflecting a narrow range of opinions, most (or all) of the participants felt this topic was important. But there was a wider range of opinions on whether the topic had been given enough time (SD = 0.99).

Qualitative written feedback:
The following are some of the comments received on the feedback forms. Trainees gave this feedback anonymously.

Comments about the trainers:

- The topic was comprehensive and clear, because of the trainer's style which was interesting and creative
- The materials were explained simply and excellently
- The trainers are excellent
- The trainers were very good

Comments about the topics

- The topics are condensed and need more time for greater benefit
- More time is needed (x2)
- Lectures are condensed in time, if the lectures were more dispersed over time, it would have been better
- All the topics were very important and useful for our work

- Suggestion: more practical training for the forthcoming training [events]
- More training is needed on time management and presentation methods
- Useful and valuable information
- All the topics are excellent

General comments

- I hope there will be continuous communication and follow up for this project especially for field workers.
- To follow up for any new data or studies about the districts
- All is excellent, all is useful, we learned many things
- The rooms: double room occupancy not single rooms
- The time is very long (exhausting)
- The time is not enough, we need more training in some topics
- To have the training separately in each district (Jenin, Hebron)