



PROCEEDINGS OF THE TRANSFORMATIONAL LEADERSHIP TRAINING

Federal Ministry of Health and International Institute for Primary Health
Care in Ethiopia, in collaboration with Ethiopian Public Health Institute



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Acronyms

CHW: Community health worker
CPD: Continuing professional development
EPI: Ethiopian Public Health Institute
FMoH/MoH: Federal Ministry of Health
HC: Health center
HEP: Health extension program
HEW: Health extension worker
HH: Household
HIS: Health information system
HMIS: Health management information system
HSTP: Health sector transformation plan
HP: Health post
HRH: Human resources for health
HSTP: Health sector transformation plan
IIfPHC: International Institute for Primary Health Care in Ethiopia
JHU: Johns Hopkins University
KM: Knowledge management
MDGs: Millennium development goals
M&E: Monitoring and evaluation
ODF: Open defecation free
PHC: Primary health care
PHCU: Primary health care unit
RHB: Regional Health Bureau
SNNPRS: Southern nations nationalities and peoples' regional state
WDA: Women development army

Summary report

The transformational leadership training was offered to Woreda health office and primary health care unit heads and health officers drawn from the different Regions of Ethiopia. A series of trainings were organized by the Federal Ministry of Health (FMOH) and the International Institute for Primary Health Care in Ethiopia (IIfPHC), in collaboration with the Ethiopian Public Health Institute (EPHI). A total of 321 trainees participated in seven rounds between December 5, 2016 and June 16 2017.

The objectives of the training were: to see the overall progress of the implementation of the health sector transformation plan (HSTP); to strengthen healthcare systems in Ethiopia through enhanced capacity of health leaders and managers; to make critical self-assessment and identify one's strengths and limitations in leading oneself and others; and to develop skills in managing change.

The first training program took place between December 5 and 9, 2016. This proceeding was mainly based on that training session.

The first session was on introduction, opening speeches and developing norms. (See Section I) Professor Mengesha Admassu, Executive Director of IIfPHC, gave a brief introduction on the rationale for the establishment of the Institute, its vision, mission and main objectives. Then, the opening speech was made by Dr Tsigereda Kifle, Deputy Director General of EPHI. Following the speech, a welcoming address was convened by Dr Zufan Abera, the Director of the Health Extension Program Directorate of FMOH. Next, Dr Henry Perry of Johns Hopkins University gave an introductory speech. He explained his involvement in the establishment of IIfPHC. He said that Ethiopia has been a leading country in PHC and other African countries could learn from the great success.

The program introduction and training norms were facilitated by IIfPHC training officers, Ato Tilahun Debebe and W/t Melody Kelemu. Participants were informed on some administration issues such as accommodation, catering, and per diem. Then, trainees developed norms to be used during the training period. Following that, training participants introduced themselves. Finally, trainees were requested to complete a questionnaire to collect case studies for future trainings.

The second session was on "Implementation of HSTP" and it was presented by Ato Kahsu Bekuretehon. (See Section II) The next session was on "Woreda transformation" and the presenter was Dr Zufan Abera from the Health Extension Program Directorate. (See Section III) The following presenter, Ato Noah Elias, focused on "Translating information revolution to the woreda level". (See section IV) After the three presentations were made by FMOH, training participants had group work and presentation. (See section V)

The next presenter, Prof Mengesha Admassu, presented "attitude is everything". He explained what attitude is and how one's attitude impacts on the work one does, which was followed by a group work. (See section VI) Then, Prof Mengesha presented on "Change

management” (see section VII); “Teamwork” (see section VIII), and “Styles of conflicts”(see section IX).

Following that, Ato Dereje Ayele presented on “transformational leadership” and “leadership”. (See sections X and XI) In the following rounds of trainings the two topics were covered by Ms Kidist Nadew, Ato Abreham Zerihun and Dr Netsanet Fetene, from Yale Global Health Leadership Institute. (The presentation is available in section XII)

Prof Mengesha presented “Critical thinking” and its importance in the work place. (see section XIII) Then, Ato Betemariam Alemu presented on “Strategic health communication”. He explained what it is and why it matters in public health. (see section XIV)

That was followed by “Health sector planning” presented by Ato Mideksa Adugna. He highlighted the sector’s planning process, principles and approaches. He also briefed on the 20-year strategy plan. (see section XV) In the following rounds, Ato Melaku Yilma presented “Planning and implementation: balanced scorecard (BSC)”. He focused his presentation on the nine steps of the BSC. (see section XVI)

The next presentation was on “Monitoring and evaluation” and delivered by Mr Mesoud Mohammed and Ms Eyerusalem Kebede, interchangeably in the training period. (See section XVII)

“Presentation skills” was presented by Ms Melody Kelemu (section XVIII).

Dr Tedla W/Giorgis’s presentation focused on “Knowledge management: global trends and issues”, which gave trainees insight into how creating and sharing knowledge for the health sector is essential. (see section XIX) That was followed by Dr Seblewongel Lemma’s presentation on “Ethics in leadership” that is covered under section XX. The final presentation was on “Success as a leader” by Hiwot Tadesse (see section XXI)

Then, questionnaire administration and evaluation session followed to gather some suggestions on how the course could be improved in future rounds.

Finally a closing remark was made by Dr Zufan Abera and Prof Mengesha Admassu. Certification program followed and Dr Zufan handed the certificates of achievement to participants. Finally, Prof Mengesha thanked all for their active participation and for sharing their experiences.

The proceedings of the transformational leadership training has been written and compiled by IlfPHC’s resource center officer, Emebet Zerfu.

Section I Opening speeches

I.1 Introduction

Prof Menegesha Admassu
Executive Director
IIfPHC

IIfPHC's communication officer, Ms Luidina Hailu, thanked all participants for coming to attend the training on transformational leadership. Then, she introduced Professor Mengesha Admassu, the Executive Director of IIfPHC, who has 38 years of service in the health sector. Luidina stated that Prof Mengesha has served as President of the University of Gondar for 8 years. She invited Prof Mengesha to make formal introduction. Then, Professor Mengesha introduced Dr Tsigereda Kifle, the Deputy Director General of EPHI, Dr Zufan Abera, Director of the HEP Directorate at FMoH, and Dr Henry Perry, the technical advisor of IIfPHC at Johns Hopkins University.



Prof Mengesha explained for training participants why IIfPHC was established. He stated Ethiopia has achieved the health-related MDGs because of its health extension program that was started 13 years ago. About 38,000 health extension workers (HEWs) were trained and deployed in the program. Prof Mengesha said that African countries visited Ethiopia to learn from Ethiopia's experience; but it was conducted in an informal way. Hence, there was a need for the establishment of IIfPHC to formalize the training program and to share Ethiopia's experience for African countries and beyond. The other reason for IIfPHC's establishment is to strengthen the HEP and PHC through research. Prof Mengesha said that the Institute was launched in February 2016 and is hosted by EPHI on the first year of its operation. JHU provides technical support. As to the types of trainings offered by the Institute, Prof Mengesha mentioned: three-day training for policy makers, parliamentarians, economic advisors; two-week training for health programmers; and 4 to 6 week training for PHC implementers.

Prof Mengesha informed participants that the FMoH has sponsored the transformational training program to build the capacity of 400 Woreda and Primary Health Care Unit health officers and heads at Regional, Zonal and Woreda levels. The 400 participants will be trained in batches of 50-60 trainees in 8 rounds.

Then, Prof Mengesha invited Dr Tsegereda Kifle to make an opening speech.

1.2 Opening speech

Dr Tsigereda Kifle

Deputy General Director

EPHI

Dr Tsigereda welcomed everyone and stated that Ethiopia has made progress in the health sector. The HSTP serves as a strategic document and there are policies and guidelines for its implementation. She added that the plan is ambitious. Dr Tsigereda indicated that policies alone are not enough and the development of human resources for health (HRH) is equally important. She emphasized the need to develop leadership capacities of health personnel through training as essential part of HRH.

Further, Dr Esigereda stated that although Ethiopia has been given international recognition on the health-related achievements and could show its best practices for others, the health sector plan has not yet been achieved. She specified that although the HEP is progressing well, there are problems of implementation in different Regions. She stated that the HEP needs community participation and everybody needs to participate for full coverage of PHC.

Finally, Dr Tsigereda said that IfPHC will be a good arm for advancing PHC in the country. She stated that EPHI will provide full support to the new Institute in the training programs anticipated for 400 Regional health personnel. Dr Tsigereda wished participants a good stay with active participation. She remarked that the training will help them implement the health sector strategy more effectively.

1.3 Welcoming speech

Dr Zufan Abera

Director, HEP Directorate

FMoH

Dr Zufan welcomed trainees and stated that the government of Ethiopia is designing policies and guidelines to prevent diseases and advance the health of citizens. She stated that capacity building programs had been undertaken to implement the guidelines. Efforts were also made to involve the communities in urban and rural areas to improve their health. Particularly, the HEP that has been implemented through the HEWs and health development army (HDA) enabled Ethiopia to achieve the health related MDG goals, which have been recognized by international and national reports. Dr Zufan thanked participants, who contributed a lot at Woreda and PHCU levels for these achievements. Although these achievements were remarkable, she emphasized the need for addressing many health-related issues yet. She specified that many mothers and children still die through preventable diseases. Both communicable and non-communicable diseases are becoming health problems. Particularly, Dr Zufan indicated that implementation gaps exist from region to region/woreda to woreda and these problems need to be dealt with.

Dr Zufan stated that the HSTP second year plan is under implementation. The plan has 4 goals and four transformation agendas. To implement these goals and agendas, she stressed

the need to build the capacities of Woreda and PHCU. Thus, Dr Zufan said the transformational leadership training program is part of the capacity building program.

On behalf of the FMOH, Dr Zufan invited participants to share their rich experience and actively participate in the discussions. She thanked participants and wished them a successful training. Finally, she thanked IIfPHC and EPHI for organizing the training and declared the official opening of the training.

1.4 Introductory speech

Dr Henry Perry

IIfPHC technical advisor

Johns Hopkins Bloomberg School of Public Health

Dr Henry Perry wished a very good morning and stated that he was much honored to be in the occasion. He said it was the first local training for IIfPHC. Dr Perry explained he worked with FMOH to establish IIfPHC and believed that the Institute has a lot of potential to improve PHC. He said that Ethiopia has been a leading country in PHC. Many people admire what has been achieved by HEWs and HDAs by making service available to the population. He indicated that African countries could learn from the great success of Ethiopia.

Dr Perry thanked participants and wished them all the best.

1.5 Program introduction and norming

Mr Tilahun Debebe, Training officer, IIfPHC

Ms Melody Kelemu, Training officer, IIfPHC

Mr Tilahun thanked participants for coming to the training. He discussed administration issues, including accommodation, catering service, per diem, transportation services and travelling allowance. Mr Tilahun, then, requested training participants what issues to include as training norms. Participants mentioned punctuality, switching/silencing their mobiles; avoiding side talks, active participation and energizer. Mr Tilahun thanked for the rules and showed a list of additional norms that could be suggested by IIfPHC. These include: being a volunteer; being attentive; projecting voice while participating; respecting the opinion of others; bringing constructive ideas; leading a group; and not bringing food into the training room. He asked if trainees would accept these as norms and participants accepted the norms unanimously.

Following that, Ms Melody introduced the program of the day. See Annex I for program schedule.

1.6 Self-introducing



Prof Mengesha introduced the concept of secret admirer. He asked participants to write their name on a piece of paper, including trainers and IfPHC staff. The names were collected in a basket and each trainee picked a name randomly from that basket. Participants later on introduced themselves so that they would know each other's secret admirers. Prof Menegesha told participants that each trainee will be followed up by his/her secret admirer during the training period and will collect the notes written to her/him from the secret admirer's board.



Section II Health Sector Transformation Plan (HSTP)

*Ato Kahu Bukretsehon
State Minister Advisor
FMoH*

2.1 Implementation of the HSTP



Ato Kahu's presentation focused on 'envisioning' of the HSTP. Before he explained the topic, he reminded the health sector's vision and mission to participants. The vision is "to see healthy, productive and prosperous Ethiopians". The mission is "to promote health and wellbeing of Ethiopians through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services of the highest possible quality in an equitable manner."

Ato Kahu stated that FMoH, Regional Health Bureaus and Woreda health offices have the same vision and mission. He indicated that the mission focuses on the provision of health care services. There are service providers (eg MoH and line offices), service purchasers (eg insurance) and health regulatory agencies (eg FMHACA). In providing and regulating the service, Ato Kahu stressed the need to consider quality and equity and that the service provision should be comprehensive. For instance, if a mother comes to a health facility, she should be given information in a comprehensive way.

Using a flowchart, Ato Khasu discussed the policy and strategic plans of the health sector. He showed the relationship among the HSTP, national health policy and the health program strategic plans, Regional HSTP and Agencies strategic plans. (see annex II)

Then, Ato Khasu discussed on "Envisioning Ethiopia's path towards 'universal health coverage' through strengthening PHC (2016-2035) as well as mapping of the process of the envisioning exercise. In relation to the HSTP (2008-2012 EFY), Ato Khasu indicated that although the progress achieved so far was good, focus should be given on quality and equity as per the Growth and Transformation Plan II. He described the strategic themes of HSTP that encompass: excellence in health service delivery; excellence in quality improvement and assurance; excellence in leadership and governance and excellence in health system capacity. Ato Khasu elaborated the four excellences in detail. He considered quality, equity, universal health coverage and transformation as the four key words of HSTP.

Next, Ato Khasu explained the health sector strategic perspectives from the points of the community; financial stewardship; internal process, as well as learning and growth. (see Annex II)

Finally, Ato Khasu elaborated the transformation agenda which are: transformation in equity and quality of health care, information revolution, woreda transformation and caring, respectful and compassionate health workforce. Transformation in equity and quality in health care mean providing the best quality care for all despite peoples' differences in age, gender, socio-economic status etc. He suggested ways on how caring, respectful and compassionate health workforce could be implemented and concluded his presentation.



First round transformational leadership training participants
(December 5-9, 2016)

Section III Woreda transformation

Dr Zufan Abera
Director, HEP Directorate
FMoH

3.1 Why woreda transformation?

Dr Zufan stated the four transformation agendas, ie, equity and quality, woreda transformation, compassionate, respectful and caring health professionals and information revolution, are equally important. But, she said her presentation will focus on 'woreda transformation' to elaborate on what FMoH expects from woreda heads who attended the training. Dr Zufan explained woredas as middle level government structures that have mandate and power to self-administration. Woredas play a crucial role in all development initiatives. Woredas need to be transformed to ensure excellence in health service quality and equity. Dr Zufan stated that woreda transformation is the engine of HSTP and helps to achieve the health sector vision.



Explaining the expected outcomes of woreda transformation, Dr Zufan mentioned creation of model kebeles; creation of high performing PHCU; and creation of community based health insurance for all. In a model kebele, she said at least 85% of the households should be free from open defecation and free from home delivery. It is also expected that there is 100% community based health insurance coverage in the kebele and no one is left behind. In addition, all schools in the kebele implement school health services including

WASH and have good health clubs. Highlighting the outcome expectation on high performing PHCU, Dr Zufan stated that implementing the PHCU reform and having high key performance indicators ($\geq 85\%$) is required.

In implementing the second generation HEP, Dr Zufan elaborated the implementation approaches that encompassed: fostering community engagement and ownership; and ensuring individual and social accountability. She indicated that building the capacity of health development armies; strengthening referral systems; and celebrating success as additional implementation approaches. In PHCU, the areas that need to be strengthened include: capacity building of health managers; good governance and inter-sectoral collaboration; data use; as well as infrastructure and supply chain systems. Dr Zufan stressed the need for the community to be aware of community based health insurance. Using a diagram, she explained the implementation approaches of model household, model village, model kebele and model woreda and their linkages/relationships. (see annex III)

Dr Zufan finally stressed that the implementation of the HSTP targets require collaborative efforts. (see annex III for details)

Section IV

Translating information revolution to the Woreda Level

Ato Noah Elias
Director, policy and planning directorate
FMoH

4.1 Information revolution

Ato Noah started his session by informing participants that information revolution is one of the four transformation agendas of the health sector. He explained that the word revolution indicates change. Ato Noah explained that the objective of information revolution for health is to transform and enhance the culture of data use to positively impact population health and health system performance through evidence-based decision making at all levels of the health system.



Ato Noah emphasized that information revolution is not about digitizing every data. The information could be collected over the phone and/or manually. He stressed that the most important issue is using the information for decision making. Ato Noah elaborated the information revolution roadmap developed by FMoH. The map will be used by Regions and Woredas and it will be implemented at all levels in the health sector.

Ato Noah explained the reasons why information revolution is essential. These included: transforming the health sector; using reliable, multi-dimensional and timely information in the health system; and addressing issues related to equity in the health sector. He said that if, for instance, EPT coverage was 80% in a woreda, focus should be given on remaining 20% who have not received the vaccine. We should be able to collect information on why, which tribe, which religion, etc did not benefit and promote the use of information.

As to the areas where information revolution is expected, Ato Noah indicated data collection, aggregation, reporting and analysis practices. In addition, promoting the culture of information use, harnessing ICT, data visibility and access, and strengthening verification and feedback systems were mentioned as areas that require revolution. He explained each point in detail. (see annex IV) Ato Noah stated that getting information is not easy in Ethiopia. He also indicated the absence of verification and feedback system in reporting. Usually there is a tendency to increase numbers at woreda and zone levels. Ato Noah stressed the need for having verification and feedback methods for accurate reporting. He stressed the need that all reports should be based on facts and evidence.

Later, Ato Noah explained cultural transformation for health data use and digitization and scale-up of priority HIS as the two pillars of information revolution. (see annex IV for details) He explained that the pillars will lead to connected woreda demonstration project and then to transformed woreda.

As to the efforts made so far to digitize data, Ato Noah mentioned the point of service health information systems such as EMR/HER; TM, TE; mHealth; eCHIS; eLMIS. (see slides on the topic) The standards-based digital registries he indicated were national health data dictionary and master facility registry. Ato Noah elaborated that the Masters facility registry will help us collect facility data. He said Regions do not know the number of health centers available and the data is not clear at present. Whenever a health facility is constructed or demolished, it should be registered in the master facility. Ato Noah also mentioned about a plan to digitize family folders as of the current year. Digitizing the folders will help a woreda to make the information useable. The information collected by HEWs is not even used at woreda level at the moment.

Finally, Ato Noah clarified the different activities carried out under the first year HSTP. He explained the information revolution goals at Woreda level and the concept of connected woreda, connected woreda end state, connected woreda pathway and connected woreda assessment criteria using diagrams and pictures. (see annex IV for details)

Section V General discussion and group work

5.1 General discussion

The Q&A sessions and the group exercise for section II, III and IV were facilitated by Dr Zufan, Ato Khasu and Ato Naoh.



Q: To transform the health sector, the involvement of all stakeholders is important. A participant requested why accurate information is not given at kebele and woreda levels.

A: There is false reporting because figures are sometimes changed at woreda or kebele levels. This practice should be avoided since a small percentage change has big implications in figures. The MoH will use different verification mechanisms from the federal to office levels. In addition, responsible bodies should educate the community to provide accurate information. There should be accountability in reporting.

Q: There are no toilets and other facilities in many kebeles. How could a kebele be model if these facilities are not available?

A: The health sector could not bring transformation by itself. Other sectors need to also play their roles. All sectors have their own transformation plans extracted from the Growth and Transformation Plan. For example, there is transformation agenda on ODF. The community should mobilize resources to build toilets and other facilities and have to use them properly. Awareness raising is crucial so that the community could take the initiative and get involved.

Q: Any strategy for health insurance in urban areas that could serve as a model for rural areas.

A: For urban areas, a new agency has been established to facilitate the community based insurance scheme.

Q: On community-based insurance, the woreda has a problem collecting the fee of Birr 240 from each farmer. Those farmers who could not afford to payment requested the woreda to pay by installments. There is information that woredas should cover the health insurance if the peasant association could not afford it. Could you explanation on that?

A: The woreda should cover the insurance for the poorest of the poor to make the health service equitable.

Q: A participant from SNNPRS mentioned that they have just started the community insurance scheme. He asked if there are woredas who have implemented the program and if they could share their experience.

A: A participant from Debub Omo said that the first activity involved creating awareness among the community. He said the residents gradually accepted the idea and believed that they should not sell their property to get treatment when they are ill. Then, a couple (husband and wife) started to pay Birr 10.50 per month. But there was change and the Woreda instructed to collect Birr 240 per family, plus Birr 5 for ID card at once. However, some people are still complaining that they cannot afford to pay.

Q: Is there any change in the health insurance scheme premium?

A: The insurance fee should not be changed. It is Birr 240. For average farmer, it is not much. For instance, the time of payment must be adjusted. eg during the time of harvest and selling of crops.

Q: The Woreda transformation agenda involves ODF. In many areas, people are not aware. Even in Addis Ababa, where there is awareness, there is a problem. What is the problem?

A: Addis has complex problems of hygiene and sanitation. The World Bank has given grant for environmental hygiene and sanitation. More needs to be done in this area.

5.2 Group work

Trainees were given discussion questions/issues (see annex V for the Amharic version of the questions). Each group was given 40 minutes to discuss the questions and prepare their presentation on flip charts.

Discussion point I

- 1) What should be done to create high performing primary health care units? How? By whom?
- 2) How could a model kebele be created? How could the model have continuity? Please use good practice examples from your woreda and discuss the issue.
- 3) List how the community based health insurance could be implemented by involving all people; what are the opportunities, challenges and solutions.



Responses from groups

Group 1

Question 1

What should be done?

- organize PHCU in five satellites
- provide training
- include the community in the planning process
- implement the plan
- consult with the community

How?

- support and follow-up visit
- collaborate with stakeholders
eg NGOs



By whom?

- health development army and other health officers
- stakeholders
- the community

Question 2

- first, the community should take ownership so that it will have continuity
- establish training committee at kebele and woreda levels
- kebele and woreda committees should have guidelines to guide others

Question 3

- identify the poorest of the poor and give them ID cards
- supply the inputs required

Group 2

Question 1

What should be done?

- educate HEWs and increase their numbers to increase the HRH
- improve supply chain and inputs
- train health workers who have skill gaps

How?

- design better structures
- support and monitor implementations
- involve all stakeholders
- send feedbacks of reports

By whom?

- community participation
- involve partners
- Health extension workers

Discussion point II

- 1) What does health equity and quality mean?
- 2) How could health service equity and quality be described?
- 3) Mention inequality and inequity health services and practices in your woreda. How are you addressing these problems?



Responses

Group 2

- 1) Equity refers to the provision of health services for all people in the community
Quality service includes professional skills, ethics and giving time for patients
- 2) Increased community awareness
 - community is satisfied with the type of service given
 - decrease in communicable and non-communicable diseases seen
 - HR and health facilities are available based on the standards
- 3) Problems:
 - people are not served equally. There is favoritism/preferential treatment
 - health workers lack motivation
 - low standard health facilities
 - input/resource problems
 - lack of skilled manpowerSolutions:
 - health workers and heads attitudinal problems need to be corrected
 - health facilities are working to improve community participation
 - use the limited human and inputs to provide the service to the community

the 'green group'/group 4

- 1) Equity - the services in health facilities should be given to all, irrespective of gender, age, religion, ethnicity or urban/rural classification. All community members should be served equally.
- Quality - healthcare services should be given on time, with qualified health professionals and support staff. The health care staff should work collaboratively to fulfill the needs of the community



- 2) Equity and quality could be described through:
 - Price/affordability; acceptability; service provision and community feedback
- 3) Problems:
 - health facilities are not community focused
 - shortage of qualified staff
 - shortage of drugs
 - poor infrastructure (eg no access road)

Solutions: the responsible bodies should assign the required manpower; supply drugs and construct infrastructure

Discussion point III

- 1) There is low level of information use at facility and Woreda levels. Health information is gathered mainly for reporting purpose rather than use. What do you think are the main reasons for not using information for decision making at local level?
- 2) What do you think should be done to promote information use at local level?
- 3) What do you think are the major challenges to implement information revolution in your Woreda?

Responses

Group 3

- 1) The causes for the low level use of information are:
 - a culture that does not believe that information is important
 - poor culture on documentation and storage of information
 - health professionals lack motivation to collect information
 - manpower is not allocated to gather information (lack of ownership)
 - data are not recorded on time
 - lack of knowledge
 - lack of resources/inputs
- 2) Assign qualified staff and make them responsible
 - use family folder
 - use resources/inputs in the right place and at the right time
 - review reports on time and provide feedback eg. PRT
- 3) Problems
 - Lack of knowledge
 - Concerned stakeholders do not think that information is resource and tend not to use it. The same holds true for health professionals and management staff
 - Health professionals (nurses, HIT, etc) are careless in handling information
 - There is no manpower to gather information
 - Turnover of trained personnel, eg HIT

Lack of support

- Not collecting PRT as per the standard and not providing feedback
- Health posts, health centers and health offices are not working closely. There is no linkage and relationships among these institutions
- Lack of feedback

Lack of resources/inputs

- No information tools at health posts and health centers eg. eHMIS (lack of computers)
- No infrastructure (no phones)
- No vehicles

Solutions

- Have knowledge: have discussions with relevant stakeholders to create awareness on the importance of information
- Develop skills: provide training of trainers. The trainers then could train others
- Resources: have discussions with concerned bodies to supply the needed resources

Problems

- Manpower shortage
- Lack of networking and discussions with stakeholders
- Failure to gather information for decision making

Solutions

- On-going training
- Develop a culture of using information
- Have discussions with concerned bodies

5.3 Facilitators' elaboration on the group work

Dr Zufan thanked participants for sharing their views in the three discussion points. To add some, she stated the leadership, including kebele leaders, civic organizations, religious leaders and kebele command posts need to be aware of the transformation agenda. Good governance needs to be strengthened.

Ato Kahsa appreciated the good points raised on quality and equity. He indicated the importance of quality improvement planning with a goal. To achieve that goal, HR, input, infrastructure, process, and so on are required. Ato Kahsu underlined that there are standards for quality assurance and quality control. There are internal and external standards to check service quality. Ato Kahsu advised participants to check their works against those standards. He said that the work we do habitually may look right. But, we could identify that it is wrong only when we know the standard.

Ato Kahsu also elaborated the concept of equity by comparing healthcare services in Debu and Tigray Regions. He said that there are variations among Regions and Woredas in the provision of health services and that consideration should be given for those who are under-served. For instance, he said if the service coverage is 90%, then we should focus on the remaining 10%. High coverage does not imply good service. We have to see equity in terms of the problems that each area have and then address those problems so that no one is left behind.

With regards to information revolution, Ato Noah said MoH have identified system-related and practice-related problems. He indicated problems related to attitude from the systems perspective. Some Regional Bureaus think it is the problem of MoH. Others may have knowledge gaps to improve the system. Ato Noah stated that means of verification is import; but that system is broken currently. These malpractices need to be changed. Complicated formats need to be simplified and everybody should be able to work on the forms. There should also be incentives for good reporting.

Section VI Attitude

Prof Mengesha Admassu
Executive Director
IIfPHC

6.1 Attitude is everything

Professor Mengesha informed participants that skill, behaviour, knowledge and attitude are the common manifest in people. Giving example, he told participants to assume that he is inviting them lunch in a restaurant. There is a hand washing basin with CCTV at the top. Hand washing is knowledge and washing hand is practice. They know that hand washing using soap avoids bacteria. If they did not wash their hands with soap before eating, their knowledge did not go with their attitude. That means their attitude has created a gap. Prof Mengesha stated that attitude needs to be integrated with knowledge.



Then, Prof Mengesha explained the learning objectives of the session, which included: understanding what attitude means and why it is importance; assessing its difference with knowledge and skills; and describing examples of positive and negative attitude from experience. Prof Mengesha stated that knowledge, attitude and practice go together. In principle, he said the question of knowledge, attitude and practice should be at the same level. Knowledge is acquired after birth and it is part of attitude. The more we know, the more successful we become. Prof Mengesha informed trainees that there is a saying “knowledge is power”. But, he said it is knowledge plus action, which is power. Someone’s knowledge may not be powerful until he shares that knowledge to others. Prof Mengesha stated that knowledge of facts is necessary to work with confidence.

Later, Prof Mengesha explained attitude using different proverbs, stories and illustrations. (see Annex VI) Using a picture of an iceberg, Professor Mengesha asked how much could trainees see of the iceberg. He explained that only 10% of any iceberg is visible for us; while 90% is hidden. Professor Mengesha stated that this phenomenon could be adapted to people. People usually try to make conclusion/decision by observing only 10%, which accounts to knowledge and skills (behavior). He stated that the other 90% is attitude.

Finally, Prof Mengesha clarified that attitude includes: values, standards, judgments, motives, ethics, and beliefs. Attitude impacts behavior. What makes our life 100% is attitude plus behavior. A ‘can do’ attitude is essential for life. By having this principle, Prof Mengesha stated that we can do and achieve more.

6.2 Group work on attitude

Trainees were given different questions and a case study on attitude. They worked in groups and presented their discussions.

Later, Prof Mengesha summarized the presentations. He said as healthcare providers, our attitude affects the service we offer to clients. He stressed the need to clearly communicate with clients and provide good services with a positive attitude.

Finally, Prof Mengesha indicated that to manage healthcare services properly, there may be a need to change manpower, re-structure the service, and/or train and shape employees to develop positive attitude. He advised participants to use suggestion boxes to collect feedback from clients to bring positive attitude in employees.



Section VII Change management

*Prof Mengesha Admasu
Executive Director
IIfPHC*

7.1 Managing change

Prof. Mengesha gave a lesson on change management. Before going into the subject, he started off with an energizer exercise that consisted of having the trainees quickly get off their chairs and get up if he had called out the numbers 4, 1, 8 and stay put if they heard the numbers 5, 3, and 6. The exercise entertained all as some stood up at the call of the wrong number. Prof Mengesha explained that they should use this technique to further attract the audiences' attention when they are conducting training or presentation.

He started by emphasizing that changes happen around us every single day. As long as there is a need, there is always change. Prof Mengesha said human beings are constantly changing because there is constant change in what they need and desire. Saying that, he gave the learning objectives, which included: understanding what change management is; when and where change is needed; why there is resistance to change; and the techniques used to overcome those resistance.

Prof Mengesha defined change management as “the process of alteration or transformation of individuals, groups, and organization undergo in response to internal and external factors.” He indicated that change management comes in naturally. Everything that naturally happens within us and around us forces us to change in order to adapt. He stated change requires going outside of one's comfort zone. For instance, he said if we are afraid of change, we would never find out our capability and succeed. Prof Mengesha emphasized that the only time we appreciate success is when we have been through the ups and down to achieve our goal.

Explaining why change is needed, Prof Mengesha mentioned the need to meet the: changing customer needs; changing market conditions; responding to internal/competitive pressures; as well as the need to take advantage of new opportunities. He underlined the four key factors in managing change which are: what do we want to achieve; why are we inducing change; how do we plan to make that happen; and what consequence do we anticipate from the change.

Prof Mengesha cited Kurt Lewin's force field analysis and the three-step change process to participants as follows:

1. Unfreezing - identifying the obstacle that is preventing us to change and breaking out from the past
2. Changing - identifying what can be changed and following up a chronological order for the desired change. Changing requires developing a new behavior pattern.

3. Re-freezing - enforcing the changes by constantly making sure that they are being applied appropriately and stabilizing the new behavior.

In addition, Prof Mengesha cited Kanter and co-authors who proposed the ten steps for executing change effectively. (see Annex VII)

Then, Prof Mengesha elaborated resistance to change. He stated the reasons why people resist change must be studied carefully and thoroughly. The techniques used to overcome resistance to change included: communication and education; participation and involvement; facilitation and support; and negotiation and agreement.

Finally, Prof Mengesha explained the basic functions that are required to accelerate the pace of change and ended the lecture. (see Annex VII for the details.)

Section VIII Team work

*Prof Mengesha Admassu
IfPHC*

Prof Mengesha started his session by asking trainees what they understand by the word 'team' and they explained what they have understood. He gave two definitions of a team as: "a group of people who work together cooperatively to achieve a common goal" and "a small number of people with complementary skills who are equally committed to a common purpose, goal, and working approach for which they hold themselves mutually accountable." He said that it is proved in a research that a team with 5 members is strong. For instance in a period, 5 members could take 10 minutes each and make effective lectures.

Then, Prof Mengesha read quotations and used illustrations for better understanding of the concept of team and teamwork. He explained the benefits of teamwork, which include: shared responsibility; motivation; flexibility; delegation; ownership; proactive approach; and skills development. For the drawbacks, Prof Mengesha mentioned that it could be time consuming. Some members may feel uncomfortable and confused leading to conflicts. For the team to function well, Prof Mengesha indicated that it needs good leadership and change management. He stressed that the benefits of working in a team much outweigh the drawbacks.

Later, Prof Mengesha explained what high performing team is what characteristics they possess. He said high performing team focuses on results. Team members trust one another and hold each other accountable. Members commit to decisions and plans and communicate openly. Following that, Prof Mengesha explained Lencioni's 5 dysfunctions of a team in detail. These include: absence of trust; fear of conflict; lack of commitment; avoidance of accountability and inattention to results. He indicated the symptoms of each of the dysfunctions. He ended his presentation by explaining the team building tools, which encompass: ensuring trust; effectively handling conflict; achieving commitment; embracing accountability and focusing on results. (see Annex VIII)

8.2 Group work



The participants formed a team of 6 people. Each team was requested to make five equal rectangles using 15 pieces of cut-out papers. They were not allowed to talk or snatch papers from each other. Each team selected an internal auditor to check on how they worked as a team and a member. External auditors were also assigned to observe all the teams. No single team was able to make the 5 equal rectangles. The internal and external auditors explained what they observed and the dysfunctions within the teams.

Section IX Styles of conflicts

*Prof Mengesha Admassu
IfPHC*

9.1 Managing conflict

Prof Mengeha asked trainees if they think conflict is bad, good, or bad and good, and the latter provided their opinion. Then, he highlighted the learning objectives of the course which included: gain an understanding of what conflict means; describe how conflict impacts on individuals and groups and affects workplace; assess personal comfort level with conflict; and discuss the actions that can be used to master conflict in a workplace.

Prof Mengesha stated that there are two types of conflicts: task conflict and relationship conflict. He used Thomas and Kilmann's conflict model to explain the styles of conflict. (See Annex IX) Prof Mengesha stated that some people fear conflict. However, he said that fear of conflict creates artificial harmony, inhibits unfiltered and passionate debate and creates veiled discussions. Using examples, he explained conflicts in different situations and the ways to resolve the conflicts. Prof Mengesha indicated that to master conflict, there should be: trust, communication skills, healthy debates and ground rules. For instance, trainees created norms at the start of the training session to avoid conflict of interest.

9.2 General discussion and group work

9.2.1 Q&A

Participants were divided into groups and discussed the following questions:

- 1) How might your previous experience in managing conflict impact how you respond to a conflict in the work place?
- 2) What rules about conflict have you learnt from your personal, professional and community life?
- 3) Conflict is a disaster. Do you agree or disagree? Whatever your answer, please explain the reason.
- 4) Conflict is a development. Do you agree or disagree? Whatever your answer, please explain the reason.
- 5) List conflict resolution procedures/ methods in order of their importance.
- 6) Tell us a situation where you got an advantage as the result of having conflict with someone or something. Also, please tell us a time when you have been deeply hurt/ disappointed and regretted the situation due to the conflict.



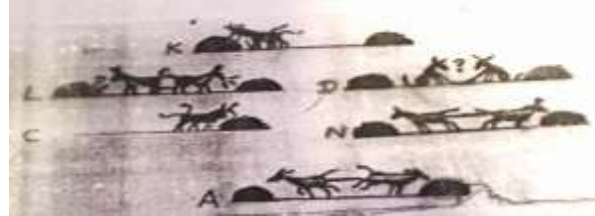
The discussions were followed by presentations by each group.

9.2.2 Cooperation vs competition

Trainees were given a task on cooperation vs competition. (See the picture below)

The groups discussed the order as to how the picture needs to be prioritized and wrote the order in the white board.

Later, Prof Mengesha explained the right order: Aspiration/desire should come first, which is indicated with 'L'. Then each donkey tried to eat the hay separately, which is 'N'. Then, there was competition to reach the hay, which is 'A'. The donkeys discussed under 'D' what they should do. They understood that cooperation is important and went together to eat the hay 'K'. Then, they went together to eat the second hay 'C'.



Prof Mengesha stated that people perform better and more creatively in situations where there is cooperation, rather than competition. Success often depends on sharing resources, efficiently. This is impossible if people work against each other.

Finally, trainees were given a case study on conflict and each group discussed and made presentation.

Section X Transformational leadership

Ato Dereje Ayele
MSH

10.1 Transformational leadership: an overview

Ato Dereje informed training participants that there is leadership problem globally. He said if there is good leadership, undoubtedly, there will be good result. Ato Dereje stated that if we are leaders, it is a must to have results. He indicated that a lot of money is invested to organize such kinds of trainings. But, training alone does not lead to good leadership. Ato Dereje reminded participants that MoH wants results from the training. He stated that the health sector results are indicated by achieving MDGs/SDGs. Although Ethiopia is better off in the achievements of the MDGs compared to other African countries, the results are not as much as the donations received.



Ato Dereje elaborated that leadership is not only about the top level; it should be cascaded to the bottom level. Gone are the days where senior/top levels are the ones who are the leaders.

Ato Dereje then explained about the concept of power. Usually, rich people are powerful than the poor. He discussed the different types of powers such as expert power, community power and a leader's power. Ato Dereje said woreda heads have legitimate power that is given by the government.

Later, Ato Dereje indicated that leadership is a missing element in the health sector. At pre-service level, there are complaints that the curriculum needs to be revised. He gave an example whereby there is no health management course in the medical doctorate courses; but doctors are assigned to work as managers upon completion of their training.

Following that, Ato Dereje explained how leadership roles could be expressed in different ways. For example, each one of us is leading our families; and some of us leading employees. In the work place, leaders should target for tangible results. At the end of the day, there must be a better health service delivery and improved community health, besides the reduction of morbidity and mortality rates. Availability and utilization of healthcare services need to be improved in the Woreda. Ato Dereje said a good leadership indicators are the results that are achieved through better services. He said that managing resources is easy; but the most challenging resource is human resource.

Ato Dereje also explained the two models of leadership: 'expert' model and empowerment model. He elaborated each in detail. In expert model, ideas and motives come from the outside. For instance, MoH helps woredas to solve their problems; or consultants are hired

to solve complex organizational problems. This approach is easy and provides an immediate solution. However, the problem with this approach is that the problems re-occur later on. In other cases, experts are hired to develop strategic plans.

In the empowerment model, Ato Dereje stated that employees are empowered to solve the problems of the organization. There are no other people who know the problem other than the employees. Empowerment, or 'mabekate' in Amharic, involves, motive, commitment, desire and plan. In the model, leadership takes a calculated risk. People are given power to take risks. Ato Dereje stressed the need to empower people who work with us to make change happen. He stated the command and control type of management or the carrot and stick management is dead in the 21st century. What leaders need to do is empower employees and work together. Explaining the benefits of empowerment, Ato Dereje mentioned the concern level of employees being at the same level to that of the leader. Commitment comes with empowerment, which enables sustained performance and innovation. However, Ato Dereje stated that empowerment requires cost and time. He advised for leaders to take time and to have patience and perseverance to empower people. As transformational leaders, they have to think that people who work with them can transform. He said, there may be fast and average learners. At the end of the day, they will all learn and contribute to the success of the organization.

Discussing on the fundamental types of leadership and their characteristics, Ato Dereje explained the three types as follows:

- transformational leadership - characteristics include: idealized influence, inspirational motivation, intellectual stimulation and individualized consideration.
- transactional leadership - the characteristics include: contingent rewards, management by exception (active); management by exception (passive) and laissez-faire.
- servant leadership. The servant leadership is derived from the Bible and it is a type of leadership that has paradox.

Ato Dereje said that good leadership focuses on improvement of organizational performance. In the health sector, good leadership focuses on health outcomes. He advised trainees that the health profession is a missionary service and leaders should not command. Leaders should empower staff and transform the services at federal, woreda and health center/post levels. Ato Dereje indicated leadership is learned over time. It is sustained through management systems. He said leadership at all levels is important. Leaders should make sure that whether they are there or not the organization should function.

Following that, Ato Dereje mentioned the leadership theories that have developed over centuries.

1. Trait theory assumes that leaders are born for leadership roles.
2. Behavioral leadership focus on employee and production.
3. Learning to lead – focuses on training ourselves as leaders. People can change themselves through learning and practicing leadership. The subconscious mind tells

- them who they are. They have to talk to themselves and jot down about who they are.
4. Leadership is learned over time. A leader needs to read and observe. He/she has to also learn patience.
 5. Transformational leadership – Leaders should work on management systems that need to be changed. The systems of procurement, monitoring, finance and so on need to be changed.

10.2 Looking at your mindset and values

Ato Dereje explained the concept of looking at one's mindset and values. (See Annex X) He asked participants if they think about their mission and when they will fulfill that mission. He also asked if it is their mindset; and if people in their organization think the same way. He left these questions for trainees to answer all for themselves. Ato Dereje said that if trainees look to lead, they need to invest about 40% of their time managing their ethics, motives, principles, characteristics, motivations and conduct. He stated that if people invest 40% of their time on these issues, then they can lead their organizations. He defined mindset as a habitual way of responding to a situation. To be a leader and to change the organization, Ato Dereje indicated that this mindset should change. Managers should shift their mindset a little bit at a time for there is no 360 degree shift at one time. They should shift their mindset toward seeing themselves as people who mobilize and empower others to create the future. Ato Dereje said that the series of shifts in mindset are called leader shifts.

Ato Dereje stated that the underlying principle to look at one's mindset and values is the belief that all organizational members, regardless of their position, are valuable contributors to the results. He explained the importance of giving value to all organizational members, from guard and cleaners up to the leader. He said if we see an organization as a human body that has different systems, the whole body will be affected if one part is not functioning well. In the same way, all members contribute to the success of the organization. All have the ability to change the way they work with others to achieve results together. For mindset to shift, a leader should believe that every employee has an ability to change the way they work/do things. The leader needs to nurture their potential and act as a coach and an aligner.

Ato Dereje gave a number of examples on leader shifts or shift perspectives including:

- from individual heroics to collaborative actions - leaders don't say 'I'; they say 'we'. They want to be part of the result and give the credit for all.
- from despair and cynicism to hope and possibility - Psychologists say between 15,000 and 20,000 thoughts come to the brain in a second, out of which 80% are negative. Only 20% is optimism and hope. Ato Dereje gave an example on the Abay dam construction. He said people forgot the despair and cynicism when the former Ethiopian Prime Minister said 'Abay dam will be constructed with our own resources'. Leaders should capitalize on the 20%. They should go out of despair and cynicism and implant hope and possibility.

- from blaming others for problems to taking responsibility for challenges - Leaders should work with others and take responsibility together. They should not blame others for mistakes done.
- From scattered, disconnected activities to purposeful, interconnected actions – all departments should work together and be result oriented. If one unit is successful and the other is not, it will affect the overall result. All departments need to connect for better actions and results.
- From self-absorption to generosity and concern for the common goal – a leader should not take all benefits for himself/herself eg. travel, training, etc. Going out of the self-absorption is not easy. It is a process and takes time as well as struggle with self.

Section XI Leadership

Ato Dereje Ayele
Management Sciences for Health

11.1 Leadership: an overview

Ato Dereje defined leadership as “... a process where by an individual influences a group of individuals to achieve a common goal.” He explained the four leadership concepts, ie, leadership is a process; it involves influence; leadership occurs in a group context and it involves goal attainment. Ato Dereje stated that leadership is a process and everybody is going in the same direction, till they reach the common goal/mission. The goal is in everybody’s heart. He stated leadership fails from the beginning when a leader thinks that people should follow them. He stressed that leadership could be a tiresome process for a leader is dealing with the complex human being. Employees come from different culture and background and with different behaviors.



Ato Dereje elaborated how leadership involves influence. He said to have influence, a leader needs power, expressed in terms of personal and legitimate power. However, he advised to use legitimate power towards the end, after training and consulting with employees and these are not working. Expressing how personal power works, Ato Dereje said that people willingly open the door for the leader and lay the red carpet for them. People imitate the leader. Without this power, he said, it is difficult to lead an organization. Personal power

requires integrity. A leader needs to walk the talk. Ato Dereje gave different examples from his personal experience about good leaders who have personal power. He advised trainees to ask themselves how they are leading their organizations: whether they have personal power that influence employees or legitimate power that is given by the government.

To explain how leadership occurs in a group context, Ato Dereje used his lecture. He said the words that he spoke pass through 60 filters. Some trainees write; some say it is good; some take it all; others take some. Change occurs passing all these filters. He stated that group context is not a simple issue. One could not say that 100% change will be achieved. But the early majority will shift and others follow.

Leadership involves goal attainment... If there is no leadership, there is no result. But, if there is leadership, there is absolute result and goal achievement. For example, Ethiopia is expected to be a low middle income country by 2025 and middle income country by 2035.

This is our goal, and leaders play a crucial role in attaining the goal and followers learn to go towards that direction.

Transformational leadership

Ato Dereje stated transformational leaders have the ability to inspire and motivate followers to achieve results that exceed expectations. He said that this ability is generally based on three personality characteristics: charisma, individual attention and intellectual stimulation.

Ato Dereje divided leaders into two: pseudo and true transformational leaders and elaborated each. Pseudo transformational leaders mobilize people; but their ultimate goal is to satisfy their personal ego and self-interest. True transformational leaders serve the aim of others. They are optimistic and inspire and instigate energy on others.

Classifying employees, Ato Dereje said that there are three types:

- 1) comply – those who work, eg $2+2=4$
- 2) non-comply - those who do not work. They are late. The leader should train them; empower or fire them.
- 3) malicious non-comply – those who do the wrong things deliberately. They want to destroy the leader; but tell them that they are with them. They say 'ok' to the leader; but they talk behind them.

To be transformational leaders, Ato Dereje advised trainees to work to achieve extraordinary work and exceed expectations. He repeated the ultimate goal of the sector, which is good health outcome through better delivery of health services. To be transformational leaders, he advised trainees to be visionary and to inspire and empower staff. In this way, staff will have ownership and good working relationship. As leaders, trainees have to enable themselves and others to face challenges and achieve results. Ato Dereje indicated that the result will be improved health systems, improved work climate, stronger management systems, responsive health systems as well as prudent allocation of resources. At woreda and zone levels, he said there are transformational leaders who have the ability to achieve result. He advised participants to be true transformational leaders.

Section XII
Introduction to leadership and followership
December 14, 2016

Ms Kidist Nadew
Country Director
Yale Global Health Leadership Institute

Mr Abreham Zerihun
Yale Global Health Leadership Institute



Mr Abreham informed participants that the session will focus on leadership and followership. He said trainees need to share the varied experiences that participants have at Regional, Zonal, Woreda and health post levels to make it more participatory. Mr Abreham stated that leadership for the health sector plays a crucial role for better performance results and patient outcome. Thus, leadership need to be built to serve the community well.

12.1 Exercise

Ms Kidist requested trainees to be in pairs and sit back to back. In each pair, Trainee 1 was given a picture and trainee 2 a blank paper. Trainee 1 gave description to trainee 2 about how to draw the hidden picture; but should not show Trainee 2 the picture. Trainee 2 was expected to draw the item by listening to Trainee 1's direction. Each pair was given 15 minutes to create a new drawing.



Each team was requested to compare the two drawings. They were asked to explain the process how they worked together; what they found difficult about the exercise and the challenges they faced. Some said their pictures were too difficult to describe; thus, complex messages were sent. In this case, the sender may not transfer the message adequately to the receiver. Then, participants were requested to relate it to their daily life and leadership. A participant stated the need to communicate effectively. Ato Abreham explained that a leader should give detailed information about a task and should give direction to followers to achieve goals. He stated that whenever leadership is mentioned, followers need to also be considered. Both play equal role. Leaders need to communicate to followers effectively.

12.2 Leadership

Ato Abreham Zerihun

Ato Abreham gave the definition of leadership as “the process of influencing other individuals, formal (structured) groups or informal (not-necessarily structured) groups towards attainment of a given goal.” Followership has been defined as “...a roll we all occupy in each of our positions, all the time.” Ato Abreham stated people may play both leadership and followership roles at the same time. The definition of management has also been given as: “the process of achieving objectives through human, technical and financial resources.” Ato Abreham indicated that leadership is more on influencing and management is on mobilising resources to achieve goals.

Then, participants were asked to think of a person they admire as a good leader and what role in the family or community these leaders have and what attributes or qualities they possess. Participants listed the characteristics of the leaders they admired as those who serve as model for others; encourage personal development of people; love people; good listeners; show the direction; leads by example; motivate staff; decision maker; committed to serve others; and convince others.

Ato Abreham stated that the roles of leaders include: goal setting; problem solving; managing external stakeholders; managing internal workforce and influencing organizational culture. He explained the concept of organizational culture, ie, the written and unwritten laws in an organization. He said leaders usually create the culture. Ato Abreham said followers should share the goals and use resources to solve problems and achieve goals.

Following that, Ato Abreham highlighted the historical perspectives of leadership. These are: trait theory of leadership; behaviour theory of leadership; contingency theory of leadership and contemporary theories that include transformational and transactional leadership. (See Annex XI) Ato Abreham also explained the leadership styles, mainly transactional and transformational leadership. Transactional leadership: rewards for performance; quickly correct problems; refrain from performance interruptions; and non-inter in organizational change. Whereas transformational leadership: influence through the vision; motivate through inspiration; stimulate intellect within a team and offer individualized consideration.

Later, Ato Abreham, elaborated on followership styles, which are: passive; yes-people; the alienated; the pragmatics; and the stars. He explained each style and their relationships in a continuum. (see presentation materials)

12.3 Transformational leadership

Ms Kidist Nadew

Ms Kidist talked about transformational leadership. She stated that leadership is a vast topic which could be given as a one-year course. She highlighted that the session is to give participants the idea. Kidist stated she wished to give trainees a seed that they could grow.

She asked participants to take time and think individually who they are, whether their leadership style is transactional or transformational.

Ms Kidist asked participants what they understand from a word 'transformation'. The responses included: it is about bringing structural change, shifting; and radical change. Kidist defined transformation as a word that implies "a basic change of character and little or no resemblance with the past configuration or structure." She stated that we can't change backwards once transformed. For instance, transformation occurs from egg to larva and gradually to a butterfly. A butterfly can't change into a larva. Whether transformation is for good or for bad, Kidist said that it depends on the aim.

Ms Kidist stated that transformational leadership approach causes sustainable change in individuals and social systems. It creates valuable and positive change in the followers with the end goal of developing followers into leaders. The approach seeks permanent change. She stated that we may have different campaigns; but these campaigns may or may not be sustainable. Ms Kidist said that transformation should be positive. Leaders and followers will have the same goal.

Explaining the characteristics of transformational leaders, Ms Kidist said that these leaders: are sometimes called quiet leaders and lead by example. The leaders understand the strengths and weaknesses of their followers and align followers with tasks that optimize their performance. Ms Kidist stated that transformational leader's style tend to use motivation, rapport, inspiration and empathy to engage followers.

Finally, Ms Kidist indicated that transformational leadership is a long process since we are working with people's attitudes. People have different personalities and experiences that require patience. It starts from the individual and his/her leadership. She advised participants to think about it and reflect on what qualities and attributes are required to be effective in their roles.

12.4 Group discussion

Q&A

Ato Abreham requested participants what type of followers they are in their work situation. He asked what challenges they faced at woreda/health post level which prevented them from being star followers.

From participants' responses, it was observed that 'passive' and 'yes followers' were the most dominant. Some stated that if they oppose their boss, it would be considered as non-compliance. A participant said some leaders may feel that their weaknesses are exposed. Yet, another stated that employees may assume the follower is looking for a position or promotion. A participant stated that if they bring different ideas, leaders usually inform them that "it is a guideline. It is in the structure". The majority of participants agreed that they prefer to be quiet and say 'yes' to their boss, and do the tasks as instructed. Generally, they agreed that this is the common type of followership in Ethiopia. The boss is considered the most 'knowledgeable person' and gives instruction to followers, who are expected to obey without arguments. The culture is not accommodating the presentation

of different ideas from that of the leader. Many leaders exercise dictatorship/authoritarian leadership and believe that this style is the one that works in Ethiopia.

Then, Ato Abreham asked what we should do to change this culture as followers and have star followers. A participant stated that staffs need to be involved in goal setting, not only implementation. Another said followers need to develop confidence and share their experience. Yet another said followers need to share responsibility. A participant suggested that followers need to have evidence-based information to proof what they are saying is right and is a good idea.

Ato Abreham asked what should be done to change the culture as a leader? A participant suggested understanding the working environment and the need to learn to listen to others' opinions.

Finally, Ato Abreham asked how the trainees will apply the concepts that they learnt in their situation when they go back. A participant said, as a leader, he should be a positive thinker and a listener to take good ideas. He said that they have to change the system. Another participant stated that followers should not be afraid of suggesting their ideas and being challenged. Another participant stated they should learn to convince others. They should also learn to openly discuss with other employees. Yet another participant said that the concept he learnt from the session is not practiced in his work place, and stated he has found the training very useful. He said that he will use the concepts to make change in his work. He stated that change may take time, but they need to be flexible and achieve results.

Ato Abreham appreciated the responses given. He reminded participants that all leaders are not rigid leaders and that we all need to change as a community. Ato Abreham said that the culture of taking and receiving feedback should be developed, both by the leader and followers. If people say 'yes' all the time, leaders should encourage them to make some suggestions and share their views. Ms Kidist added that when a follower says something is not wrong, he/she must bring some evidence. She advised trainees to try it bit by bit and take baby steps.

Case study

Training participants divided into groups and discussed on a case study. They related the case to the real-life situation that they have encountered in their work experience.



Section XIII

Critical thinking

Prof Mengesha Admassu
IIfPHC

13.1 What is critical thinking?

Prof Mengesha stated human beings should think in a better way than a computer or any other machine. He clarified the learning objectives of the session, which included: understanding what critical thinking is; why it is important and evaluate its' pros and cons. Prof Mengesha stressed that critical thinking skills involve reasoning, analyzing, decision making, problem solving and evaluating. He said that precision is important in critical think, which requires giving more details in more specific ways.

13.2 The benefits of critical thinking

Prof Mengesha explained the benefits of critical thinking for improving academic performance as well as for reflecting and getting a deeper understanding of own and others decisions in the work place. Critical thinking also helps in daily life to avoid foolish personal decisions. (See Annex XII for details)

Professor Mengesha gave a variety of examples related to critical thinking. For instance, he asked trainees if air, food or water is important, if we are supposed to choose only one. After some discussions and through crucial thinking, participants agreed air is most important for life. Prof Mengesha told trainees that until the question arose, no one was concerned about air. As health workers, trainees were advised to think critically.

13.3 Role play

Then, Prof Mengesha requested for 10 volunteers. The volunteers were given 1 to 10 numbers using a draw and were told to close their eyes. They were not allowed to talk. The volunteers were requested to make a line in a descending or ascending order. After 10 minutes, the volunteers were requested to callout their respective numbers and it was not in the right order. Prof Mengesha told the group that out of the 112 groups that he asked to do the same exercise, only 55 were able to make it. He asked why this group was unable to make the line. Some said because they were not allowed to see. But he told them that there are many people who can't see but are fit and live competitively in the world. Prof Mengesha said that since all the volunteers were moving around, they should have thought other options. Participants suggested different options as to how the group could make a line from 1 to 10. A trainee suggested using figures to communicate a person's number. None of them, however, were convincing. Prof Mengesha said that volunteers could write their numbers on each other's palms what number they were. Critical thinking create solutions to problems. He told them that critical thinking requires going out of the box and that they should develop this skill.

Section XIV Strategic health communication

*Ato Betemariam Alemu
Johns Hopkins Center for Communication Program*

14.1 Health communication

Ato Betemariam introduced the objectives of the session, which included: gaining an understanding of why communication is important; understanding what social and behavior change communication mean; better understanding on how to conduct situational and barrier analysis of intervention for behavior change; applying socio-ecological model for communication intervention and developing high impact communication strategies. (See annex XIII for details on his presentation.)



Ato Betemariam cited Parker J to define communication. “To communicate is to create space where the community of truth is practiced.” He stated that the key question in health communication/ promotion is to “begin with the end in mind”. What is the end or the success we would like to see? He stated thinking about the vision and how the mission could be achieved is crucial.

Ato Betemariam explained as farmers produce food, families, individuals and communities produce health. He said health workers usually think they are the health producers. Ato Betemariam gave comparisons of healthcare service at household and health facility level. For example, at household level, in 1000 births, there are 4000 healthcare providers. But in a government facility, there may be 4 midwives. With regard to the time on duty, people are present 24/7; their commitment is higher; but their skill is lower at household level. Government staffs are there only for 40 hours; commitment is lower; but their skill is higher. Ato Betemariam asked participants which path participants preferred for the health system: households as primary producers of health or primary health care units as producers of health. He further asked, if institutions need to fight diseases to save people or if institutions enable people to act and fight diseases. Ato Betemariam emphasized that the primary producers of health are not health professionals but ordinary people. The goal is not to ‘fight disease’ but to enable people to promote and protect their health. He stressed the importance of communication to empower people in the community.

14.2 Why communication matters in public health?

Ato Betemariam gave examples to elaborate the importance of communication, which is not that much effective in many cases. He cited EDHS 2016 report for ANC coverage in four regions: Oromia, Tigray, Amhara and SNNP. The routine ANC coverage from skilled providers was initially high. But, the 4th ANC visit was found to be much lower in all the regions. (See annex XIII) Ato Betemariam stated the reasons may be manifold; but one could be poor communication and lack of awareness among mothers. On their first visit, mothers may not be convinced that the 3rd and 4th visits are necessary. They may not know the importance of the visit and they may not be informed about the importance. Ato Betemariam further gave an example about the need to educate mothers about HIV transmission through breast-feeding and the need to take drugs to reduce the transmission. He informed participants to communicate the importance of skilled delivery as visionary leaders.

Ato Betemariam cited EDHS 2016 report to show how immunization services for Penta, Polio and Pneumococcal have been decreasing over time. He stated the reasons might be that mothers were not informed about the side effects, or they were not informed about the importance; or it could be lack of compassionate care that resulted from the communication style used at the health post/center. Ato Betemariam stressed the need to change these practices and hence the importance of communication.

14.3 Strategic behavioral change communication (SBCC)

Ato Betemariam explained that strategic communication is a process carried out with the active participation of stakeholders and beneficiaries that addresses a long-term vision and affects the causes and the barriers to behavior and social change. He said a comprehensive knowledge is important and that we have to address the barriers and causes. Ato Betemariam stated that a generation ago, the type of communication was monologue – expert (sender) sent message to the non-expert (receiver). Doctors spoke to patients. Even though the patients had different concerns, they had to listen attentively. This type of health communication was not meaningful; but this type of communication is still practiced in Ethiopia.

Ato Betemariam explained the assumption that giving correct information based on science will lead to behavioral change; but this is not sufficient to change behavior by itself. Only addressing the problem could lead to behavioral change. In the 1970s, in the 'Field Extension Era', he stated, the communication style moved from monologue to dialogue between the expert and non-expert. 'The social marketing era' followed in the 1980s which moved from non-paying clients to customers who ask and pay. Since the mid 1990s, 'the strategic era' is used. It is based on mutual adjustment and convergence of experts and non-experts.

Ato Betemariam walked trainees through the different types of communication theories. He said 'a magic bullet theory', the communication from a doctor to influence a patient's

behavior, did not work. He stressed the need for communication to be multi-dimensional. For instance, for a behavioral change there are multiple factors. He explained the multivariate ideation theory, which involves knowledge, personal advocacy, attitude, self-image, self-efficacy, emotion and social influence. The theory implies simultaneous effect of all influences. It also implies that communication can affect all of these factors.

Ato Betemariam also elaborated the key facts about human behavior. He said people interpret and make meaning of information based on their own context. The culture, norms gender and so on need to be addressed. There may also be competing priorities for people's decisions about health and well-being.

Then, Ato Betemariam discussed the socio-ecological model which explains how personal and environmental factors determine behaviors. Communication used to overcome barriers to normative, social and behavior change at individual, family, peer network, community and society levels. The system should be seen holistically and problems need to be addressed. In the model, the knowledge and attitude, skills, beliefs, values and perceived risks influence an individual/household. At community level, community norms (religious and traditional practices) shape behavior. Well informed and motivated health extension workers/community health workers are crucial. At service delivery, the service should be accessible and available. Friendly service should to be given by skilled service providers. Enabling environment such as supportive legal and policy frameworks, infrastructure, committed leadership and multi-sector coordination is also needed. The MoH has designed the national health strategy based on identified needs.

Following that, Ato Betemariam explained the required steps to design strategic communication. These included: situational analysis; audience analysis and program analysis. He advised trainees to use the monthly meetings with PHCU to analyze situation and define health problems. Once the problems are understood, they have to think how they need to communicate. He advised them to conduct audience analysis to understand the audience better. In order for the communication to be effective, they should be in the audience's shoes and see/understand things from their points of view. Ato Betemariam also advised the need to understand the individual and social contexts.

Ato Betemariam then showed participants an abstract picture and asked them what they saw. Participants suggested different things. He explained how people fill the gaps and make conclusions from their own perspective when they are given incomplete data. He stated people who look at the same thing may see different things as in the picture. Similarly, people who listen to information understand it in different angles. Hence, Ato Betemariam stressed the need to organize information for people to understand it better. In addition, he said people do not see things in the same way. For instance, when a word drug is mentioned, some may see it as enjoyment while for others it is danger. He gave more words and how they are interpreted among people.

Finally, Ato Betemariam advised trainees to be creative in communicating things, to think outside the box and not to let their existing tools define their communication.

14.4 Group work

After the lecture, participants were requested to break into five groups and to pick one of 5 topics: maternal health; nutrition; WASH; immunization and family planning. They were then told to:

- analyze the current situation which is common in their areas
- segment the barriers based on the socio-ecological model
- identify the audience they wanted to change
- identify their communication strategy

Participants, then, went through the discussion points in their groups and two groups made presentations.

Group 1

Group 1 said the biggest challenge they have observed is negative cultural barriers. The speaker said since men pay dowry for their wives, they feel like they have ownership of her and full control over her including deciding where she gives birth.

Another challenge is infrastructure. There are roads that take over 8 hours to go from one kebele to the other. Also, vehicles, especially ambulances are not available. The zone was not granted any transformation vehicles based on some criteria that wasn't made clear to them.

Yet another challenge is that healthcare providers don't give equal treatment to city patients and rural patients. There are many cases where pregnant mothers from rural areas were ignored in favor of their city-dwelling counterparts.

The solutions suggested included: working closely with partner organizations; strengthening the 5 to 1 supervision system; working hand in hand with local community members and building better access roads in addition to buying more ambulances. In addition, civil servants and healthcare providers need to be educated and trained on equitable healthcare service. Also, service-oriented, customer-centered health facilities need to be created.

Group 2

The second group dealt with the issue of inadequate coverage of vaccinations. The identified root causes were: lack of security; hard to reach (remote) locations; low pay for rural workers; lack of awareness in the community; negligence on the part of healthcare providers; and infrastructure issues such as inadequacy of refrigerators.

The solutions suggested included: working with the available human resources; giving salaries and benefits that commensurate with cost of living; educating the community in an organized coherent manner; using checklists to make sure all materials are brought along on vaccination field visits; and working closely with stakeholders.

Ato Betemariam took over and thanked the participants for presenting. He, then, recounted his personal experience going to a woreda in the South. They went on a site visit to try to understand why even though child mortality had been reduced, neonatal mortality remained high. Ato Betemariam's team went from house to house with the HEW to visit women who had just given birth recently. They saw that in 3 out of 5 houses, the mothers and infants slept in small service quarters behind the main house. When they asked why, the mothers responded that was because they did not want to cheapen or pollute the house. Based on the understanding of this religious belief, Ato Betemariam and his team congregated all the local religious leaders and went through the Family Health Card with them. Afterwards they asked the religious leaders if there was anything in the Card that opposed their religious beliefs. The response was that only the Family Planning portion was incongruent with their beliefs. So they were told to ignore that part and teach mothers everything else in the Card because they already visited mothers' post-partum. Ato Betemariam mentioned the necessity of advocacy. He said that since the participants were themselves empowered, it was their job to advocate for their community and ask for any materials or services that they needed. Lastly, he said that social mobilization is key. He emphasized that the exhaustive and full use of the local community has continuous benefits with a rippling effect.

Section XV Health sector planning

Mr Mideksa Adugna
Assistant director
FMoH

15.1 Health sector planning process: principles and methods



Ato Mideksa introduced himself and gave the outline of his presentation including: an overview of the health sector planning process; principles of planning; approaches and methods of planning and strategic recommendations.

He elaborated the health sector planning process starting from the concepts and definitions. He said planning is about deciding ahead of time and how to do it. It is a process of what to achieve, when and how, by using what resources.

Planning helps to identify priorities and focus on implementation of set priorities.

Ato Mideksa stated many stakeholders are involved in the health sector. They have various interests, which need to be identified and incorporated in the planning process. He explained the seven principles of planning as: one plan, one budget, one report, resource constrained principle; result oriented budgeting principle and evidence-based planning (EBP) and the flexibility principle. Each principle was explained in detail. (see Annex XIV) Ato Mideksa emphasized the need to consider evidence-based, high-impact and low cost planning.

Explaining the approaches and method of planning, Ato Mideksa mentioned three themes: evidence-based planning; top-down and bottom-up approach; and balanced scorecard (BSC) framework. He illustrated the top-down and bottom-up approach using a diagram. (see presentation material) He said the one-plan principle applied at national level is derived from the experiences of other countries with decentralized government systems. Ato Mideksa stated Ethiopia has a decentralized system. A woreda has authority with its own entity. Sector wide approach thinking needs both top-down and bottom-up approach. Explaining the approach, he said it starts from resource mapping at national level and stakeholders are involved in the mapping exercise. At national level, there is indicative annual core plan which is going down to regional, woreda and health facility levels. There is also mapping at regional, woreda and facility levels. The Woreda and facility will have their own plans.

15.2 Envisioning Ethiopia's path towards universal health coverage through strengthening primary health care

Ato Mideksa stated this is a 20 year general strategy plan for Ethiopia. Explaining on the rationale for the development of the strategy, he said although the health sector used to focus on access to health, effective coverage, quality and equity aspects had gaps. It was agreed to give emphasis at PHC level to address such issues and at the same time strengthen the health extension program. Thus, the country has developed a 20 year- plan to attain better healthcare and maintain good health and wellbeing.

Ato Mideksa said Ethiopia is expected to be a lower middle income country in 2025 and a middle income country by 2035. The health system should fit the higher expectations and demographic, environmental and health challenges, which require a new strategy. He explained that six strategic recommendations come out of the exercise. These are: empowering the community; strengthening health service delivery; ensuring a robust human resources development; enhancing the role of non-state actors; developing institutional capacity in the health sector; and developing sustainable financing mechanisms. Ato Mideksa said that the 6 points should be considered in every planning and decision planning process. As planners, he advised trainees to refer the 20 year and 5 year plan.

15.4 Strategic themes of HSTP

Ato Mideksa reminded the vision of MoH to trainees – ‘to see healthy, productive and prosperous Ethiopians.’ He elaborated the four pillars or focus areas of HSTP: excellence in health service delivery; excellence in quality improvement and assurance; excellence in leadership and governance; and excellence in health system capacity. He elaborated the four pillars of excellences. As planners, he advised participants to see the document for more details.

Later, Ato Mideksa informed trainees that as planners they should know about UHC and the potential health service coverage indicators. He stated countries should define their indicators based on their context. The three dimensions to consider when moving towards universal health coverage are: 1) expand the service to non-covered areas; 2) service delivery package (PHC coverage – if non-communicable disease is not included, the package should be revised. It could be through PHC or general service approach.) 3) reduce cost sharing and fees (People should share the cost. Out of pocket costs need to also be reduced.) If the cost is above 40%, the health system is called catastrophic system. There are different mechanisms to reduce costs and one mechanism is health insurance. Trainees were advised to consider these issues during planning exercise.

15.5 General discussion

Ato Mideksa responded to the following questions from training participants.

Q: The one plan tool is complex? Could you explain how it works?

A: The one health tool helps to plan on a yearly basis. Target settings may be updated each year. The types of resources from MoH and other stakeholders should be explained clearly. Planning is a leadership exercise and need to be done carefully by involving all stakeholders. A Woreda's resources and outputs need to be defined. Ato Mideksa advised using evidence to support the plan and budget.

Q: What is the difference between principles and approaches.

A: Organizations have values; ie principles. They are bound by these principles. These values should be considered in all aspects of work. For instance, HSTP principles include community empowerment. The community, once empowered, can produce its own health. The planning should address that. The approach is the method we use in the process.

Q: Plan is usually imposed from top-down, and it is not bottom-up, at the moment. How do you see that?

A: Mixed approach to planning is better. We need to have a strategic direction, which is top-down. There is the HSTP five year plan. Indicative plan at national level is approved by joint steering committee (a forum of MoH, Regional and Woreda offices). Evaluation is conducted every 6 months and the result is included in the indicative plan. New global initiatives are also included each time.

The bottom-up approach helps to give more focus at the grassroots level. In this way, the problems of the community will be addressed. At woreda level, plan should be comprehensive and with quality to address the overall health issues.

Q: How does the one plan-one budget principle work?

A: At MoH, resource mapping exercise starts early and February 10 is the deadline. The MoH, then distributes it to the woreda. The woreda submits indicative budget in June for the finance office. All activities have their own schedules.

Section XVI

Planning and implementation: balanced scorecard (BSC)

Ato Melaku Yilma
FMoH
27 April 2017

16.1 Balanced score card

Ato Melaku stated that BSC is a vast course and could be given as one-month training. He distributed a 150 slides manual on BSC implementation that has been prepared by the FMoH for further reference by training participants. (see annex XVI) Ato Melaku related BSC to a balanced diet, in which different food items like protein, carbohydrate, fat and so on are consumed in different proportions to make a balanced diet. Similarly, he indicated that the measurements used in an organization should be balanced.

Then, Ato Melaku gave background information on BSC and informed participants that Kaplan and Norton developed the tool in the 1990s. Ato Melaku indicated that the shift from industrialized economy to knowledge/ information technology has necessitated change and the use of intangible skills and knowledge of people. He defined BSC as "...a tool that translates an organization's mission and strategy into a comprehensive set of performance measures that provides the framework for a strategic measurement and management system."

Following that, Ato Melaku explained how BSC is a balanced approach. He stated that BSC is a balance between: financial and non-financial indicators of success; internal and external environments as well as lag and lead indicators of performance. Ato Melaku gave example on how the internal environment could be measured, which included: using working hours, cost and time. For instance, he explained that the external environment could be checked by the number of people who used the products of a company.

Next, Ato Melaku elaborated the 9 steps of BSC, of which the first 6 steps are building steps and the last 3 are activities. The 9 steps in ascending order are: assessment, strategy, strategic objectives, strategy map; performance; strategic initiatives; automation; cascading and evaluation. Ato Melaku explained each step in detail. (See power point presentation in Annex XV) Explaining step 1, assessment, Ato Melaku stated that different methods could be used to assess an organization to reflect and to look at the various areas to check what is working and what could be different. He indicated SWOT analysis; stakeholder analysis; the mission, vision and organizational core values as methods that could be used for assessment of an organization. Ato Melaku suggested checking service delivery, human resource (eg turnover), time, logistics, and information (data registration and generation) when conducting SWOT analysis. He also suggested using PEST analysis (political, economy, social and technology) to examine the external environment. Ato Melaku emphasised the need to make decisions based on knowledge and facts. In addition, he explained the concepts of stakeholder analysis and the need for an advocacy work if stakeholders have negative position about the organization.

Discussing step 2, strategy, Ato Melaku defined what strategy is; what customer value proposition is; as well as strategic theme and result. Giving example, he explained that excellence in immunization is a strategic theme and fully immunized community is a result. As the result of immunization., he said, there won't be any outbreak of the disease. Ato Melaku indicated that the four pillars of the HSTP are the strategic themes for FMOH and that the results are shown in the SBC on a yearly basis. He said the focus areas show if there are technology, skills and capacity to perform the tasks. Then Ato Melaku discussed the four strategic perspectives: learning and growth perspective (capacity); internal process perspective (quality); financial perspective (efficiency) and community perspective (satisfaction). He explained each perspective using examples. (see annex VX)

Elaborating step 3, strategic objectives, Ato Melaku said it is the basic building block of strategy and the organization's intent. He clarified that the objectives identify the most important things that need to be improved within each perspective and that the objectives break the strategic themes and results into action.

Next, Ato Melaku explained step 4, strategic map which defines the causal relationship among strategic objectives leading to results. As an example, he said improving the nurses' efficiency in giving vaccines improves immunization coverage. Ato Melaku indicated that the step is an important tool for communicating value internally and externally.

Explaining step 5, performance measures, Ato Melaku clarified that it is used to demonstrate the change or the result of an activity or program. He explained performance target as the current situation minus the desired destination. Ato Melaku clarified to participants the differences among minimum target, universal coverage and total coverage by using examples. He said universal coverage is 85% coverage and total coverage is 100%. For instance, he stated that in the CLTS (community-led total sanitation) approach, every household should have pit latrine and disposal bins. The hygiene and sanitation need to be 100% to achieve total coverage and to avoid diseases.

Then, Ato Melaku elaborated step 6, strategic initiatives, as programs or projects that turn strategy into operational terms and actionable items to meet strategic objectives.

The next step involves automation. Ato Mekau defined automation as applying performance management software to get the right performance information to the right people at the right time. For instance, he said computer assisted patients' notes, results and prescription help to transfer data into information and knowledge.

Ato Melaku, explaining step 8, cascading, which translates high-level strategy into consistent lower-level objectives, measures and operational details. He explained that spiritual cascading is sharing the vision of the organization and that physical cascading involves providing services. At Woreda level, Ato Melaku said different departments cascade different activities.

Explaining the final step, evaluation, Ato Melaku explained that the step helps to answer the questions such as: "are our strategies working?" "Are we measuring the right things?" "Has

our environment changed?” He said performance of the system is also evaluated to see how value is created.

16.2 Group work

Ato Melaku instructed training participants to apply the first six BSC steps in relation to the following health programs:

1. health education & promotion
2. environmental health
3. reproductive health
4. diseases prevention and control
5. injury prevention and control
6. clinical service

The groups who worked on environmental health and disease prevention and clinical services were randomly picked to present their group work. Each group presented the goal, objectives, vision, values, SWOT analysis, stakeholders; strategy; strategic map and performance measures. Ato Melaku thanked trainees for their presentation and made some suggestions for each group to make them aligned with the steps discussed. He elaborated the need to take relevant issues in our context and finalized his session.

Section XVII

Monitoring and evaluation

April 27, 2017

Mrs Eyerusalem Kebede
FMOH

17.1 Information revolution

Mrs Eyerusalem started her session by asking participants to respond to the following questions: ‘what are the transformation agenda for the strategic period?’ and ‘what is information revolution for health?’ Participants wrote their answers on a piece of paper and discussed their responses. Then, Mrs Eyerusalem clarified that her presentation will focus on information revolution (IR), one of the four transformational agendas. Explaining why IR has become a transformation agenda, Mrs Eyerusalem said the need to use appropriate technology; the need for multi-dimensional, accurate and timely information as well as the need for evidence-based decision making, served as push factors. She also explained the areas where information revolution is expected to be achieved, which included: advancing data collection; promoting the culture of information use; harnessing ICT; encouraging data visibility and access; strengthening verification and feedback system as well as strengthening research, evaluation and survey.

Next, Mrs Eyerusalem explained the importance of digitization and scale up of eHMIS, eFMIS, eHRIS, HGIS, eLIS, eRIS, HDD as well as data presentation tools and techniques. Mrs Eyerusalem elaborated each system in detail and how beneficial they are to IR. (see annex XVII for details) She stated that ICT minimizes error and reduces manipulation of data.

17.2 What is monitoring and evaluation (M&E)?

Participants were requested to define M&E before they were given the working definition. Then, Mrs Eyerusalem defined M&E as “the process of data collection and analysis for informing policy, program planning and project management.” She clarified that M&E aims at improving the efficiency and effectiveness of a project or an organization. Mrs Eyerusalem explained that monitoring is a systematic collection and analysis of information on a project to measure progress and track changes. She clarified that monitoring is based on the targets set and activities planned. As managers, trainees were advised to use information for monitoring and to utilize their resources effectively.

Next, Mrs Eyerusalem defined evaluation as a comparison of actual project impacts against the agreed strategic plans. She explained that evaluation could be formative or summative and that M&E show efficiency, effectiveness and impact. Mrs Eyerusalem stated that M&E enables participants to check the ‘bottom line’. Through M&E, she clarified that they could review progress, identify problems in planning and implementation; and make adjustments to ‘make a difference’.

17.3 M & E framework of the Ethiopian health sector

Mrs Eyerusalem explained the M&E framework of the Ethiopian health sector in detail. (see Annex XVII) Also, she clarified the M&E framework context which focuses on service quality and equity. Mrs Eyerusalem stated that the principles used in the framework include: consistency, integration, simplicity and institutionalization. Elaborating on the key initiatives to transform the M&E system, she emphasized on the digitization of the manual system; implementation of quality improvement program; strengthening accountability and reinforcing towards zero parallel reporting.

Following that, Mrs Eyerusalem explained the key components of the M&E framework which included: health information sources; data collection and analysis; health indicators; data quality; integrated supportive supervision; performance monitoring team; information use for action; dissemination of health information and evaluation. She explained each framework in detail. (see Annex XVII)

Moreover, Mrs Eyerusalem clarified the health data sources of the Ethiopian HIS, as well as the health data collection and analysis at health post and health center levels. She explained the health data reporting, which needs to follow the 'one report' principle of 'one plan-one budget-one report' harmonization. Mrs Eyerusalem stated standard reporting formats need to be used and that the monitoring calendar needs to be followed. As to the health indicators, she specified that there are 167 Input, Output, Outcome, and Impact Indicators and 122 HMIS indicators that need to be monitored regularly.

The other topic that Mrs Eyerusalem addressed was supportive supervision by FMOH and the supervisions at all levels from RHBs to HPs. She also mentioned about the data quality improvement plan developed by FMOH.

Finally, Mrs Eyerusalem explained the media in which health information resulting from the M&E is disseminated to stakeholders. (see annex XVII)

17.4 Group discussion and presentation

The participants broke out into seven groups and discussed on the following three questions.

1. What are the challenges of data collection, reporting, analysis, and interpretation at the health facility and administration levels?
2. What are the key determinants that affect information use for decision making?
3. What are the best practices that others could learn in relation to evidence based decision making in your respective administrative unit?

Responses from all the seven groups on question 1, ie the challenges of data collection, reporting, analysis and interpretation, are as follows.

Participants stated:

- We don't understand the use of data
- We don't use data and information for decision making
- There is no accountability while using data
- There is no plan to check and evaluate data quality
- We don't use technology
- There is no commitment
- Collecting tools are not used
- Shortage of resources
- Accuracy of a report is an issue
- Believing that the task is only that of the HMIS unit
- We don't follow the system and lack infrastructure (eg. There is no light)
- Management problems

Responses for question 2, ie the key determinants that affect information use for decision making, include:

- False reporting doesn't enable good decision making
- Lack of evaluation
- Attitude problem
- Performance monitoring teams do not make follow ups
- Poor leadership – no commitment
- No feedback from PHCU
- Staff turnover

A response for question 3, ie best practice in participants administrative unit, was:

- Data cleaning provided good result.

Mrs Eyerusalem finalized her presentation by recommending that data cleaning should be done monthly to avoid data manipulation.

Section XVIII

Presentation skills

Ms Melody Kelemu
IIfPHC

Melody welcomed trainees and highlighted the learning objectives of the session, which were: understanding the importance of presentation skill; describing communication styles; developing checklists for presentations; and understanding the 'secrets of success' to organize a memorable presentation.

Melody elaborated that presentation requires preparing and knowing the audience as well as selecting the right materials for the power point slides. She stated success much depends on preparation. She advised participants to get themselves a starting date for the project. In this way, they can do little every day and soon it will be finalized. Then, Melody discussed the importance of knowing who they will be speaking to and what type of presentation would be appropriate based on the audience (eg colleagues; students; national or international meeting participants). The session or the duration of the presentation is also important.

Following that, Melody discussed the 'hardware' used in presentation, which included: blackboard/ white board, hand outs, power point slides, lectures, flipcharts and drawings/ pictures. While making presentation, trainees were advised to talk to the people, and not to the white board or flipcharts. They should hold interactive sessions, depending on the type of presentation (class lecture, research presentation, lecture/press release, etc) When preparing slides, trainees were advised not to let the message be overwhelmed. Too much text should not be on a single slide. One minute per slide would be appropriate. It is also good to have pictures. It is also better to use graphs rather than tables.

The other secret of success Melody mentioned was making rehearsals by writing out exactly what one is going to say and learn it. Trainees were informed to use short sentences, active tense, to be precise, as well as project their voices. They should also use lively language. Contrarily, they were advised not to use long complicated sentences and passive tense. Melody told trainees that it is not acceptable to read a talk; rather they should use key words to remember the talk. Participants were advised to rehearse in front of a mirror or to make an audio or video recording to evaluate themselves. They could also give the talk to a friend or family. She advised trainees to accept criticism and to improve their presentations based on the feedbacks received.

Then, Melody raised 'stage fright'. Fear is a normal physiological response and everyone has a certain amount of stage fright. She advised trainees to think positively about the event and get well prepared and well-rehearsed to build more confidence. Melody stated a presenter should believe that the audience is on their side. If someone disagrees with them, they should not take it personal.

Melody gave tips on four issues: the presenter, the meeting, the talk and the questions. She stated that the elements of dynamic delivery consist of 55% body language; 7% content and 38% voice. The presenter should dress smart, smile and eat a light meal (avoid alcohol, tea/coffee or drugs) and do relaxing exercise beforehand. They need to be in time to check out the hall and get acquainted on how the equipment works. While speaking, the presenter should stand up and speak up slowly. They have to pause from time to time, use the pointer. The presenter has to also thank the audience at the end.

Melody mentioned that another secret of a successful presentation is anticipating questions. The presenter should know the subject, stay calm, tell the truth and if they do not know, they should say so. They have to break long questions into smaller units.

Finally, Melody gave a checklist for a presenter that included: stating the purpose, speaking clearly; clarifying concepts; having questioning skills; encouraging learning; calling the audience by name and encouraging discussions.

See annex XVIII for details.

Section XIX

Knowledge management: global trends and issues

Dr Tedla W/Giorgis
Advisor, FMOH

19.1 What is knowledge management?

Dr Tedla informed participants that he would relate knowledge management (KM) with his experience. For instance, he related KM to his work experience as a staff recruitment team to the World Bank. He said when people are interviewed for jobs, they usually say 'yes' for all types of skills required for a job. Dr Tedla stated that his team designed a different interview technique and the kind of skills required. They used to identify the most important three skills for any type of job. If one of these three is missing, then the candidate is not given the post. Dr Tedla said knowledge is changing every time and that people need to develop their knowledge and update their skills. He advised participants to read and improve themselves continuously since knowledge is changing and is becoming critical. Dr Tedla stated continuing professional development (CPD) will be applied for every course and about 28 sectors have been ratified by the Government of Ethiopia.

Dr Tedla explained that KM is about up-to-date information. He said so many resources are produced at the end of each working day, for instance in terms of FP, maternal care, and so on. He advised participants to upgrade their knowledge using the opportunity available in their environment. He also emphasized the need for having a good knowledge sharing culture.

Then, Dr Tedla focused on KM for the health sector. He stated that the sector has to work with new knowledge. Transformation needs change, knowledge and skills. He elaborated that knowledge is the enemy of disease and that the application of what we know will have a greater impact in the sector.

Citing WHO, Dr Tedla defined KM as: "... a set of principles, tools and practices that enable people to create knowledge, and to share, translate and apply what they know to create value and improve effectiveness." He mentioned about a research entitled "The state of knowledge management" (2014) by John Ragsdale. The research finding revealed that a third of the respondents claimed improving productivity by 30% or more if they were sharing knowledge effectively.

Dr Tedla mentioned 'people', 'processes' and 'technology (platforms)' as components of KM. People create, share and use knowledge and collectively comprise organizational culture that nurtures knowledge sharing. He stated working alone is not the right approach to work and that the culture of knowledge sharing needs to be developed. He elaborated 'processes' as the methods to acquire, create, organise, share and transfer knowledge. He stated technology (platforms) is "...the mechanisms that store and provide access to data, information, and knowledge created by people in various locations."

Explaining the reasons why KM is important, Dr Tedla mentioned: avoiding costly mistakes; better decision making; change in traditional knowledge transfer; and better management control. (See Annex XIX)

Following that, Dr Tedla discussed the concepts of tacit and explicit knowledge; as well as internal and external knowledge. (see presentation material) KM involves collecting knowledge from implicit to explicit knowledge. He also explained the relationships among data, information, knowledge, and wisdom. Data is converted into information through understanding relations. Through understanding patterns, information is converted to knowledge, and knowledge to wisdom through understanding principles. For instance, he said, creating a database for MoH is managing knowledge.

Finally, Dr Tedla elaborated the concept of learning organization. He defined learning organisations as: "... organizations where people continually expand their capacity to create the results they truly desire, when new and expansive patterns of thinking are nurtured, where collective aspiration is set free and where people are continually learning how to learn together". He informed trainees that they have to produce learning staff and learning organizations.

Section XX

Ethics in leadership

Dr Seblewengel Lemma
Research Officer
IIfPHC

20.1 What is ethics?

Dr Seble asked if there has been anyone who has not heard about ethics and participants affirmed that they have heard about it. She invited all to contribute to the discussions for they are familiar with the term. Then, Dr Seble introduced the learning objectives of the session, which encompassed: understanding ethics in general and in the context of leadership; explaining the principles and components of ethics; and learning how to evaluate one's ethical decisions using some questions.

Dr Seble stated that people use morality and ethics interchangeably and tried to explain the difference between the two words. She explained that morality refers "...to our widely-shared, stable beliefs about what is good and bad, right or wrong." Ethics has been defined as "...rules or standards governing the conduct of the members of a profession" or "the study of the general nature of morals and of the specific moral choices to be made by the individual in relationship to others". Elaborating morality further, Dr Seble said it is shaped from our childhood to adulthood life. As children, Dr Seble said, we were told what is good and what is bad/evil. She stated the process of taking/not taking these principles makes it ethical/unethical. Dr Seble clarified that the big question in ethics is 'what is the right thing to do?' She explained that we have a number of approaches to do a thing. But, which one is right?

Then, Dr Seble explained ethical choices and how being ethical is not easy. She said the society has already defined what is good and what is evil and that it is easy to make a choice between good and evil. However, Dr Seble stressed that ethics is an issue and becomes a challenge when choosing between two goods such as: truth vs loyalty; short term vs long term; justice vs mercy; individual vs community. She emphasized the need to internalize the situation to oneself when one is in between the two goods. Giving example Dr Seble mentioned harvesting water, which may avoid drought but at the same time may arise the issue of malaria. She said our decisions may have immediate effect. Dr Seble stated that participants make decisions representing their woredas; but making those decisions might be difficult sometimes since the choices may not be easy.

Following that, Dr Seble elaborated how every discipline has ethics. She stated there are rules or standards governing the conduct of members of different professions. As an example, Dr Seble mentioned the ethics surrounding patients' care and research ethics. Prof Mengesha added how ethics is necessary in different professions. Giving example, he said patients take medicines prescribed by medical doctors because they trust them. Thus, the doctors should have professional ethics. Lawyers decide on social and economic issues

and on people's properties, which again require ethics. Engineers build houses; but if they try to save money and use sub-standard materials, the building will be demolished.

20.2 Ethical leadership

Dr Seble explained that leaders guide people to reach their goals and that ethics is important in leadership. She said leaders need to be ethical and with good behaviour to win others. Dr Seble stated ethical leaders are good leaders and that they will start from themselves and make ethical decisions. The leaders also foster ethical organizational behaviour by creating conducive environment.

Next, Dr Seble explained the principles of ethical leadership using a diagram. (See Annex XX) She stated that five principles: respect others; serve others; show justice; manifest honesty; and build community, as central elements of ethical leadership. Dr Seble explained each component as follows:

Principle 1: respect others – leaders should respect other people, ie, respect their ideas, experience, and so on. She said respect brings in understanding and motivation, which leads to good performance. People will be comfortable to come to the leaders if they respect them.

Principle 2: serve others – leaders need to serve customers as well as their followers. Leading people involves serving them. Dr Seble stated people have their own legitimate goals and therefore, leaders need to serve others to reach their personal goals, besides organizational goals.

Principle 3: show justice – leaders should be fair and impartial. They need to see people equally, which is one part of ethics. Dr Seble clarified the importance of transparency. She stated that if a leader treats an individual in a different way, they have to document and explain the reason. If that is not happening, she alerted that there will be conflict within employees.

Principle 4: manifest honesty – Leaders need to practice honesty. As leaders, everybody see them. If leaders are not honest, nobody will trust them.

Principle 5: Build community – building community is about the people who are working with the leader. It is about helping them to achieve their personal goals. By the time the organizational goals are achieved, the people have also achieved their goals.

20.3 Why practice ethical leadership?

Dr Seble clarified the reasons why ethical leadership need to be practiced and those reasons included: building trust; leading to collaboration; bringing credibility and respect for the leader and for the organization; creating good climate within the organization and

affording self-respect. In addition, Dr Seble emphasized that being ethical is simply the right way to go. She said we like people who are ethical and our nature approves it.

Dr Seble stressed the need to practice ethical leadership all the time by those who are in leadership position. She said if anyone considers themselves as leader, they have to be ethical. Explaining the components of ethical leadership for leaders, Dr Seble included: putting the good of the organization before their own interest; considering the consequence to others of their decisions and looking for ways to minimize harm; and encouraging the discussion of ethics and ethical choices in the organization by creating conducive environment. Dr Seble also specified that leaders need to practice fairness, be honest and respectful while treating people. She stressed the need to consider cultural sensitivity and cultural competencies. Dr Seble explained that the community we serve have its own culture and we have to recognize cultural differences by being cautious. She said leaders should also work to be inclusive and respect everyone's contribution. Dr Seble added that leaders should develop their competences and should always re-examine their ethical practices.

Elaborating the universal ethical values, Dr Seble quoted Albrecht's 10 ethical values: Honesty; Integrity; Promise-keeping; Fidelity; Fairness; Caring; Respect; Responsibility; Striving for Excellence and Accountability. She said organizations usually post the values to remind their people to abide by those values.

Next, Dr Seble explained the relationships and differences among ethics, moral and the law. (See Annex XX for more details) She also elaborated the concept of illegal but ethical issues using some scenarios. She stated that ethical things may not necessarily be legal. For instance she asked participants if they consider running a red light if someone's life depended on it. She said passing a red light is violation of the law; but saving life is ethical.

20.4 Evaluating ethical choices

Dr Seble stressed that there is no formula to evaluate ethical choices. However, she stated there are a set of questions that participants could ask themselves, like:

- Is the action they have arrived at one that lives up to their sense of moral integrity? She said, if they hide, it does not go with their ethical values.
- Would it be the action chosen by someone they consider a moral model?
- Would they be comfortable if the action or its results were made public?

Dr Seble advised participants to evaluate their actions by asking those random questions. She said if they respond 'No' to all the questions, the decisions are unethical.

Next, Dr Seble outlined the ethical challenges that participants could face in public health. These included: resource allocation; data use and management; control of infectious diseases; immigration; community engagement; and balancing individual choice with protecting the public good.

At the end, Dr Seble advised trainees to be cautious and to make justification ethically. As a take away, she also advised trainees not to be emotional and to consider the community they serve and to let them make the greater good. Although ethical choice is not easy, Dr Seble emphasized the need to be honest with their decision and to be critical with evidence.

Section XXI

Success as a leader

Ms Hiwot Tadesse
IIfPHC

Ms Hiwot explained the learning objectives of the session, which included: understanding what success involves; describing the challenges of success; understanding what issues lead to success; and describing the characteristics of a successful leader. Ms Hiwot started by asking participants what the word 'success' mean for them. Some responses were: having a dream or vision and achieving that dream/vision and planning and then achieving the plan. Ms Hiwot cited a quotation from Colin Powell, who said: "There are no secrets to success. It is a result of preparation, hard work and learning from failure". Ms Hiwot added some quotations to elaborate the concept of success. (see annex XXI)

Ms Hiwot explained the questions a leader should ask themselves if they wish to be successful. The questions included: "Do I get results? Do I give people a sense of meaning to others by reminding them of what is important? Do I create authentic human relationships? Do I generate and sustain trust? Do I convey a feeling of hope? Do I motivate others?"

Discussing some of the essential elements that lead to success as a leader, Ms Hiwot included: the ability to develop a vision, and to appreciate the specifics of the environment and the tasks to be accomplished. As to the characteristics that leaders should have to be successful, she mentioned: drive, honesty and integrity; leadership motivation; self-confidence; cognitive ability/intelligence; knowledge of the business; emotional intelligence and flexibility.

Ms Hiwot indicated that the strategies that a leader should adopt to be successful as: making their expectations clearly known; sharing their goals, visions, motivations and reasons; giving feedback about contributions; listening; building team players; rewarding cooperation and hard work; and admitting mistakes.

She ended her session by reading out some quotations on success.

Annex I

TRANSFORMATIONAL LEADERSHIP TRAINING SCHEDULE Ethiopian Public Health Institute, Addis Ababa, Ethiopia

December 5 - 9, 2016, National Public Health Training Center, Addis Ababa

Day	Time	Activities	Presenter	Moderator	Training Room	
Monday, Dec. 5	8:30 – 9:00am	Registration	FMOH/IIfPHC	Luidina Abebe, Communications Officer, Prof. Mengesha Admasu And Temesgen, FMOH	Floor 1, Syndicate Room 4	
	9:00 – 9:05am	Opening Speech	Dr. Tsigereda Kifle, EPHI			
	9:05 – 9:10am	Welcoming Speech	Dr. Zufan Abera, FMOH			
	9:10 –9:20am	Program Introduction & Training Norms	Prof. Mengesha Admasu			
	9:20 –9: 40am	Self-introduction	IIfPHC			
	9:40 –10: 30 am	Questionnaire Administration	IIfPHC			
	10:30 –10:45am	HEALTH BREAK				
	10: 45 –11:15am	Implementation of HSTP	Kahsu Bekuretehon, FMOH	Melody Kelemu, Training Officer, IIfPHC and Temesgen	Floor 1, Syndicate Room 4	
	11:15–11:35am	Woreda Transformation	Dr. Zufan Abera, FMOH		Floor 1, Syndicate Room 4	
	11:35 –11:55am	Information Revolution	Noah Elias, FMOH		Floor 1, Syndicate Room 4	
	11:55am –12:30pm	Discussion	FMOH		Floor 1, Syndicate Room 4 & 5	
	12:30 –2:00pm	LUNCH				
	2:00 –3:00pm	Group work	Kahsu/ Dr. Zufan Abera, Noah Elias	Melody Kelemu, Training Officer, IIfPHC and Temesgen	Floor 1, Syndicate Room 4 & 5	
	3:00 –4:00pm	Presentation and discussion			Floor 1, Syndicate Room 4 & 5	
	4:00 –4:20pm	HEALTH BREAK				
4: 20 –5:00pm	Attitude	Prof. Mengesha Admasu	Melody Kelemu, Training Officer, IIfPHC and Dr.Zufan	Floor 1, Syndicate Room 5		
5: 00 –5:30pm	Group discussion and evaluation			Floor 1, Syndicate Room 4 & 5		
Tuesday, Dec. 6	8:30 –9:30am	Change Management	Prof. Mengesha Admasu	Tilahun Debebe, Training Officer, IIfPHC and FMOH	Floor 1, Syndicate Room 4	
	9:30 –10:30am	Group work and discussion			Floor 1, Syndicate Room 4 & 5	
	10:30–10:45am	HEALTH BREAK				
	10: 45–11:45am	Team Work	Prof. Mengesha Admasu	Tilahun Debebe, Training Officer, IIfPHC and FMOH	Floor 1, Syndicate Room 4	
	11:45am –12:30 pm	Group work and discussion			Floor 1, Syndicate Room 4 & 5	
	12:30 – 2:00 pm	LUNCH				
	2:00 – 3:00 pm	Styles of Conflict	I Prof. Mengesha Admasu	Tilahun Debebe, Training Officer, IIfPHC and FMOH	Floor 1, Syndicate Room 4	
	3:00 – 4:00 pm	Group work and discussion			Floor 1, Syndicate Room 4 & 5	
	4:00 – 4:20 pm	HEALTH BREAK				
	4: 20 – 5:00 pm	Leadership	Dereje Ayele, MSH	Tilahun Debebe, Training Officer, IIfPHC and FMOH	Floor 1, Syndicate Room 4	
5: 00 – 5:30 pm	Group discussion and evaluation		Floor 1, Syndicate Room 4 & 5			
d., De	8:30 – 10:00 am	Transformational Leadership	Dereje Ayele, MSH	Melody Kelemu Training Officer, IIfPHC and FMOH	Floor 1, Syndicate Room 4	
	10:00 – 10:30 am	Group work and discussion			Floor 1, Syndicate Room 4 & 5	

	10:30 – 10:45 am	HEALTH BREAK			
	10: 45 – 11:45 am	Critical Thinking	Prof. Mengesha Admasu	Melody Kelemu Training Officer, IfPHC and FMOH	Floor 1, Syndicate Room 4
	11:45– 12:30 pm	Group work and discussion			Floor 1, Syndicate Room 4 & 5
	12:30 – 2:00 pm	LUNCH			
	2:00 – 3:00 pm	Communication Skills	Betemariam Alemu, JH,CCP	Melody Kelemu Training Officer, IfPHC and FMOH	Floor 1, Syndicate Room 4
	3:00 – 4:00 pm	Group work			Floor 1, Syndicate Room 4 & 5
	4:00 – 4:20 pm	HEALTH BREAK			
	4: 20 – 5:30 pm	Discussion			Floor 1, Syndicate Room 4 & 5
Thursday, Dec. 8	8:30 – 9:30 am	Planning & Implementation	Mideksa Adugna, FMOH	Tilahun Debebe, Training Officer, IfPHC and FMOH	Floor 1, Syndicate Room 4
	9:30 – 10:00 am	Group work			Floor 1, Syndicate Room 4 & 5
	10:00 – 10:30 am	Discussions			Floor 1, Syndicate Room 4 & 5
	10:30 – 10:45 am	HEALTH BREAK			
	10: 45 – 12:30 am	Group work and discussion	Mideksa Adugna, FMOH	Tilahun Debebe, Training Officer, IfPHC and Dr.Zufan	Floor 1, Syndicate Room 4 & 5
	12:30 – 2:00 pm	LUNCH			
	2:00 – 3:00 pm	Monitoring & Evaluation	Mesud Mohammed, FMOH	Tilahun Debebe, Training Officer, IfPHC and FMOH	Floor 1, Syndicate Room 4
	3:00 – 4:00 pm	Group work and discussion			Floor 1, Syndicate Room 4 & 5
	4:00 – 4:20 pm	HEALTH BREAK			
	4: 20 – 5:00 pm	Assessment & Evaluation	Prof. Mengesha Admasu	Tilahun Debebe, Training Officer, IfPHC and FMOH	Floor 1, Syndicate Room 4
	5: 00 – 5:30 pm	Group discussion			Floor 1, Syndicate Room 4 & 5
Friday, Dec. 9	8:30 – 9:30 am	Presentation Skills	IfPHC	Melody Kelemu and Tilahun Debebe, Training Officers, IfPHC and FMOH	Floor 1, Syndicate Room 4
	9:30 – 10:00am	Knowledge Management	Dr. Tedla W/Giorgis, FMOH		Floor 1, Syndicate Room 4
	10:00 – 10:30am	Group work and discussion			Floor 1, Syndicate Room 4 & 5
	10:30 – 10:45am	HEALTH BREAK			
	10: 45 – 11:45 am	Ethics	Prof. Mengesha Admasu	Melody Kelemu Training Officer, IfPHC and FMOH	Floor 1, Syndicate Room 4
	11:45– 12:30am	Group work and discussion			Floor 1, Syndicate Room 4 &5
	12:30 – 2:00pm	LUNCH			
	2:00 – 3:00 pm	Success	Prof. Mengesha Admasu	Melody Kelemu Training Officer, IfPHC and Chala, FMOH	Floor 1, Syndicate Room 4
	3:00 – 4:00 pm	Group work and discussion			Floor 1, Syndicate Room 4 & 5
	4:00 – 4:40 pm	Questionnaire Administration & Evaluation	IfPHC	Melody Kelemu Training Officer, IfPHC and FMOH	Floor 1, Syndicate Room 4
4: 40 – 5:00 pm	HEALTH BREAK				