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**INTEGRATED INDUCTION, PHAST AND CLTS TOT TRAINING FOR COMMUNITY HEALTH
VOLUNTEERS HELD AT THE MML GUEST HOUSE IN WABAG, ENGA PROVINCE ON 23TH – 28TH
NOVEMBER 2015**



Standing left: Wasato, John, Mek, Newman, Steven, Paul, Besawe, Benson, Johanne, Stanley, Henson, Max, Wesley, Julius, and Judith

Siting left middle: Linet, James, Linda, Keplina, Ben, Andakan, and Lary

Sitting front: Peter, Tani, Lynette, Opos, Iki, Simon and Judith



Integrated Induction, PHAST and CLTS ToT training for Community Health Volunteers

The ongoing El Niño associated drought has resulted to decreased water levels, and food shortage, making people unable to partake in good hygiene and sanitation practices. Through a broad framework of Disaster Risk Reduction (DRR), IOM aims to mitigate the increased risk of disease due to the lack of safe and adequate water. It is in response to this, IOM's AGWA project organized a 5 day training workshop on integrated induction, Participatory Hygiene and Sanitation Transformation (PHAST) and Community-Led Total Sanitation (CLTS) for Community Health Volunteers (CHVs). The residential workshop was attended by 30 CHVs drawn from Kandep and Laiagam districts in Enga province. (*See participants list in annexure*).

Structure

Trainings were conducted from 23th to 28th November, 2015. Lessons were characterized by three (3) two-hour interactive and participatory sessions spanning the whole day from 8:30 am in the morning to 4:30 pm in the afternoon. Training was organised and conducted by the International Organization for Migration (IOM), in Papua New Guinea. The sessions were facilitated by the Water, Sanitation and Hygiene (WASH) Officer, Mr. Benson Mwarongo. Topics covered included maternal and newborn child health (MNCH), management of common illnesses such as diarrhoea, respiratory ailments (TB), malaria and HIV/AIDS, sexual and gender based violence, Participatory Hygiene and Sanitation Transformation (PHAST), Community-Led Total Sanitation (CLTS), and use of information tools for monitoring and evaluation of their activities at the village level. (*See training programme annexed*)

Training Objectives

The training was meant to;

- To introduce participants to concepts on health, disaster risk reduction and their relationship
- Equip learners with skills on community governance, good leadership and problem solving techniques
- To orientate learners on advocacy and social mobilization

- To enable participants to understand their roles, responsibilities and their relationship with CHCs and other partners in health
- To build the capacity of trainees to impart knowledge to their community on prevention of diarrhoeal and water-related diseases
- To equip trainees with practical hygiene promotion facilitation skills
- To orientate learners on basic health care and life saving skills
- To provide trainees with tools for community mobilization and planning in order to address existing hygiene and sanitation problems
- To discuss factors that affect behaviours and how they can be altered in order to bring about positive hygiene behaviours

DAY 1

Introductions, norms, expectations, and objectives of the workshop

All present were welcomed by the Disaster Risk Reduction (DRR) Assistant. The session was started with a prayer after which all members were given a chance to give an introductory statement of their names, their locations, any positions they held and to share their most memorable events.

Opening Remarks

The residential workshop was officially opened by the Acting Director for Public Health of the province, Mr. Johannes Kundal.

Mr. Kundal welcomed and



Mr. Kundal, the acting Provincial Public Health director during the workshop opening

thanked all the participants for taking time off their busy schedules to attend the workshop. Volunteering for community work, he said is a calling that came at a timely moment with IOM as the communities faced the El Niño that had brought in its wake food shortage, declining water levels, and increased communicable diseases. He thanked the government department of health and the disaster Centre for their quick efforts in identifying and assisting the needy populations. The newly created provincial health authority, he affirmed, was there for the people; to always assist and support the partners with whatever assistance they would need for the benefit of the communities.

Responsibilities were allocated to identified participants for the smooth running of the sessions. The need for the following roles was felt and allocated such individuals in Enga as;

1. Chairman – Ben Besawe
2. Spiritual leader - Lynette Warae
3. Time Keeper – Simon Sopia
4. Welfare persons – Steven John
5. Energizer – Meck Lane

Training methodology

A participatory approach entailing interactive lectures, brainstorming, role plays, facilitated group discussions and feedback, experience sharing and plenary sessions was used for content delivery.

The medium of expression chosen by the participants was Pidgin and English. Presentations and note taking was done using such resources as flip charts, felt pens, biro pens, note books and masking tapes.

Enhancing Climate-Resilient Agriculture and Water supply in Drought-affected communities in Papua New Guinea (AGWA) project overview

The DRR Assistant, Tamar Amean described the project, that is, its objectives and activities, and how the roles of the CHVs to be trained were tied to the ultimate goal of



The IOM DRR Assistant giving a project brief

the project.

The six (6) months AGWA project, funded by USAID and EU through OFDA and ECHO aims to reduce the risk of potential disaster by stabilizing the highland communities worst affected by El Niño induced drought and frost in Papua New Guinea.

The roles of the CHVs, he further explained, will be restricted to hygiene promotion at the household level through such activities as mapping the households in the initial stages to obtain baseline information in the targeted intervention areas, improving access to, storage and usage of safe water through drilling of boreholes and provision of water containers, promotion of good hygiene behaviours through community dialogue sessions, and drama, songs, and dances through community open sanitation days and soap provision.

Concept of Health and Disaster Risk Reduction

Health was defined both locally and according to the WHO definition. DRR on the other hand was described as a conceptual framework of reducing the risk of disasters encompassing three main pillars that include: Prevention; Mitigation and Preparedness.

Relationship between Health and Disaster Risk Reduction

Better health makes an important contribution to economic progress, as healthy populations live longer, are more productive and save more. The importance of health under the framework of DRR was discussed: economic status, education, religion, culture, traditions and attitudes, infrastructure, political instability, leadership and policies, corruption, transparency accountability, dependency and insecurity, food and water. For a community to actively engage in reducing their risk and increasing their resilience to disasters, all of these factors must be considered and thus the relationship between these variables were discussed.

Participation assessment, planning and implementation of community health & disaster risk reduction

Community assessment is an evaluative study that uses objective data to assess the current social conditions of a specified community or targeted area. They were taught the steps of community assessment: to plan and organize, design the data collection, gather review and

analyse the data, make decisions and be introduced to community assessment tools, including a survey, asset inventory, community mapping, daily activities schedule, seasonal calendar, focus group and panel discussion.

Governance structure of community health strategy

Governance, management and coordination were defined and discussed. The structures of health in relation to level 1 - the Community Health Committee (CHC), Hygiene promoters and Community Health Volunteers (CHVs) - were discussed, detailing the criteria/eligibility for election/selection and the characteristics of each. The linkage between the community-level health workforce and the link facility was outlined. Moreover, steps and guiding principles in resource mobilization were summarized. Trainees were also taught financial management in relation to community governance.

Community Involvement and Participation

Community participation is a process by which the communities are actively involved in all stages of project or programme implementation. Trainees were taught the steps in community participation, the importance of community participation, factors hindering community participation, how to promote community participation through partnership and what community participation involves.

DAY 2

Basic principles of health promotion

Health promotion was defined as the process of enabling people to increase control over their health and its determinants and thereby improve their health. The concepts and principles of health promotion, priority interventions, basic strategies and action areas of health promotion were discussed.

Socio-cultural practices and the associated outcomes

Social and cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviours, the effectiveness of health promotion efforts and access to, availability of and quality of health care. In addition, such factors



Plenary session on factors promoting and hindering community resilience

contribute to understanding societal and population processes such as current and changing rates of morbidity, survival and mortality. Among the factors discussed were child rights, care for development, child abuse, exploitation and neglect, early marriage, spouse battering, violence against children, post-rape and defilement care and incest.

Nutrition and health

The CHVs were introduced to nutrition and malnutrition. They were taught about what constitutes a balanced diet and what factors can lead to malnutrition. Common cases of malnutrition were discussed and ways of curbing the same suggested.

Antenatal care, breast feeding and care of the baby

They were introduced to those immunizations required for children and pregnant women. All the immunizations were discussed and their importance stressed. Basic oral hygiene and eye care of the baby and the importance of exclusive breastfeeding were also discussed.

Reproductive health and gender based violence

The CHVs were introduced to gender and health and taken through the reproductive system. Sexual and reproductive health was discussed, together with gender role analysis and its implication for health. Sexual and gender based violence was defined as any harmful act done to a person against his/her will and is based on the society's view of what men or women should be, or should do. The different forms, contributing factors, as well as their effects and reporting for the care (at hospital, police station, and community) of the victim was well explained.

Drug and substance abuse

It was defined as misuse of such substances as drugs, alcohol, and/or chemicals that can change a person's behaviour or make them addicted. The contributing factors, signs, and the roles of CHVs in reducing this vice were discussed in details.

DAY 3

Communicable diseases prevention

Disease prevention was defined and the CHVs introduced. Trainees were introduced to the common communicable diseases, their modes of transmission and preventive measures that can be taken to forestall their occurrences. Among the priority diseases for prevention discussed were: high morbidity and mortality diseases - STIs, HIV/AIDS, TB, malaria; under-five childhood illnesses - diarrhoea, pneumonia, malnutrition; outbreak/epidemics and notifiable diseases, e.g., cholera, dysentery, yellow fever, plague, typhoid fever, meningococcal meningitis, measles and viral haemorrhagic fever.

Among the priority diseases of public health importance discussed were malaria, tuberculosis, new AIDS cases, childhood pneumonia, childhood diarrhoea, cholera, dysentery, meningitis, typhoid fever, plague, measles and H1N1

Case identification, diseases for eradication, disability and rehabilitation

Among the diseases earmarked for eradication/elimination discussed were polio, neonatal tetanus, guinea worm, and leprosy. Trainees were introduced to disability, types of disability, a

few common disabilities and possible causes, and ways of preventing disability. The CHVs were also introduced to rehabilitation - especially community-based rehabilitation (CBR) - the purpose of rehabilitation and the role of CHVs in rehabilitation

Health promotion in schools

Trainees were introduced to this component and to the importance of having school health programmes. Among the activities looked at were: Vitamin A supplementation, de-worming, hand-washing with soap, safe faecal disposal, peer education and information on growth and development.

Lifesaving skills and demonstrations

The CHVs were introduced to the life-saving skills for infants, children and adults. They were also shown how to conduct cardiopulmonary resuscitation for infants/child and adults, and first aid procedure for choking. They were shown basic skills of conducting first aid: opening the airway, checking breathing and circulation, counting breaths per minute, taking of pulse and placing the victim in recovery position.

Referral

CHVs were shown the importance of directing those from the community with health needs to nearby hospitals for appropriate services. A few cases requiring referral were discussed, to provide an insight into the importance of timely and appropriate referrals.

Introduction to Community health information management

Data, information and health information were defined. The importance of community health information management, methods/techniques of information collection, types of information/data to be collected at the household level, sources of information and the tools used were all discussed.

The processes of data collation, data analysis techniques, the presentation of information, information dissemination and the use of data for community health planning and action were elaborated.

Performance-based reward system for hygiene promoters

Performance-based reward was discussed, its purpose being to encourage behaviours that strengthen the community unit and create an environment that can enable CHVs to achieve their targets. The benefits of performance based rewards and the steps to successful performance-based rewards were highlighted, as well.

DAY 4

Concepts in Hygiene promotion

The different concepts used in hygiene promotion such as community participation, sustainability, factors affecting sustainability, hygiene, sanitation, health and hygiene promotion were explained.



A participant explaining on community-resilience building concept to the others

The different models for hygiene and sanitation promotion such as the BASNEF and behaviour change ladder as well as such tools as PHAST, CHAST, CLTS, and SLTS were exploited in details.

Hygiene domains and F-Diagram

The five (5) domains of hygiene encompassing personal, safe disposal of excreta, water, food, and household and domestic hygiene were well defined as well the measures of ensuring their achievement covered in details.

The F-diagram comprising of 5Fs (fingers, flies, fluids, faeces, and fields) representing the various transmission routes of how faecal matter from the host ends into a new host were also

explained and their blocking routes entailing latrine use, protection of food and water sources, handwashing at key times, safe eating and protection of water in transit and storage amongst other means.

Demonstrations

Hand washing with soap was shown to be the most effective tool in breaking the faeco-oral contamination routes as it prevents faeces, germs and dirt getting into contact with the food and the water consumed. Participants were also shown the proper hand washing technique to enhance hygiene practices. These activities were to be incorporated in the action plan to be developed by the end of the training and follow up done in two weeks' time by the facilitators to check on progress made.

CHVs were shown the techniques in use of Point of Use water treatment products (POUs). PUR and Aqua tabs were shown and their usage described, that is, 1 sachet of PUR is supposed to be used on turbid waters preferably water from open sources (ponds) while aqua tabs should be used on clear water waters from shallow wells, rivers, and streams. The mixing ratios were 1 sachet: 10 liters and 1 tab: 20 litres for PUR and aqua tabs respectively.

Hygiene Improvement Framework (HIF)

Hygiene promotion aims at preventing diseases through linking good health and hygiene practices with sanitation facilities. The hygiene improvement framework shows how all the pillars work together and how they are interlinked to prevent diarrheal diseases. The pillars are access to hardware (community water systems, sanitation facilities and household level materials), and hygiene promotion (community mobilization, school programs, and social marketing) complimented by an enabling environment (policy improvement, community organization, Public Private Partnership (PPP), and institutional strengthening). All the pillars as discussed with the participants are necessary and must be present for hygiene improvement resulting to diarrheal and related diseases prevention.

Integrated PHAST and CLTS approach

Participants were given a short brief on the step-by-step framework of the integrated PHAST and CLTS approach. The steps were;

1. Community entry and pre-triggering where the participants were led in identifying a community for hygiene promotion using community diagnosis and river crossing roleplay;



...and a role play to reiterate points covered

2. Problem identification in the community using a seasonal calendar;
3. Problem analysis and triggering of good and bad hygiene behaviours, community practices, mapping water and sanitation facilities, shit and medical expenses calculation, walk of shame, role of flies in water and water and food contamination, and how diseases spread;
4. Identification of solutions entailing blocking spread of disease, selecting the barriers, choosing water and sanitation improvements, choosing improved hygiene behaviours and allowing for questions from communities;
5. Planning for implementation and change in mind of gender roles, natural leaders, developing a community action plan, and planning for what may go wrong;

6. Monitoring for implementation progress using a checking chart to check for progress; and,
7. Participatory evaluation for progress achieved.

DAY 5

Field exercise

This activity was done in Amala village, one of the project sites. The aim of this activity attended by all the CHVs being trained as ToTs was to contextualize the theory and put into practice the



A section of the community members seeking clarifications during the hygiene promotion session

knowledge and skills gained for hygiene promotion. The community members were mobilized the day preceding the activity with more being mobilized during the occasion by the participants doing door-to-door visits. Topics majorly covered on hygiene domains ranged from personal, domestic and household, environmental, food and water hygiene to communicable and diarrheal diseases with special emphasis on increasing access to safe water, storage, and point of use treatment.

During the field visits, participants collected information from the households and community on their health and hygiene practices. This information was presented for a plenary session and

review after participants returned to the training venue from the field activity. More information was presented from the positive criticism that ensued enabling all to learn from the process. 143 community members (77 females and 66 males) graced the hygiene promotion session. The exercise was designed to enable them to develop the practical skills and techniques for data collection and utilization for hygiene promotion at the real field context.

Monitoring and evaluation

Monitoring was defined, and the importance of monitoring, key indicators in health monitoring and evaluation and the characteristics of good indicators: (e.g., SMART, i.e., Specific, measurable, accurate, reliable and time bound) with examples of other monitoring indicators being cited. The CHVs were also introduced to the evaluation process, within which the types and the importance of evaluation were elaborated. Monitoring and evaluation methods and tools and the importance of basic monitoring and evaluation were also discussed. Action plans were developed site wise according to the villages after group discussions. They will be used for follow up of the ear marked activities.

Way forward/next steps

The first two weeks after the training, the newly trained CHVs will have a familiarization meeting, when they will all come together to get to know each other and to discuss how best to divide the number of households they will be serving (minimum of twenty (20) for each). IOM will play a key role in facilitating these meetings, together with the Department of Health, and CHWs working in these sites.

Thereafter, IOM and the Health officers from the DoH will start a thorough follow up of the developed action plans; share the progress with stakeholders; identify sources of strengths and weaknesses; brainstorm on indicators and timelines; identify unforeseen challenges and possible solutions; plan weekly meetings to review progress; and start work on social mobilization to get everyone involved. The CHVs will then embark on a mapping of all the households in the project sites and identification of hygiene promoters who will consequently be trained by them (ToTs) for further hygiene promotion impact at the village level.

Closing remarks

The workshop was closed by Mr. Cleopas Roa, the Enga provincial Disaster Centre director. He urged the participants to implement the work plan that they drafted and seek assistance where necessary from the government departments and IOM. The importance for follow for developed action plans was thoroughly emphasized.

The WASH Officer thanked the team for their full participation in the training workshop and called on their commitment to realizing their action plans and beyond for ownership and sustainability of projects. He promised to offer certificates of participation in January 2016 after work plans had been implemented.

Mr. Ben Besawe gave a vote of thanks to the facilitators and IOM on behalf of other participants.

Annex 1: Participants list

	NAME	SEX	Province/Area	Designation	CONTACTS
1.	Simon Sopial	M	Enga/Kandep	Health Education officer	79204467
2.	Wai Simon	M	Enga/Kandep	Community Health Worker	73465858
3.	Steven John	M	Enga/Laiagam	Community Health Worker	71853215
4.	Kennedy Isaac	M	Enga/Kandep	Community leader	71129486
5.	Wesley Warae	M	Enga/Laiagam	District CHW supervisor	79467591
6.	Keplina Was	F	Enga/Kandep	Kandep LLG women rep	72938235
7.	Opos Yum	M	Enga/Kandep	Wage LLG women rep	73696325
8.	Paul Puli	M	Enga/Laiagam	Nursing officer	72198811
9.	Linda Kone	F	Enga/Kandep	Women village court magistrate	72202134
10.	Tani Mar	M	Enga/Kandep	District Education Officer	72228560
11.	Lary Lart	M	Enga/Kandep	Hospital dispenser	71394793
12.	John Samuel	M	Enga/Laiagam	District Nutrition Officer	73509164
13.	Peter Yamaen	M	Enga/Laiagam	Nursing officer	71682423
14.	Iki Luai	M	Enga/Laiagam	Nursing Officer	79521966
15.	Meck Richard Lane	M	Enga/Laiagam	Community Health worker	73516618
16.	Judy Timothy	F	Enga/Kandep	Community Health Worker	70593281
17.	Ben Rupha	M	Enga/Laiagam	Community Health Worker	70082511
18.	Andakan Tanyo	M	Enga/Laiagam	Nursing Officer	73004926
19.	Benny Simon	M	Enga/Laiagam	Community Health Worker	73028868
20.	Pias Yom	M	Enga/Laiagam	Community Health Worker	70866993
21.	Max Otto Maso	M	Enga/Laiagam	Community Health Worker	72781008
22.	Lynette Warae	F	Enga/Kandep	Teacher	71305092

23.	Wasato Lakao	M	Enga/Kandep	Community Health Worker	71830730
24.	Lakel Philipo	M`	Enga/Kandep	Community Health Worker	79543345
25.	Julius Kei	M	Enga/Kandep	Community Health Worker	72070009
26.	Stanley Walend	M	Enga/Laiagam	Health Education Officer	71328561
27.	James Alandi	M	Enga/Kandep	Community Health Worker	73129778
28.	Ben Besawe	M	Enga/Kandep	District Administrator	73398147
29.	Henson Andamale	M	Enga/Kandep	Law and Order Officer	70172617
30.	Wai Simon	M	Enga/Kandep	Community Health Worker	73465858

Annex 2: Timetable

Time	Day 1	Day 2	Day 3	Day 4	Day 5
Morning (8:30 – 10:00 am)	<ul style="list-style-type: none"> - Introduction - Learning environment - Workshop objectives and schedule - Background on IOM and projects - Pre-test and experience sharing 	<ul style="list-style-type: none"> - Recap day 1 - Importance of health promotion - Roles of CHVs in health promotion - Concepts in MNCH (ANC &PNC) 	<ul style="list-style-type: none"> - Recap day 2 - Preventable diseases - Common conditions at HH level - Lifestyle diseases 	<ul style="list-style-type: none"> - Recap day 3 - Concepts and models - Hygiene domains - Common health practices and challenges - Water cycle/related diseases (traditional beliefs & F-diagram) - Components of hygiene promotion 	<ul style="list-style-type: none"> - Recap day 4 - Step 4: Identification of common hygiene and sanitation solutions in relation to various hygiene domains <ul style="list-style-type: none"> - <i>Three pile sorting</i> - Step 5: Planning for implementation and change – <i>Pocket Chart, Gender role analysis</i>
15 min	Break	Break	Break	Break	Break
Mid-morning (10: 15 – 12:00 pm)	<ul style="list-style-type: none"> - Importance of health - Relationship between health and DRR - Participatory approaches to community health and DRR - Age cohorts and life services 	<ul style="list-style-type: none"> - Risk factors for women - FP, MNC nutrition and malnutrition - Growth monitoring and assessment 	<ul style="list-style-type: none"> - Promotion of healthy lifestyles - Drug and substance abuse - S&GBV (forms, contributing factors, effects, reporting) 	<ul style="list-style-type: none"> - Integrated PHAST and CLTS approach - Step 1: Community entry and pre-triggering – <i>River crossing role play</i> - Step 2: Problem Identification – <i>Seasonal Calendar</i> 	<ul style="list-style-type: none"> - Step 6: Monitoring implementation progress and evaluation <ul style="list-style-type: none"> - <i>Monitoring chart</i> - Action planning - Post evaluation test - Questionnaires for filling at HH level
1 hour	Lunch	Lunch	Lunch	Lunch	Lunch
Afternoon (2:00 – 4:30pm)	<ul style="list-style-type: none"> - Community health strategy - Life cycle approach in CHS - CHVs roles and responsibilities at community tiers 	<ul style="list-style-type: none"> - Immunizations - Danger signs in under-fives, pregnancy and delivery 	<ul style="list-style-type: none"> - Basic lifesaving skills - Basic life skills on specific conditions - Referrals - Community health information and disease surveillance 	<ul style="list-style-type: none"> - Step 3: Problem analysis and triggering <ul style="list-style-type: none"> - <i>Community sanitation mapping</i> - <i>Transect walk</i> - <i>Glass of water</i> 	<ul style="list-style-type: none"> - Field activity - Closing of training
Departure	Departure	Departure	Departure	Departure	Departure

Annex 3: Harmonized action plan

S/No.	Activity	Baseline	Target	Actions to be taken	Who	When	Resources
1.	Reduce the number of diarrheal cases reported and treated at Laiagam and Kandep districts	30%	60%	Health education and awareness creation on handwashing, food handling, clean water and utensils, covering pit toilet with lids, and ash around holes	CHW, CHVs, teacher, leaders, hospital officers	11/01/16 – 30/04/16	ToTs, Soap/ashes and water, buckets, aqua tabs, posters, speakers, and empty tins for demonstrations
2.	Reduce the number of TB cases reported and treated at Laiagam and Kandep districts	15%	45%	Awareness and Health education on mouth covering, no spitting, proper ventilation, early seeking of treatment, and case tracing amongst others	CHVs, CHWs, chiefs, teachers, leaders	08/02/16 - 28/05/16	ToTs, posters, statistics from Health information office, health workers from district and hygiene promoters
3.	Identify and train hygiene promoters	10%	50%	Mobilization of communities, identifying participants and thematic areas of focus, and assistance from health	CHVs, CHW, chief, teachers, leader	04/01/16 – 9/01/16	Training manuals, charts, markers, posters, food rations, pencils, paper folders, and food

				departments and partners for the training			supplies etc.
4.	Latrine use	40%	90%	Sensitization on need for latrines, building demonstrations their cleanliness, , and their proper use	CHVs, CHWs, chief, teachers, leaders, hygiene promoters	01/02/16	Ashes, soap, water, local materials (kunai, pandanus leaves, bamboo, tools and nails etc.)
5.	Hand washing practices at key times	10%	90%	Sensitizations and demonstrations on the need for and the benefits of hand washing at critical times	CHC, CHWs, chief, teachers, leaders	05/12/15	Soap, ashes, water, bucket, and containers
6.	Dialogue days	10%	30%	Promotion of the need for dialogue days and its importance	CHWs, CHVs, chiefs, teachers	26/01/16	Time, refreshments and working tools
7.	Health promotion day	5%	50%	Health education on the need for and the importance of the resolution agreed from the dialogue day	CHW, chiefs, CHVs	21 st day of every month	Time, refreshments, cleaning tools (brooms, brushes, gloves, rakes), wheel barrows, etc.

8.	Increase coverage of ANC	30%	100%	Sensitization on need for ANC services at community level and training of hygiene promoters oriented on MNCH services	Religious leaders, CHVs, teachers, CHWs, chiefs	12/04/16	Loudspeakers, charts, posters, books and other training materials for hygiene promoters training
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