



TRIP REPORT: Maternal Neonatal Child Health Portfolio Review

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Report to MSH/ SDSH - Pwojè Djanm

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STTA - Maternal Neonatal Child Health Portfolio Review

Consultants:

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Objective of this consultancy:

The goal of SDSH-Pwojè Djanm's service delivery component is that, by 2010, at least 50% of Haiti's population will have access to and will be using high-quality, integrated basic health services. To this end, the project provides technical assistance, training and funding to 152 (NGO and MOH) service delivery sites for the organization and delivery of a "Paquet de Services Prioritaires Intégrés – PSPI".

The objective of this consultancy is to conduct a comprehensive technical review of SDSH-Pwojè Djanm's service delivery component (with a specific emphasis on its maternal neonatal and child health portfolio), and to make recommendations to MSH/Haiti for strengthening related technical assistance, training, and service delivery strategies and interventions in order to maximize the positive impact of USAID's assistance channeled through this project.

Scope of work:

- To review the definition and content of the "Paquet de Services Prioritaires Intégrés" and assess its appropriateness in light of USAID and SDSH-Pwojè Djanm's objectives, the new GOH "Document Stratégique National pour la Croissance et la Réduction de la Pauvreté", the conclusions of the "Enquête Mortalité, Morbidité et Utilisation des Services 2005-2006" (EMMUS IV) and the relative cost-effectiveness of possible interventions.

Documents reviewed and discussed. PSPI reviewed in detail, National Strategic Plan reviewed, Project PMP reviewed and discussed in detail, DHS studied and forms important base line. The PSPI is appropriate and complete and consistent with the other policies.

- To review technical strategies and interventions in place at service delivery level for organization of services at both institutional and community levels (in both NGOs and "zones ciblées" supported by the project) to evaluate appropriateness in the context of a holistic approach, integrated service delivery and a continuum of care across service delivery levels.

Integrated strategy is sound and strategies largely in place, though of varied quality. Referral is logistically a huge constraint and most places should attempt to modify activities to be as self reliant as possible.

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- To review Project's technical assistance and training strategies, and evaluate capacity in place to implement project's strategy and respond to local needs.

Suggestions on technical assistance are made in detail to improve both the frequency of field visits and supervisory activities. These include a standard checklist covering all aspects of the project, more attention to quality of care, focuses attention on selected statistical measures of progress and their display and use in the facility, and logistical support to assure the availability of essential supplies and medicines.

- To review capacity and roles of MSH and its subcontractors (JHU, JHPIEGO and AHF) and make recommendations to maximize value-added, coordination and synergy.

Capacity seems sound but activities are far too centralized and at times theoretical. More contact with the field, performance oriented training objectives derived from field needs, training in place and especially followup in the work place of training to improve implementation are needed by both MSH and the subcontractors. Expertise needs to be aggressively interacting with decision makers to bring field realities more forcefully into central decisions.

- To identify internal and external constraints to be addressed and opportunities to be seized to ensure achievement of outcomes expected.

See detailed suggestions made on presentation to USAID and MSH staff. Some 35 recommendations made and detailed below. All seem affordable within project budget (save for the need for RUTF for malnourished) and can be implemented with existing staff in a time frame that can substantially improve project outcomes.

- To review Project's Monitoring and Evaluation Plan, data collection, data processing systems in place.

Plans and documents reviewed. Collection tools studied in the field and recommendations for simplification made with greater use of data and more graphic feedback to field users. Negotiations initiated with USAID to reduce burden of reporting required by the project.

- To meet with MYAP (Title II) partners to identify opportunities for coordination and synergies with SDSH-Pwojè Djanm interventions.

This was not done in the time of the consultancy

Project strengths (a brief list from field observations and discussions with partners):

- ▶ **Flat Project structure** allows good communication at central level and little need for formal hierarchy
- ▶ **Highly decentralized** project with focus in the departments – this is clearly a project that thinks and works on results in the field
- ▶ **Clearly focused and targeted on specific outcomes and populations** – an impressive attribute in that not only MSH staff are constantly aware of targeted outcomes, but also virtually all the partners in the participating facilities are as well – a highly focused project across the board
- ▶ **PSPI covers nearly all necessary elements** – the package is thorough and lacks only a few elements which we have suggested adding below
- ▶ **Excellent technical staff** with high degree of respect by partners – we encountered a uniform respect for and clear collegiate attitude towards all MSH staff from the NGO partners as well as from the MSPP

Overview of Project weaknesses and summary suggestions for change:

- ▶ **Technical assistants visiting facilities do not always communicate with each other** back at office – specific suggestions made for trip reports, check lists and sharing main insights by office email to all technical staff
- ▶ **Variable quality of supervision** and engagement with facilities by departmental technical advisors – see supervisory check list proposed below
- ▶ **Regular stock-outs in MOH system** likely to derail project attaining objectives – the absence of ORS packets, vitamin A capsules, vaccines and iron folate tablets must be urgently addressed. Until the MSPP capacity can be objectively and consistently improved, we strongly suggest that MSH assume prime supply functions for ESSENTIAL commodities as they are presently doing for the contraceptive supplies. This will require negotiations with various donors to enable MSH to handle and account for the donated supplies in child and maternal health.
- ▶ **Overall lack of understanding of Quality of Care** processes and monitoring quality – attention has been on maximizing coverage and service delivery – we believe more attention to quality through active supervision and focus on measurable indicators will both improve objective measures of quality and result in higher utilization of services – specific suggestions below
- ▶ **Variable use of registers and data** – registers are well designed and widely available but most are not used as management tools by nurses to assure continuity of care and followup. Suggestions made for strengthening
- ▶ **Lack of internalization of information use** at all levels – statistics for statistics sake – the project partners are overwhelmed by project statistic requirements, resulting in lack of use of information at the service delivery level as well as poor quality of data. Substantial cut back in data demands with focus on more precise indicators to be used on site for management decisions will result in better achievements of targets for the project. Specific suggestions below.
- ▶ **Multiple missed opportunities for education** – health education in the facilities and the field is very desultory and not aided by appropriate tools. Hands on demonstrations and dialogue are needed. Better communication materials design is required, especially for engaging the public and a rethink of the project provided technical tools is indicated.
- ▶ **Maternal Health and Obstetric Care -Basic emergency care needs more field presence and hands-on training** – the six standard actions of Basic Obstetric Care must be instituted in all those institutions where referral is not possible or practical. Training should be followed by onsite reinforcement by training staff.

- ▶ **Matrones not being supported** and used to full potential – more simple, nonliterate aide-memoires for field use and emphasis on monthly matrone meetings to reinforce messages, gather information and strengthen referral
- ▶ **World Food Program working well**, single example of MYAP was not working well – the WFP food is organized well and along set objective criteria, in support of the programs at collaborating facilities. The MYAP, however, seems to be setting up competing health service activities, even in zones of project coverage. MYAP should be asked to provide food and nutrition education in collaboration with project facilities and let the project collaborators handle the health activities
- ▶ **Some facilities overwhelmed, others with few patients** – question of cost efficiency – project should review costs in relation to services delivered and consider reducing or terminating support for non-cost efficient facilities. Model for evaluation proposed
- ▶ **Measles vaccine being given too late** – even if only measles rubella vaccine available, it should be given at 9 months – waiting to 12-15 months threatens measles epidemid
- ▶ **Nutritional issues related to growth monitoring and response to severe PEM** –intervention is needed for response to severe PEM detected in weighing sessions. Use of RUTF in highly selected cases recommended below.

Specific Recommendations – Project Staff Functions:

- ▶ **Role and performance of Departmental technical assistants and central staff**
 - **More time outside of office** – partner facilities is where things happen – staff should be in the field at least 3 days a week or more, working with facilities to implement and improve performance.
 - ▶ Departmental staff should be travelling to health facilities to supervise and support
 - ▶ PaP staff should be organizing visits to the Departments – sometimes accompanying Technical Advisors to facilities, at other times conducting meetings and trainings at departmental or commune level.
 - ▶ Training plans indicate a heavy presence in PaP – consideration should be given to shorter courses conducted closer to the field – even at collaborating institutions with other institutions joining in the field – this will facilitate both active learning as well as learning from each other on the ground
 - **More focus on problem solving and supervision** – field visits are not fault finding, but rather problem solving opportunities – objective deficiencies need to be identified and specific written responsibility taken by both facility staff and MSH staff to solve problems as they are found
 - **Field visit should include outreach activities in the communities** taking the opportunity to observe AdS at work, matrons and community leaders, assuring more community feedback to project staff to be fed to project HQ
 - Possibility of tying **annual MSH staff performance assessment to institutional performance** with direct financial consequences of success/failure to meet targets
- ▶ **Total Project approach when staff visit facilities** and communities each technical advisor reviewing all activities
 - **Project-wide checklists** with referral of problems to appropriate technical offices and partners (see check list below)
- ▶ **Improvements to training making it more relevant to field** needs and requirements as defined by the technical staff based on field observations
 - **Formulate written training objectives with technical staff** and assure they meet the identified needs in the field, and are signed off on by the relevant technical advisors. Objectives should be written as clear competencies: eg: At the end of this session the

participant will be able to: describe, demonstrate, conduct, explain, show, perform..... defines actions. Evaluation then simply asks that these actions be demonstrated by the trainee.

- **Provide objectives of any training along with the invitation** to participate
- **Conduct evaluation of each training and transmit to all participating institutions**
- **Give take-home materials** so participants can share and teach what they have learned with other staff.
- **Conduct training as close to field as possible**, emphasizing field experience during training – briefer training will be possible if objectives are refined to reflect actual field needs, rather than theory. Training at collaborating facilities, even inviting neighboring institutions should be encouraged to make relevance to actual daily work more salient part of training
- The scheduled training activities for the next quarter seem to be **heavily PaP based and take more time than should be necessary** or ideal. As all doctors and nurses have ALREADY been trained, to some degree, 2 weeks of further training in a single subject area seems excessive. This merits re-examination.
- **Follow-up training in the field** by trainers to reinforce and consolidate training – provide other MSH staff with succinct guide to training outcomes to enable feedback and field reinforcement of training on the job

Policy Issues affecting Project Performance and Efficacy:

- ▶ **Concern for shift in age for measles vaccination.** Measles is a devastating disease of children, carrying a substantial mortality in those malnourished (especially if they do NOT receive high dose of Vitamin A at the onset of disease). Haiti continues to have significantly high levels of severe malnutrition – about 4% and endemic measles transmission (though not recently in epidemic form). Rubella remains a relatively minor disease of children, and congenital rubella is unusual or even rare in populations where natural transmission of rubella continues. The decision to introduce measles rubella vaccine, and to shift the age of administration to 12 months or more carries a substantial risk of measles susceptibility for infants from 6 months until vaccinated. Either measles vaccine alone at nine months should be continued and widely followed, or the measles rubella vaccine should be administered at the earlier age of 9 months. It is notable that at least one manufacturer has tried rubella vaccine at 9 months of age and found 100% protective seroconversion for rubella with the single dose (GlaxoSmithKline (GSK) Biologicals)link - ([208136/018 \(MeMuRu-OKA-018\)](#)) In the same trial measles protection with a single dose at this age was 93% (recognized in all studies that measles at 9 months leaves a few children unprotected which is why a repeat before school entry is recommended). Thus, the recommendation to delay measles-rubella vaccine appears unjustified and a substantial risk to Haitian children. This recommendation is apparently made on the basis of North American and European practice where the threat of measles outbreak is far less and the desire to obtain higher measles seroconversion is considered worth the risk. Rubella seroconversion in any case, is not an issue at 9 months. Immediate action should be taken to revise recommendations.
- ▶ **Clarification on what now constitutes a fully immunized child:** Attention should remain on each child completing full primary immunization as early as possible. Thus, until revision of the norms is done as recommended above, the project will have to accept RR vaccine by 15 months as fully immunized, in spite of the desirability to vaccine with measles vaccine, or if not available the RR vaccine, before 12 months of age.
- ▶ **Resolution on making ORS widely available** – in health facilities, with AdS and to every household: Unfortunately, ORS packets are not available in many or most facilities and stock rupture is frequent. The Sels La Vie are also not in the market. Although USAID informs us that Sel la Vie will be produced soon, its absence indicates the inability of social marketing programs to reliably meet needs. Several actions are recommended:

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- **Negotiate with Unicef** to provide an adequate supply direct to MSH for distribution to the 152 facilities and their 1200 AdS
- Support the development of **local production of packets** – perhaps through a USAID or other small industry project – Serum Oral of international quality was made in Haiti during the 1980s to considerable positive impact
- Formalizing policy in support of **home-based Sugar Salt Solution (SSS)** – many think this is not approved, although discussions with MSPP indicate that the policy of using SSS when ORS is not available remains official policy – this should be reemphasized with a MSPP directive
- Use of AdS to gain widespread competence through **teaching and demonstrating to each mother at home visit how to prepare SSS herself**. This approach has been proven highly effective in such large populations as Bangladesh where 13 million households were individually taught with a fall in diarrhea mortality by more than half. Diarrhea remains the likely major cause of death (sharing this distinction with malnutrition) in Haiti. The Project AdS reach some 30,000 homes each month – nearly 400,000/year which could substantially reduce deaths from diarrhea.
- ▶ **Increasing responsibility of AdS to provide community based services**
 - AdS already provide vaccines in the field – an excellent policy. They should be trained and supplied to **give repeat doses of Depoprovera** (first and second doses to be given only in the health facilities) to those who have no complaints nor side effects. This would vastly improve acceptance and continuity rates. Even though the MSPP policy does not specifically allow for this, the project can conduct this as a pilot and provide proof through documented OR that this is an effective approach to stimulate policy change.
 - **A simplified protocol of counting respirations can enable early treatment of lower respiratory infection (pneumonia) by AdS-**
 - ▶ while a watch or timer is useful, a stone or any weight tied to a 50 cm length string swung as a pendulum has a period of 50 swings/minute. A child who is breathing faster than the pendulum swings has respirations over 50/minute and can be treated on the spot. Cotrimoxazole one dose twice a day for 5 days is effective treatment. Those with fast breathing accompanied by difficulty breathing or too rapid to count should still be sent to the health facility urgently.
 - **For fever**, parents should be taught to gently bath the child and fan to increase evaporation. In refractory cases, Paracetamol could be provided for fever (tablets only, to be crushed for small children) with continued fever beyond 3 days referred for possible assessment and treatment of malaria. A small charge could be made for this service as it is not life saving.
 -
- ▶ **Resolving what is “free” and what is not under the new policy for mothers and children**
 - There have been recent radio announcements that “all health services for mothers and young children are to be provided free of charge throughout the country”. This is neither practical nor sustainable and should be limited to preventive services only except where locally decided to exempt charges for specific cases.
 - The SOG project of the BID offering free prenatal, postnatal and delivery care plus free transportation in selected institutions should be asked to reconsider the level of support offered. (the current subsidy does not nearly cover the actual costs)
 - The forms used by the SOG are impossibly detailed, complex and uniformly unused in the sites we visited. Revision to a far simpler form is needed

Information Management

- ▶ **Address information overload at MSH supported facilities (MNCH & HIV)** –The current large amounts of data to be recorded and reported result in little attention to what the data means. Many

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required items are not real indicators in any case, being “bean counts” only, rather than true indicators that can drive positive actions. A far more focused set of key indicators will better measure accomplishments while providing improved quality of care and better service management at the facility. An illustrative set to cover MNCH and TB:

- **%children Fully immunized before 15 months**
- **%cases Diarrhea treated with ORT**
- **%<3 SD Wt/Age of all children weighed**
- **FP – %Depo users returned for repeat dose as expected**
- **FP Users as % of all women 15-45**
- **ANC – % HIV tested, % assisted deliveries**
- **TB –cases under Rx % expected, %HIV tested, outcomes by %** (cumulative annual figure)

A detailed review of each indicator in the PMP has been conducted, redundant or irrelevant items removed, some redefined, and suggestions on how to more efficiently gather the information required has been provided to Dr. Desmangles. Some redesign of forms will be needed to assure that every working indicator is indeed measurable and has a clear target.

- ▶ **Focus on display** and use of information at every supervisory visit. As noted earlier, many facilities do not use, or understand the need to use, the data they collect. Data that is presented is done so in the format designed by the project, which is in tabular form and difficult to interpret and use. In order to rectify this, the project should develop a set of standardized graphic displays of data which will enable facilities to more clearly understand the data, and will provide the focus for supervisory visits in the future.
- ▶ **Narrowed focus of Project indicators**, with more emphasis on local use of data and quality of care indicators
- ▶ Possible use of **semestrial or annual data collection** for other reporting requirements
- ▶ Explore the **possible use of Internship/Fellowship** in information management at HAS, a participating institution that makes excellent use of data for decisions and quality measurement

GENERAL MANAGEMENT ISSUES IN THE HEALTH SYSTEM

- ▶ **Problem of leadership capacity development at central and departmental MSPP** – given the range of demands on MSPP staff from many directions, and the emphasis on Project performance in the field, efforts envisioned in leadership development seem a bit unrealistic. We suggest that the Project be opportunistic in this regard without commitments.
 - ▶ **Improvements in MSPP capacity to manage essential drugs**, on the other hand, is essential to project success. Other MSH projects may be in a better position to help develop MSPP logistic capacity until which time, the Project should endeavor to assure supplies directly to its 152 sites independently. Formal agreements with donors presently supplying MSPP with essential MNCH and TB drugs and supplies should be sought to assure supplies are delivered and accounted for.
 - ▶ **Food supplementation programs should focus on food supplementation**, and not try to duplicate project’s health programming in the areas where both are working simultaneously. Negotiations with USAID and the Title II NGOs should clarify this issue to avoid overlap and apparent competition.

Improvement in Quality of Care and of Services:

- ▶ **Modifying the emphasis of the project to improve use of services** The Project has placed emphasis on access to services and coverage, to very substantial effect. It is now time to move towards higher quality services to both increase utilization and assure outcomes that meet the potential of services provided.

- ▶ **Strengthening supervision to be problem solving and supportive** Supervision visits by Project staff should focus more on quality of care and problem solving using standardized checklists (see illustrative checklist for visits and planning remedial actions - appended). It may include:
 - **Registers:** FP, EPI, TB, Birth, ANC, Diarrhea (completeness of recording, missing data, completion of each service)
 - **Quality of clinical care review:** IST syndromic Rx; Diarrhea ORT use; records of institutional births and proper use of partogram for each delivery, review of obstetric referrals; death reviews of any maternal and infant/child deaths
 - **Statistics (5-7 key indicators shown above):** Graphs posted on walls, up to date, actions to take identified in management meetings and recorded
 - **Stock outs: 10 indicator items** out of stock any time in past month
 - **Communication:** demonstrations and interactive dialogue in patient areas – appropriate and attractive communication tools
 - **Management:** office arrangement, files, financial records, general appearance of work areas; trash management, both medical and other
- ▶ **Assessment of client satisfaction and community interaction:**
 - Institution of **periodic client surveys** (6 monthly): Exit interviews: 10 clients – 5 items: (service, wait, weight card use, client actions at home, overall satisfaction)
 - **Informal interactions with patients** in waiting areas to assess satisfaction
 - Use of proposed Conseils Communaux de Sante or other community body as a mechanism to **pilot a facility rating system** (models available from MSH work in Senegal and Philippines)
 - ▶ a star rating system for service provision and quality by objective criteria and satisfaction surveys
 - ▶ Community Involved in the assessment and improvement activities both in the facility and the community at Postes

Issues and suggestions in Child Health:

- ▶ **Securing essential medications** As noted above, there are regular stock-outs of essential supplies. The project is already taking care of family planning commodities, and should consider taking charge of vaccines and Vitamin A supplies which MUST be secured and reliable
- ▶ **ORS needs to be available universally** (see Policy section above)
 - Supplies of packets
 - Home made SSS
 - Demonstration corners at every health facility
- ▶ **Addressing treatment and care of children -Simplify and use a facility-based treatment program** (full IMCI is not being used) deal with diarrhea, ARI, fever (appended guide) (full IMCI with detailed forms has been recommended by OMS – we found huge amounts of paper in files with not a single mark on these detailed IMCI records – a far simplified guide and brief record is needed)
- ▶ **Treatment of severely malnourished children** The Project is conducting a huge number of nutritional assessments each month (something over 300,000), with no nutritional response save for advise (when given). A **therapeutic intervention for the few (about 3%) of children severely malnourished (<3SD)** using locally produced RUTF could not only save lives, but importantly add substantial credibility to the project child survival profile.

We recommend the **provision of a RUTF (Medika Mamba) for malnutrition** rehabilitation, (requires about 15 kgm of RUTF costing \$75 for a complete course of treatment lasting about 8 weeks), perhaps combined with food supplementation for families from PAM or Title II. Donor

support for the RUTF should be sought. A small pilot with 10-20 children in each of 5 centers should provide feasibility and cost estimates before expansion.

Issues in Maternal Health:

- ▶ **Saving mothers lives is a key Project objective**, highly relevant in a country where maternal mortality is near 700/100,000 births (and probably higher in the most remote and difficult areas). **Family Planning is the first and most basic intervention** to prevent maternal deaths. The Project has done much to assure needed training, supplies and continuity of service. While institutional delivery is encouraged, currently fewer than 20 % of women deliver in facilities and far fewer in rural areas. **Actions are needed to improve home delivery care** and encourage timely identification and referral of problems and to **strengthen facilities obstetrical capacity**, especially where referral is difficult or impossible.
- ▶ **Family Planning**
 - **Ensure consistent supply of contraceptives** – this seems under control, with the recent decision to have MSH handle the supply – the numbers of commodities delivered over a year provides a reasonable basis on which to calculate Couple Years of Protection. The use of pills and Depo alone this year up to June suggest 150,000 current users. Added to the large use of condoms and the few long term method users, this gives a protection of something like 23% of women in the protect area. Expanding contraceptive supply through AdS in the community (and advocate for policy change to allow Depoprovera in the community) will increase use.
 - **Institute early follow-up of “abandons” by AdS** – this should be a monthly task
 - **Encourage consistent FP users with one-on-one counseling** to offer longer term methods – Norplant, copper T and ligation. A separate register for long term users will enable tracking these important clients better, and enable easy reporting to USAID on long term use
 - The effort of a central team to **train Departmental staff in ligation** seems sound – regular field followup is needed – a visit and joint activities with each Department every two months is strongly suggested.
 - **Improve estimation of contraceptive needs** – particularly condoms to assure continued supply
- ▶ **Community level maternal health actions:**
 - **Introduce the birthing plan at the level of Matrones** (as well as patients) to provide closer oversight and guidance and continued plan improvement (a far more simple guide is required)
 - **Institute monthly meetings for all Matrones** – review birthing plans and any referrals each has made, reinforce referral mechanisms and review danger signs and actions to take
 - **Review all referrals made** at matrone meetings and use the discussion to reinforce practical measures taken in the community and to motivate other matrons
 - **Neonatal training for matrons** – resuscitation (breath of life for newborns not crying), infection recognition (red or pus periumbilical), breast feeding advise and referral for any not breast feeding successfully (**A baby not feeding is ill, a baby breast feeding well is not sick!**) -prepare small plastic single page aide memoire
 - Make simple check list (or use existing ones) for all **maternal and infant deaths** and review as a team (not for blame!)
 - Explore the possibility to **scale-up the “Super Matrone”** program with a view to more skilled assistance nearer homes
 - **Simplify norms and standards** to ensure policy reflects practical field activities rather than the present detailed norms that cannot be instituted

- ▶ **Health facility actions:** We found inadequate personnel and equipment and supplies in the most remote facilities making effective care for emergencies almost impossible. **The 152 facilities of the Project should be classified into three types:**
 - Those that can provide emergency obstetric care including C-section – no support needed
 - Those having adequate access through referral to EOC and C- section – just assure timely referral
 - Those too remote to provide EOC or rapid referral. These require immediate actions to **provide the Basic Obstetric Care Package** by providing drugs, equipment and technical skills to:
 - ▶ **Use oxytocics for delayed labor**
 - ▶ **Give antibiotics for infection**
 - ▶ **Give MgSO4 for eclampsia**
 - ▶ **Vacuum extraction**
 - ▶ **Manual removal of Placenta**
 - ▶ **Remove retained placenta material**
 - ▶ **Resuscitation of the newborn**
- ▶ **Instructions in the use of the partogram for all institutional deliveries** should be imparted and monitored regularly as part of routine supervision.

Conclusions:

- ▶ **Project is well designed and implemented – should make its targets**
- ▶ **More field presence needed in facilities – this is where things will happen**
- ▶ **Attention to standardized supervision and aid to facilities to perform**
- ▶ **Importance of supply of drugs and supplies – MSH must assure**
- ▶ **More focused attention to fewer indicators to be used and displayed in facilities**
- ▶ **Attention to standardized quality of care measures – measure fewer better and display**
- ▶ **Additions to “package”:** Rx for ARI, Depo in community, Action for severe PEM, Basic Emergency Obstetric Care, Matrone actions

In summary:

The Best is the Enemy of the Good

A few things done right is far preferable and of more value than many things done wrong!