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THE OPTIONS FOR FAMILY CARE CONTRACT

STRATEGIC FIVE-YEAR MASTER PLAN
1995 - 2000

IMPLEMENTED BY JOHN SNOW, INC.

in collaboration with

The Association for Voluntary and Safe Contraception, International Health and Development Associates, and The Program for Appropriate Technology in Health

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INTRODUCTION

The Options for Family Care (OFC) Project[1] is funded by USAID/Yemen through its bilateral agreement with the Government of the Republic of Yemen. The primary institutional partner in the implementation of the Project is the Ministry of Public Health (MOPH), with a smaller portion being implemented by the National Population Council (NPC). A large portion of this Project -- a five-year contract -- is managed by John Snow, Inc. (JSI) in collaboration with several subcontractors: The Association for Voluntary and Safe Contraception (AVSC), The Program for Appropriate Technology in Health (PATH), International Health and Development Associates (IHDA), and World Education, Inc. (WEI).

This Strategic Master Plan is the result of the first six months of activities in Yemen under the OFC Contract -- activities which began in June 1995 when the Chief of Party arrived in country. It was developed based on travel to field sites (in the four target governorates of Hadramaut, Hajjah, Hodeidah, and Lahj), situational analyses, and needs assessments undertaken by Contract staff in close collaboration with colleagues at the MOPH, NPC, and USAID. It is consistent with the National Five Year Plan for Health Development, the MOPH's focus on district-level health care, and the National Population Strategy.

This Plan summarizes the overall concepts, approaches and activities to be undertaken over five years under the OFC Contract. It is not intended to address the detailed content or timing of specific activities -- that is the purpose of annual workplans to be developed in collaboration with MOPH and NPC colleagues. Rather, this Master Plan describes, in broad terms, what will be accomplished by the Contract and the strategy that will be used to reach those accomplishments, and will serve as a guideline for the development of more detailed implementation plans. While the OFC Contract team is confident that this Master Plan will be durable, it should nonetheless be viewed as a working document. The flexibility to respond to new, better ideas and changing circumstances must be retained as all participants learn from unfolding activities.

All work under this Contract is based on the USAID/Yemen Strategic Framework, which is summarized in Exhibit 1 and included in its entirety in Annex 1. Activities are designed to achieve USAID's three Intermediate Results, and thereby to contribute to the achievement of the Strategic Objective. This work will be evaluated in large part according to the following Performance Indicators and their associated Units of Measure: 1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 2.3, 2.4, 3.1, and 3.2.

Exhibit 2 graphically illustrates this Master Plan. The USAID Intermediate Results appear in the center of the figure, and the strategic approaches (components) to be employed to achieve them appear on the periphery. These components are inter-related: It will be necessary to succeed to a large extent in each of them in order to achieve the desired Intermediate Results. Each component, however, requires specific inputs from

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[1] *Like other large organizations, USAID employs various terms which have specific meanings. For those unfamiliar with this language, terms like "project" and "contract" may be confusing. In this document, the term "OFC Project" refers to the large USAID program for development assistance in health, which has a number of components. The terms "OFC Contract" and "Contract" refer to one of these components: the contract between USAID and John Snow, Inc.*

the Contract and from Yemeni institutions and communities, and can be described separately. The text which follows provides those descriptions.

COMPONENTS OF THE OPTIONS FOR FAMILY CARE CONTRACT STRATEGY

1. PROVIDE AN APPROPRIATE MIX OF COMMUNITY-, GOVERNORATE-, AND NATIONAL-LEVEL INTERVENTIONS

Opportunities for improvements exist at all levels of the health care delivery system in Yemen. The challenge for the OFC Contract is to identify a number of interventions -- uses of the Contract's technical and financial resources -- that not only address clearly identifiable problems in the system, but which are likely to have meaningful and lasting impact. The interrelatedness of the various tiers of the system (community, governorate, and central) require meaningful intervention at each level. For example, continued training of service providers will have little impact if the country's chronic problems in supplying drugs to the periphery are not addressed. Physical, clinical, and managerial improvements at clinical facilities will have limited impact unless outreach from those facilities to surrounding communities is improved.

The OFC Contract will therefore work at each of these levels. A balance will be struck between the spread of Contract resources across various levels of the system and the application of adequate resources at each level. Contract interventions at the national (central MOPH and NPC) and governorate (Health Offices) levels will primarily address policy and management systems issues. These will include such efforts as:

- Increasing awareness of MCH/FP and population problems among leadership and the public.
- Recommending policy changes that will promote more effective service delivery.
- Improving the logistics system.
- Improving management information systems.
- Improving supervision systems.
- Improving systems for human resource planning, training and deployment.
- Improving referral systems.

Contract interventions at the community level -- which will include work at health facilities as well as in the communities they serve -- will address direct service delivery issues, such as:

- Training of service providers -- especially females.
- Improvements in clinical facilities.
- Improvements in service quality.
- Promotion of community outreach efforts.
- Promotion of community participation in the health care system.

These and other interventions are discussed in greater detail in sections 4-8 below.

The OFC Contract will work to target its assistance in this manner through a number of mechanisms:

1. Contract implementation will be consistent with MOPH and NPC plans. Indeed, the Contract will be one resource available to the these agencies for the implementation of *their* plans.
2. Contract activities will take into consideration the broader context into which an activity fits. For example, the OFC Contract will only train those people for whom there is a reasonable assurance of a long-term, locally-funded position. Similarly, the Contract will only train those people who fit into a rational, agreed-upon staffing pattern within their home institution.
3. Contract inputs will be provided to build upon success. Eligibility for assistance under the Contract will depend upon meeting certain criteria established by Contract personnel in collaboration with Health Office management. For example, only those health centers which are using their existing human and material resources in an effective manner will be provided with additional resources. Equipment or renovation for health centers will be provided in a stepwise manner according to the performance of centers against certain criteria, and/or in conjunction with relevant training or technical assistance.

OFC assistance will thus be rational and performance-based. Assistance will be designed and targeted to meet specific needs and objectives, to be complementary with the broader workplans under which the recipient institutions operate, and to provide tangible benefit for outstanding performance.

4. PROMOTE A MORE SUPPORTIVE POLICY ENVIRONMENT

In a country like Yemen, where the resources available for health care will be limited for some years to come, it is very important that the use of those resources that are available are not constrained by absent or counter-productive policies, practices, and attitudes. While the improvement of maternal and child health status and the programs that would contribute to that improvement enjoy widespread support, there are a number of factors affecting MCH/FP that may not be fully appreciated -- factors which can be affected positively or negatively by government policy and by the attitudes of influential leaders. Examples include:

- The relationship between rapid population growth and the ability of the government to meet the social and economic needs of the population (e.g., health, education, employment).
- The relationship between maternal/child health status and high fertility and closely spaced births.
- The relationship between clinic performance and budgets for supervision.
- The relationship between clinic performance and the functioning of the drug supply system.
- The relationship between women's health status and the number and competency

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of female health care providers.

- The factors limiting the number of females being trained as health providers, and the percentage that continue to work after training.

The OFC Contract will provide resources to educate appropriate audiences on these and other important issues, to make recommendations for policy change where needed, and to strengthen institutional capabilities to continue to carry out these functions after OFC inputs have ceased.

The primary partner organization for carrying out this work is the National Population Council (NPC), an inter-Ministerial organization charged with the responsibility for coordination of projects and programs related to population issues. OFC Contract inputs to the NPC include technical assistance and support for strategic planning, inter-sectorial planning and programming, awareness-raising activities, policy research and formulation, policy reform, and staff- and institutional development.

OFC will also work on policy issues that may be internal to other organizations. Such issues as cost recovery and revenue sharing, medical standards and clinical guidelines, data collection procedures, and drug distribution and procurement policies at the central level of the MOPH are clearly critical to the success of service delivery. OFC Contract staff will work with NPC and MOPH colleagues to think through the implications of existing policies and identify areas where change may be needed. At the governorate level, local policies with respect to staffing patterns, staff responsibilities, budgeting and use of funds are examples of issues that effect service delivery. OFC staff will assist Health Office staff in identifying and implementing local policy change where appropriate.

5. IMPROVE ACCESS TO AND QUALITY OF SERVICES:

Improving access to and quality of maternal and child health services is the *sine qua non* of the OFC Contract.

To develop a strategy for high-quality, sustainable MCH/FP services, it is first necessary to identify the scope of those services and relate them to community needs and circumstances. For purposes of the OFC Contract, the basic package of MCH/FP services includes:

- Maternity Care (antenatal, delivery, and postpartum care)
- Neonatal Care
- Family Planning
- EPI
- ARI
- CDD
- Nutrition (including growth monitoring)
- the support services necessary to deliver these services (laboratory, pharmacy, education, etc.)

Next, it is necessary to determine how to organize these services into a system that offers the greatest access to the greatest number of people. To provide this access, the system must be tiered -- reaching from the community level up to the hospital-based referral center. Services should be "pushed down" as far as possible -- the limiting factors being the degree to which the cadre of care givers available at lower levels can be adequately trained to provide the designated services, and the ability of the system to provide their support needs (supervision, supplies, financing, etc.).

In Yemen, the health care delivery system can be seen as divided into two subsystems:

- the primary care sub-system organized at the district level, including community-based, Primary Health Care Unit based, and Health Center-based care, and
- a tertiary care sub-system which ties this district sub-system into the hospital-based referral center (usually at the governorate level) with the ability to provide specialty care.

In some cases, there is an intermediate level--the secondary care sub-system--based at the district hospital with the ability to provide some emergency and specialty care. OFC Contract resources will be used primarily to improve the primary care system, as discussed below.

The Primary MCH Service Delivery Sub-System

The district level system consists of three integrally interconnected tiers--the health center, the primary health care unit, and the community. Each tier should include components that 1) promote healthful behavior, 2) familiarize the population with the services available, 3) provide services within the limits of the provider's training (the assumption is that staff limitations are far more constraining over the long term than facilities, equipment and supplies), and 4) provide referral for services beyond the capabilities of the staff. Training enhances the ability of the system to push services down, ever increasing access. Supervision and referral knits the tiers together.

The OFC Contract will provide a variety of types of assistance to improve the district level health system. Some of this assistance will be material, and can be accomplished with relative ease and directness: Health Centers in need can be provided with minor renovation or replacement of/additions to their available equipment. More challenging is the creation of a reorganized model of primary care delivery which increases access, quality, and sustainability.

The model proposed by the OFC Contract is as follows:

a. The Community Tier

The community level is the tier at which access is the greatest. This is where the people live; and because of money and transportation issues, people have great difficulty accessing services beyond this level. Therefore, as much of the service delivery should be pushed down to this level as possible. The OFC target array of

services for the community tier includes:

- **Maternity Services**

  - Identifying pregnant women and educating them and their families about the importance of antenatal care
  - Educating the community about the importance of maternal care
  - Screening for and referral of high risk pregnancy for antenatal care and delivery
  - Distribution of iron folate tablets to pregnant women
  - Referral for tetanus immunization/organizing mobile tetanus immunization clinics
  - Educating women about safe delivery techniques
  - Distribution of safe delivery kits prior to delivery
  - Awareness education on the dangers signs which indicate complications during pregnancy, delivery and the postpartum period and which require urgent assistance
  - Assisting in normal deliveries; recognizing abnormal situations and arranging for emergency assistance (TBAs and other community women educated in safe delivery techniques)
  - Neonatal care (including weighing of the newborn, emergency resuscitation, management of infection, management of hypothermia)
  - Breast-feeding education
  - Referral for postpartum care (if FPHCW, Community Midwife or TBA: provision of basic postpartum care)
  - Provision of information and service for postpartum family planning (as above)
  - Birth registration; neonatal and maternal death registration

- **Family Planning/Reproductive Health**

  - Educating the community about family planning benefits, options and where each of the methods can be obtained (including LAM)
  - Provision of condoms and foaming tablets upon demand
  - Referral for initial prescription of oral contraceptives, for IUD insertion, and for surgical contraception (referrals to be broadened as other methods become available)
  - Provision of information on STDs, including HIV

- **Child Health Services**

  - Identification/census of children under 5
  - Referral for immunization/organizing mobile immunization clinics
  - Screening and referral for ARI
  - Awareness education on the dangers of diarrhea and dehydration, and the use of oral rehydration therapy
  - Distribution of ORS
  - Follow-up of cases of diarrheal diseases

- Breast-feeding and weaning education
- Nutrition education

The major constraint to developing this community tier is the ability to recruit, train and maintain the cadre of health care workers necessary to provide services at this level. It is unlikely that such an enormous cadre could be supported through the government system. Therefore, the OFC Contract proposes to test the roles of the community and the private sector at this tier of service delivery -- how to create the large cadre of "volunteers" required to provide the service and how to involve communities and NGOs in the support and management of the system.

b. The Primary Health Care Unit Tier

This is the most accessible of the government-supported, facility-based services. Government support includes the staff, equipment, facility, and supplies. The OFC target array of services for the Primary Health Care Unit tier includes all those listed above for the Community Tier plus:

- **Maternity Services**

  - Routine antenatal care
  - Tetanus immunization
  - Normal deliveries (particularly home deliveries)
  - Recognition of abnormal situations and arranging for emergency assistance
  - Emergency resuscitation of the neonate
  - Provision of basic postpartum care; referral as necessary

- **Family Planning/Reproductive Health**

  - Screening and initial prescription of oral contraceptives
  - Referral for IUD insertion, and for surgical contraception (referrals to be broadened as other methods become available)
  - Resupply of contraceptive commodities
  - Annual reassessment of risk conditions of continuing pill clients

- **Child Health Services**

  - Immunization
  - Screening, preliminary treatment and referral for pneumonia
  - On-site rehydration (through at least first packet)
  - Growth monitoring
  - Nutrition rehabilitation, where feasible

The staffing pattern required to implement the above set of services is, at a minimum, two Female Primary Health Care Workers/Community Midwives or one of each--one to provide service on-site while the other does outreach.

c. The Health Center Tier

The Health Center is the core of the primary system--the highest level of primary care available in the district. Therefore, every effort should be made to broaden MCH/FP services available at this tier so that referral is necessary only for emergencies and specialized hospital-based services. The OFC target array of services for the Health Center tier includes all those for the Community and Unit tiers above plus:

- **Maternity Services**
  - Antenatal care and delivery for all but the highest risk pregnancies
  - Normal deliveries (on-site and home)
  - Postpartum care

- **Family Planning/Reproductive Health**
  - Screening and initial prescription of oral contraceptives, and IUD insertion (to be broadened as other methods become available)
  - Referral for minilap (referrals to be broadened as other methods become available)
  - Provision of information on STDs, including HIV; treatment of common STDs

- **Child Health Services**
  - Treatment of pneumonia; referral for hospitalization where necessary

The staffing pattern required to implement the above set of services is at least one midwife (preferably two) and six Female Primary Health Care Workers or Community Midwives or combination of the two. The FPHCWs/Community Midwives would be responsible for all routine MCH services--four to provide on-site services (one for maternity/fp services, one for immunization, one for CDD, and one for growth monitoring and nutrition) and a minimum of two to provide outreach. The midwife(s) would be responsible for services requiring more advanced training (IUD insertion, more complex antenatal care and deliveries, postpartum and neonatal care). (A physician would be responsible for treatment of complicated ARI.)

Constraints to Sustaining the Three-Tiered System

Two major constraints to sustaining such a model delivery system have been identified:

- To "push down" and expand services to increase access is predicated upon the ability to recruit and train the cadres to fulfill the staffing patterns described above. In the Yemeni culture, it is difficult for young girls to travel outside of their villages unchaperoned, particularly for extended stays. This imposes severe limitations in the

initial staffing up of the model.

- In addition, it is often customary for young women to leave the labor force when they get married. Therefore, even when the models can be staffed initially, rapid attrition can be expected.

The next section discusses how the OFC Contract will work to overcome these human resource constraints.

6. IMPROVE THE AVAILABLE HUMAN RESOURCES

Strategy for Sustaining the Three-Tiered MCH Service Delivery Model

The driving force behind this strategy for sustainability is having the community itself take responsibility for the health of its people. (See the section on Promotion of Community Participation). The OFC strategy for sustainable staffing of the primary health care system, therefore, is to create partnerships with the community which help them realize this responsibility.

To staff and sustain the tiered MCH/FP service delivery model will require the creation of a self-contained system at the district level. That is, in addition to being a service delivery site, at least one Health Center in each district (or cluster of districts in areas where there is reasonable access among districts) will need to be developed into a permanent site for training FPHCWs to immediately replace those lost to attrition.

This same model of health center (or district hospital)-based training should be pursued as a sustainable strategy for training Community Midwives. (A less costly but also slightly less accessible model of Community Midwife training might include developing an extension program -- i.e., opening temporary branches -- of the Health Manpower Institutes).

To accomplish either of the health center-based models (training of either FPHCWs or Community Midwives), at least one midwife at the health center will have to be a certified supervisor/trainer. In cases where only a few FPHCWs need to be trained at a time, a single midwife might be able to combine her supervisory/training responsibilities with her clinical responsibilities. If there are larger number, it would be more effective to have two midwives--a senior one to serve as the supervisor/trainer and a more junior clinician. In any case, having two midwives provides a safety net in case one leaves the workforce (noting that there is a much longer lead time required to replace a midwife than a PHCW--three years rather than one).

The strategy for minimizing attrition in the first place is to draw the female staff (FPHCWs, community and professional midwives) from the same community in which they will ultimately work, and to involve the community in the recruitment process. In this way, women most likely to continue working after marriage will be selected in the first place, they will be working in a setting that would be most acceptable to their families and future husbands, and there would be some community pressure to continue working so as to avoid having to go through the process of recruiting and training new girls in order to continue services they have come to expect.

Timetable for Achieving Sustainable Staffing

The timetable for achieving sustainable staffing will depend on the current staffing status in the individual district, with the turnaround time most dependent on the midwife position at the health center. Becoming a midwife typically requires three years of training; going on to become a supervisor/trainer requires a one year training of trainers

program and should require at least one year of clinical experience before entering that program. Thus, it would take a site that currently has no midwife five years to reach sustainability. On the other hand, a site with a practicing midwife could achieve sustainable staffing in one year. Districts that currently have students in midwifery training would require from two to four years.

Division of Responsibilities in Developing Sustainable Services

The final sustainability strategy will be reflected in MOPH service delivery and staffing policies. The responsibility for implementing sustainable MCH/FP services will be divided among the OFC Contract, the MOPH, the governorate Health Office, and the community. The division of responsibility at a particular site will be clearly spelled out in a "partnership agreement." Before being included in the OFC Contract, each site will have to meet the requirements set forth in the agreement. (See the section on Performance-Based Programming.) When the community has met the conditions, all the other resources will be mobilized. The following is a typical Health Center Partnership Plan as it relates to sustainable staffing:

- The Community will:
  - bring forth candidates to be trained in order to round out the sustainable staffing pattern of two midwives and six[2] FPHCWs/Community Midwives
  - provide living accommodations for the temporary trainer
  - provide living accommodations for trainees from other villages, as needed
  - contribute to the living expenses of trainees (local solutions will be sought)
- The Health Center will:
  - provide space for training of FPHCWs (or Community Midwives at sites where the health center-based training model will be applied)
- Governorate Health Office/HMI will:
  - assure a place at the HMI for midwifery candidates
  - provide a place for lodging midwifery trainees
- MOPH will:
  - assure that the salaries of the staff trained through the partnership (only areas of need will be eligible to enter into a partnership agreement)

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[2] *A minimum of six FPHCW candidates will be required from the health center itself before the health center will be considered for participation in the partnership. However, the training class must have a minimum of 15 trainees in order for the partnership plan to go forward. The additional 9+ trainees may be associated with the health center, health units from the surrounding area, health centers in nearby districts, or from the community.*

- OFC Contract will:

  - For the first class while the local supervisor/trainer is being trained, provide a temporary supervisor/trainer for FPHCWs (or Community Midwives at sites where the health center-based training model will be applied)
  - renovate the training space for FPHCWs, as necessary
  - renovate the lodging space for female HMI students, as necessary
  - contribute partial support for the living expenses of trainees to supplement local contribution where necessary
  - renovate the MCH/FP service delivery space, as necessary
  - provide the necessary equipment and instruments for training, MCH/FP service delivery and education
  - provide TOT for midwives to become trainer/supervisors

<u>Typical Primary Health Care Unit Partnership Plan</u>

- Community will:

  - bring forth candidates to be trained in order to round out the sustainable staffing pattern of two FPHCWs
  - provide transportation for the FPHCWs to commute to the health center training site or arrange for lodging with relatives
  - commit to provide transportation (in cash or in-kind) for a monthly visit by health center personnel to deliver vaccines and medicines, pay staff, collect reports and do supervision (N.B. This part of the strategy is directed more at developing a sustainable supervision system where transportation is the major constraint than at the development of a logistics system. The community is not likely to understand the value of supervision, but will recognize the value of a regular supply of vaccines and medicines. Thus, instead of accepting the current pattern in which PHCU staff go to the health center, participation in OFC will require that health center staff go out to the units)

- Health Center:

  - assure training slots for the FPHCWs (or Community Midwives at sites where the health center-based training model will be applied)

- MOPH will:

  - assure that the salaries of the staff trained through the partnership (only areas of need will be eligible to enter into a partnership agreement)

- OFC Contract will:

  - renovate the MCH/FP service delivery space, as necessary
  - provide the necessary equipment and instruments for MCH/FP service delivery and education

Typical Community Partnership Plan (the HEAL model is used in the example for illustrative purposes)

- Community will:

  - commit to provide transportation (in cash or in-kind) for a monthly visit by health center/unit personnel to provide a mobile MCH clinic (immunization, family planning and antenatal care) (N.B. This provides an opportunity for linkages between health center/unit staff and village volunteers)
  - provide a place at which the mobile clinic and HEAL classes can be held
  - assist in recruiting literate volunteers to serve as HEAL trainers

- Health Center/Unit:

  - commit to a regularly scheduled outreach visits per month
  - Yemeni NGO (e.g. Red Crescent, Women's Union) will:
  - recruit and train literate volunteers to serve as HEAL trainers
  - supervise and supply health volunteers (in partnership with the MOPH)

- OFC Contract will:

  - provide the necessary equipment/instruments for training, MCH/FP service delivery and education.

7. PROMOTE COMMUNITY PARTICIPATION TO IMPROVE ACCESS AND SUSTAINABILITY:

Yemen is on the verge of a severe financial crisis. The recent commitment of the government to structural adjustment measures offers hope for the future recovery of the economy, but underscores the severity of the short- and medium-term problems. The only realistic view possible is that the government will not be able, for many years, to provide substantially greater internal resources for such social services as maternal and child health.

The Ministry of Public Health, recognizing this fact, is attempting to make plans to "do more with less", by, for example, decentralizing some resources and promoting involvement of the private sector in service delivery. Even these measures, however, will not be sufficient to fund even the provision of basic MCH/FP services in most Yemeni communities. The challenge, therefore, is to identify alternate funding mechanisms and means of supporting these basic levels of service delivery.

Fortunately, Yemen has a history of **community** involvement in meeting local needs. For reasons that are not well understood, the degree of community participation in the provision of social services varies widely across the country and has become weaker in many areas in recent years. Nonetheless, this tradition of self-reliance offers hope that the communities themselves can supplement the resources made available by the government, thereby improving the quality, accessibility, and sustainability of services.

The OFC Contract will support and encourage community participation in a number of ways:

1. In those areas where community participation is already well-accepted and/or being practiced, OFC will offer assistance which will encourage the channeling of community resources into maternal and child health. For example, if a community identifies and agrees to financially support a female service provider, OFC will provide the necessary training and equipment which will enable that woman to deliver services in her community.

2. OFC will investigate the variables that encourage and discourage a community to become involved in supporting health service delivery. These research results can then be applied in creating community involvement where it does not presently exist.

3. OFC will provide technical assistance to promote both the general concept of community participation and the specific application of community resources to health problems. A senior advisor has been recruited to concentrate efforts in this area, and local (i.e., from each governorate) professionals will be recruited in each governorate to work with communities and their health facilities to form productive partnerships. These personnel will suggest specific uses of community resources, assist in the development of community--health facility "partnership agreements", and assure that lessons learned in successful community participation schemes are made widely available.

8. IMPROVE MANAGEMENT SYSTEMS

As improvements are made in various components of the MCH/FP delivery system in Yemen -- such as availability of trained personnel; renovated, better equipped facilities; and better clinical practices -- it is critical that the management practices that support the system improve simultaneously. Only through improved management can better service delivery be sustained.

OFC will work with colleagues at all levels to improve management systems and practices, such as:

- Drug supply system: Many clinical facilities, especially in remote areas, are underutilized because clients often find the facilities do not have the curative drugs they need. Obviously, this breakdown in the logistics system limits the capacity of the facilities to deliver curative care; but it also limits the opportunity to provide preventive services, since potential clients do not come. OFC will work to identify the bottlenecks and other weaknesses in the drug supply system, and will suggest and/or implement possible solutions. For example, some health centers and health units are not being re-supplied because of lack of transportation from the governorate Health Office. One of OFC's community participation strategies, therefore, might be to identify a way for communities to provide transport for regular re-supply of drugs from the governorate capital. Assistance will also be provided to the small pharmacies inside health centers to improve their inventory and maintenance of drugs. At the central level of the MOPH, assistance will be provided in improving the overall management of the drug supply system; including better coordination with suppliers and limited assistance in improving storage facilities. (It should be noted that virtually all donor agencies in Yemen are including drug supply system improvements in their workplans. OFC will target its assistance activities to assure compatibility with other efforts and to avoid duplication of effort.)

- Management information systems: The OFC Contract will emphasize MIS improvements at the governorate and local levels. Too often, information systems are designed and operated primarily for the benefit of users at the national and international levels. This means that information is not readily available to the grass roots program managers who could make best use of it; and that data is of relatively poor quality, since there is little incentive for the lower- level data collectors to do their jobs accurately. OFC will assist Health Office staff in developing routine reports that can be quickly and easily produced, and which will contain key indicators of greatest interest to health center staff and management. Performance-based mechanisms will be utilized to assure that the data collection at the field level, and the analysis and reporting at the Health Office level, are carried out.

  OFC will also assist the central MOPH, in conjunction with other technical assistance agencies (including the NPC), in designing the standardized data collection

instruments to be adopted nationwide. OFC's interest will be in trying to ensure that the forms remain as simple as possible, with each item subjected to the test of "Who needs this data, and what decisions will be made based on its collection?"

- Human resource development, deployment, and supervision systems: For a discussion of this important management area, see the sections on Improvements in Quality of Services and Improvements in Human Resource Development.

- Clinic management systems: OFC will work with targeted health centers to improve their internal management. This is clearly both a management and a clinical task. The ultimate goal will be to help centers shift from a task-orientation to a client-orientation, but there are a number of intermediate steps that must be taken first. Examples include developing and implementing basic standards for cleanliness and infection prevention; routinizing basic record-keeping; re-organizing client flow and service structure where appropriate; planning, budgeting, and cost-recovery; and implementing effective staff development and supervision schemes.

EVALUATION AND APPLICATION OF LESSONS LEARNED

The OFC Contract will be evaluated in a number of ways:

1. Through periodic review of Contract progress by officials of the MOPH and NPC;
2. Through periodic evaluations, both formal and informal, by USAID/Yemen;
3. Through periodic formal evaluations by objective consultants commissioned by USAID;
4. Through ongoing internal reviews of Contract progress conducted by OFC staff.

Part of this contractual evaluation progress will be determinations of the extent to which the targeted changes in the Performance Indicators in the USAID Strategic Framework have been achieved. These evaluations should also consider the extent to which the Contract has:

- assisted targeted districts in developing an improved model for the delivery of primary health care;
- assisted targeted governorates in developing improved systems for implementing and managing such models; and
- assisted central governmental organizations (MOPH and NPC) in developing appropriate support mechanisms for these improved models and systems.

Achievement of the quantitative targets of the Performance Indicators will certainly contribute to the achievement of these more qualitative goals, and will provide important information concerning Contract performance over a five year period. But evaluations must also look beyond those Indicators to ask the larger question: "Has this Contract helped develop models that will improve the delivery of MCH/FP services in the long-term?" Addressing this question will allow us to look beyond the very brief period of

this Contract, and beyond the limited geographic scope of its work. Despite the difficulty in measuring the extent to which the lessons learned from this Contract can be applied in other governorates and beyond the year 2000, this may be the most important indication of its success.

CONTRACT ACTIVITIES TO ACHIEVE PERFORMANCE INDICATORS

Indicator 1.1: **Increased number of service delivery points (SDPs) providing integrated MCH/FP services.**

- Identify, in collaboration with Governorate Health Offices, a number of health facilities (approximately 35-40 over the life of the Contract) which will be the focus of the Contract's activities in improving service delivery. At these facilities, the positive effects on service delivery of a variety of material and technical inputs will be assessed; they will be the "hubs" for the delivery of community-based services; and they will be key members of the OFC Contract -- Health System -- Community Partnerships that will be formed to improve access to, quality of, and sustainability of services.

1995				1996				1997				1998				1999			
Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4

- Increase the number of service delivery points by: a) developing outreach programs from supported health facilities into the surrounding communities; b) establishing community-based service delivery sites supported by both an associated health facility and the community; and c) promoting the delivery of MCH/FP services by private sector providers.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Add MCH/FP services (EPI, CDD, FP, safe motherhood, ARI, health education, and nutrition) which are not presently delivered at supported health facilities (SDPs); and strengthen those services that do exist through a combination of material and technical inputs such as renovation, clinical equipment, training, outreach support and technical assistance.

1995				1996				1997				1998				1999			
Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4

- Use performance-based inputs to increase the quality and quantity of services. Better performing SDPs will be eligible to receive additional project inputs such as additional training, equipment, and furnishings.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Increase the degree of integration of MCH/FP services at supported SDPs by adding missing services (see above) and by providing the necessary training and technical assistance to move SDPs from a task- to a client/family-orientation.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Carefully document the inputs provided and the results of these efforts to improve MCH/FP service delivery, so that the costs and benefits of replication are well-established.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Indicator 1.2: **Increased number of service delivery points (SDPs) with trained female providers.**

- Improve the training capabilities of the Health Manpower Institutes in the supported governorates through material and technical assistance.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Establish model district-based training centers (located in a Health Center) for the training of FPHCWs and Community Midwives. These will be staffed by locally-based, Yemeni Supervisor/Trainers.

1995	1996	1997	1998	1999

Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Reach agreement with the central MOPH and Health Offices on adequate staffing patterns for different types of SDPs to assure that MCH/FP services can be delivered.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Study problems associated with recruitment and retention of female providers. This will be accomplished through focus groups and/or in-depth interviews in supported communities.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Conduct training-of-trainer and training-of-provider courses to assure adequate staffing at supported SDPs, and to assure future training capability. (These training sessions will be enlarged as much as possible to also include trainees from outside of supported SDPs, especially women from outside governorate capitals.)

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Establish, as part of the OFC Contract--MOPH--Community Partnership Agreements, agreement with community leadership to identify female health worker trainees and to support them after their training. This will address both the problems of shortage of trained providers and the high attrition rate of those who have been trained.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Work with the MOPH Task Force to identify and implement other solutions to human resource recruitment, training, deployment, and retention.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Provide a variety of pre-service training opportunities, in the form of short courses and on-the-job training, to increase the skills and the job satisfaction of existing providers.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Identify and test creative mechanisms to place female providers within individual communities. This might include community-based health/literacy programs, activation of trained but non-practicing providers (e.g., "retired" midwives), better use of TBAs, or training of community women to serve as MCH/FP "depot holders".

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Indicator 1.3: **Increased number of service delivery points (SDPs) with adequate supplies available.**

- Provide technical assistance to improve drug and supply inventory systems at supported SDPs.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Provide training to providers to raise awareness of the problems associated with use of out-of-date drug stocks.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Work with the MOPH and Health Offices to improve the logistics linkages between central and governorate warehouses.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Work with the MOPH and other interested donors to address procurement and logistics problems at the national level.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Establish, as part of the OFC Contract--MOPH--Community Partnership Agreements, agreement with community leadership to provide transportation of drugs and supplies where lack of MOPH transport is a problem.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Explore the possibility of linkages with private pharmacies as back-up for SDPs' drugs and supplies; as substitutes for poorly functioning SDP stores; or as re-supply channels where MOPH transport is a problem.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Indicator 1.4: Increased use of data for program decision making.

- Provide technical assistance to supported SDPs to improve the quality and timeliness of their data collection/reporting.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Provide technical assistance to governorate Health Offices in the processing and reporting of collected service statistics.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Use performance-based inputs to encourage the collection and use of data for program decision-making. For example, Health Offices which demonstrate substantial progress in sending processed reports back to SDPs might be provided with computers for analyzing data.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Work with the central MOPH and interested donors in establishing a coordinated, improved HMIS.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Indicator 2.1: **Increased awareness of the benefits of integrated MCH/FP services.**

- Provide technical and material assistance to SDPs and communities to improve general health awareness/education activities.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Develop and deliver messages to men designed to increase understanding and support for MCH/FP services.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Indicator 2.2: **Increased number of SDPs with active community involvement.**

- Study -- using surveys, focus groups and interviews -- prevailing community attitudes toward the health care system, and the availability of community resources to contribute to health care.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Assist Health Office and SDP personnel in designing and negotiating community Partnership Agreements.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Provide Contract resources -- material and technical assistance -- as part of the Partnership Agreements to encourage communities to contribute their own resources.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Monitor the implementation of the Partnership Agreements to assure compliance by all parties, and to identify and overcome bottlenecks.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Assist communities in establishing and operating representative Community Health Advisory Boards. Encourage the involvement of women.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Indicator 2.3: **Increased number of women who feel able to take care of their health and the health of their children.**

- Study prevailing MCH/FP attitudes, knowledge and practice among women in supported communities using surveys and focus groups. Determine barriers to both self-care and use of the health care system.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Adapt and/or design health awareness messages which will provide women with the knowledge necessary to care for the basic health needs of their families, both directly and through the health system as appropriate. Assist SDPs and communities in delivering these messages and providing the necessary support services.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Indicator 2.4: **Increased use of integrated MCH/FP services.**

Note: Improvements in the quality and accessibility of MCH/FP services and community awareness described above should lead to increased use of services. Therefore, the activities to achieve this Indicator are the same as those above, particularly those for Indicators 1.1, 1.2, 1.3, 2.1, 2.2, and 2.3.

Indicator 3.1: **Increased Government support for FP/child spacing.**

- Incorporate specific family planning objectives into the MOPH five-year plan. This will both demonstrate specific policy-level support for family planning as a component of larger MCH programs; and assure that program inputs specifically needed for FP will be made available. This activity will be accomplished by the MOPH in its planning process with support and guidance from the NPC.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Conduct and/or support specific population/MCH/FP awareness-raising events targeting leaders at the central and local government levels. This will include a variety of activities ranging from a "RAPID" presentation for senior government leaders, to more locally-focused seminars at the governorate level. This activity will be conducted by the NPC with material and technical input from the OFC Contract. As part of these events, or as a consequence of them, influential leaders will be encouraged and assisted in making specific public statements in support of MCH/FP programs, and in making policy decisions which provide support to those programs.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Prepare policy analyses and reports addressing specific population, MCH, and/or family planning issues or problems. The purpose of such analyses is to inform leaders and policy makers of the nature and extent of problems posed by rapid population growth, poor maternal and child status, and the special role of family planning in addressing such problems. The analyses will be prepared by the NPC with technical assistance from OFC Contract.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Indicator 3.2: Reduced policy barriers to MCH/FP services.

- Identify specific barriers to the delivery of MCH/FP services which can be wholly or partially reduced through policy adoption or reform. This identification process will be a combination of formal research, where needed, as well as the use of other mechanisms like policy dialogue with MOPH management and service delivery personnel.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Identify feasible approaches to overcoming barriers to MCH/FP service delivery. Again, this might be accomplished through formal research, or simply through creative thinking in consultation with service delivery managers and providers. Recommendations for implementing solutions will be made to the institution responsible for appropriate action, such as the MOPH or the MOPD.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- Provide appropriate support, either material or technical, for the implementation of solutions to service delivery problems.

1995				1996				1997				1998				1999			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

CRITICAL ASSUMPTIONS

The following assumptions have been made in selecting the strategic components of this Master Plan. Some are critical to the achievement of the performance targets and other objectives discussed herein. The failure of any one critical assumption to hold, with the exception of #1 and possibly #2, would not be fatal to all Contract activities. Such a failure would, however, make success in some areas of the Contract as described herein either difficult or impossible. Adjustment of Contract workplans and anticipated outcomes would thus be necessary.

1. Yemen will remain peaceful and stable.

2. USAID will continue to support a program in Yemen, and will provide the approximate level of financial resources and support services presently allocated for the implementation of the JSI Contract (as per the pending Contract modification).

3. The Government of Yemen does not have the resources at the present time to support adequate MCH/FP service delivery. (Hence the attempts to mobilize community and other private sector support in this Plan.) However, it is assumed that the level of financial, human, and material support provided to MCH/FP programs by the Government will continue to be at least as great as in 1995. Donor resources will not decrease to the extent that Yemeni government resources must be reallocated away from current support for MCH/FP to cover donor losses.

4. Political support for the OFC Project will remain strong within the MOPH and the Government of Yemen in general.

5. Most of the Yemeni communities within which the OFC Contract will operate will agree to participate in a meaningful way in MCH/FP service delivery. I.e., Contract personnel and MOPH colleagues will be able to convince and motivate community leadership to contribute local resources for health care.

6. The minimum staffing patterns at SDPs required for the delivery of MCH/FP services on-site and for outreach can and will be made available through the civil service system.

7. Cultural constraints to the training and employment of rural and peri-urban females as health care providers are not so strong that they cannot be overcome through the combination of interventions -- Contract, MOPH, and Community -- proposed in this Plan.

8. The central MOPH in cooperation with relevant donors will be able to import or otherwise provide an adequate supply of drugs, supplies, and equipment for subsequent distribution to SDPs throughout the country. Only if this basic logistics condition is met can Contract interventions to improve Governorate-level logistics be successful.

9. The central MOPH will be cooperative and supportive of some innovative approaches to health care delivery that might not be entirely under their control. Examples include involvement of NGOs in providing or managing services, use of "private practitioners" at the community level, and having Community Advisory Boards exercising substantial control over the delivery of services at the community level.

10. Improvements in the accessibility, quality, and awareness of MCH/FP services will result in greater use of these services by the Yemeni population.

STAFFING PLAN

Sana'a Office (Headquarters)

Chief of Party
MCH/FP Clinical Specialist
Senior Population Policy Advisor
Senior Nurse-Midwife
Program Specialist
Office Manager
Accountant
Secretary
Drivers (2)
Guards/cleaners (3)

Hadramaut Governorate

Resident Advisor/Training Advisor
Advisor
Governorate Coordinator
Nurse-Midwife
Community Participation Coordinator*
Secretary
Driver
Cleaner

Hajjah Governorate

Resident Advisor/Mgmt Systems

Governorate Coordinator
Nurse Midwife
Community Participation Coordinator
Secretary*
Driver*
Guard/cleaner*
at HMI: Midwifery Trainers (2)

Hodeidah Governorate

Resident Advisor/Community
Participation Advisor
Governorate Coordinator*
Nurse-Midwife*
Community Participation Coordinator*
Secretary*
Driver*
Cleaner*

Lahj Governorate

Resident Advisor*
Deputy Resident Advisor*
Governorate Coordinator*
Nurse-Midwife*
Community Participation Coordinator
Secretary*
Driver*
Cleaner*

* Vacant positions as of 1 March 1996