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Final Report

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Options For Family Care (OFC) Project

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FINAL REPORT

of

OPTIONS FOR FAMILY CARE

A Model for the Sustained Delivery of Improved MCH/FP Services

Republic of Yemen, 1995 - 1998

Contract No 279-C-00-95-00516-00

Funded by the United States Agency for International Development
and implemented by John Snow, Inc

in Cooperation with the Ministry of Public Health of the Republic of Yemen

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Executive Summary

Design and Management

The Options for Family Care (OFC) Project was originally designed and begun in 1990 in response to Yemen's alarming population growth rate (currently at about 3.7%). In the ensuing years a number of changes were made to the project, including the signing in January 1995 of the OFC contract between USAID and a U.S.-based health care consulting firm, John Snow, Inc (JSI). This contract focused on Maternal and Child Health (MCH) service delivery, integrated MCH and Family Planning (FP) in the governorates of Hodeidah, Hajjah, Hadramaut and Lahj. Assistance to Hajjah, Hodeidah and Hadramaut concentrated on three principal areas:

- a Training of additional female providers, and promoting better and more sustainable training capability in the governorates. This involved supporting the establishment of 11 decentralized training centers, supporting Health Manpower Institutes (HMI), supporting the training of new community midwives, and training of new female primary health care workers (*murshidat*) in areas where candidates did not meet the minimum requirements for midwife training.
- b Improving the capacity of selected health centers to deliver MCH/FP services by renovating facilities, providing equipment, and providing a variety of technical assistance and short-term training activities.
- c Forming partnerships among the Ministry of Public Health (MOPH) central and governorate health offices, health centers, communities, and JSI/OFC so that each party contributed specific inputs to improve MCH/FP services in the short term and sustain those improvements in the long term.

First year activities included collecting baseline data and executing a needs assessment which included selecting target health facilities. The results of this assessment guided the development of a Contract Master Plan and the 1996 Annual Workplan which in return began the process of implementation. Assistance targeted facility renovation, equipment procurement, training, clinical technical assistance, management technical assistance, and community liaison. The exception to this was in Lahj where assistance was more narrowly focused and ended in 1997.

A contract amendment was executed in September 1996 following a decision by USAID to limit its activities in Yemen. This amendment defined 15 contract indicators which were:

- Percentage of eligible children under five completing DPT/polio series at 22 Health Centers (HCs),
- Number of antenatal visits per pregnant woman at 22 Health Centers,
- Couple-years of protection (CYP) generated at 22 Health Centers,
- Number of Health Centers implementing the model that have sustainable female staffing,

- minimum quality standards, and communities participating,
- Detailed report/evaluation of the model prepared and distributed to MOPH and donor community,
- Number of decentralized training centers operating,
- Number of trainees nominated by communities which will contribute to their support
- Number of trained female providers in place at 22 Health Centers,
- Number of centers passing inspection for minimum quality of facility and equipment,
- Number of Health Centers following minimum clinical and management protocols,
- Average number of months that ORS is out of stock at 22 Health Centers,
- Average number of months that iron folate is out of stock at 22 Health Centers,
- Average number of months that oral contraceptives are out of stock at 22 Health Centers,
- Number of Community Participation Agreements (CPAs) signed and operational,
- Number of Health Centers adopting and implementing more effective user fee systems

Management and staffing of the contract consisted of a headquarters office in Sana'a staffed by a Chief of Party, Clinical Advisor, Senior Nurse Midwife, and a number of locally-recruited technical, administrative, and support staff. For the first eighteen months (March 1995 - September 1996) of the contract, the Sana'a staff also included a Senior Population Policy Advisor, who provided technical assistance to the National Population Council (NPC).

Four offices were also established in the target governorates, with a staff led by a senior advisor who had both overall responsibility for governorate activities, as well as responsibilities for specific technical areas, centrally and in all governorates. Each governorate senior advisor was assisted by a locally-recruited staff consisting of 1) Governorate Coordinator, with general responsibilities for activities in the governorate and specific duties depending on training and experience, 2) Community Participation Coordinator, with responsibility for community liaison, 3) Nurse Midwife, with responsibility for clinical technical assistance, and 4) support staff.

The four principal subcontractors to JSI were AVSC International, International Health and Development Associates (IHDA), the Program for Appropriate Technology in Health (PATH), and World Education, Inc (WEI).

The Development and Implementation of the MCH/FP Health Center Improvement Model

The MCH/FP Health Center Improvement Model is a set of inter-related components designed to address specific weaknesses in the health care delivery system, recognizing that MCH/FP services could be improved in three areas: inadequate numbers of service providers (especially female providers), inadequate facilities, equipment, and clinical and management practices, and lack of community participation in the local health care system.

Sustainable Female Staffing

Model development and implementation included the training of female health care providers to address the lack of such providers in much of rural Yemen. Training activities began in 1995.

with OFC participation in the MOPH Community Midwife Training Task Force. This was followed by the selection of 11 decentralized training sites which were then renovated and equipped with clinical and training equipment and furnishings. Approximately 20 trainers also attended a three month Training of Trainer (TOT) conducted by MOPH, with partial OFC support.

Almost 700 candidates applied for the 220 places available in the community midwife and female primary health care worker (*murshidat*) training programs. Candidates were selected through a process that included meeting minimum criteria established by MOPH and successfully completing an entrance test and an interview conducted by governorate selection committees which included a Health Office administrator, MCH Director, HMI staff, and representatives of the central MOPH/ MCH section. It was important that the selection process be transparent, and that the MOPH and HMI be responsible for applying criteria and selecting the candidates.

Training began immediately after the completion of the TOT workshop in April 1997. It was critical to maintain the quality of the training program and to do this a team approach was used. The OFC governorate teams support many of the logistical and management aspects of the program, while two Sana'a based training supervisors oversaw the theoretical and practical aspects of the training program. Significant attention was given to supporting the trainers given the lack of a fully-developed curriculum and the trainers' relative inexperience.

Practical experience in delivering babies was crucial. Therefore, it was necessary to temporarily move groups of trainers and trainees to higher volume delivery facilities, such as urban hospitals. The trainees at each center were divided into two groups and each group moved to the temporary sites for one to three months, depending on the volume of deliveries. One group stayed at the "home" center to continue to provide MCH/FP services. This was necessary in many centers in Hajjah and Hodeidah where the trainers and trainees were the only MCH service providers.

After the training program began the MOPH extended its length to April 1999. OFC staff worked closely with MOPH in 1998 to plan and arrange so that the graduates would be hired immediately upon completing the course and being certified by HMI/Sana'a.

OFC worked with each community to ensure they were part of the recruitment process, that they understood the OFC program and supported it, and supported the training of potential female providers. A tool known as a Community Participation Agreement was developed and signed by all parties to ensure everyone understood and supported the OFC project locally. Under these agreements, communities contributed approximately 25% of each trainees' monthly stipend and provided inputs such as food, transportation, and accommodations for trainees and trainers. By the end of the contract, approximately 200 trainees were attending the training program.

Improved Quality Standards

The second component of the Model was to assist health centers to meet minimum quality standards. The three strategies used to achieve these standards were improved refresher training

capacity, improved health facilities and equipment, and improved clinical and management practices

Initially, the main activity to improve refresher training was the development of governorate training teams who then implemented an in-service training strategy which led to improvements in the skills of the providers, and consequently improved service quality. Clinical workshops were also developed and provided in Acute Respiratory Infection treatment, HMIS management and midwifery skills upgrade. In 1997, the focus of in-service training shifted from off-site workshops to on-site, mini-workshops and on-the-job training. This was in response to inadequate improvement in provider skills and the quality of services, which had been the rationale and anticipated result of the off-site refresher workshops.

Strategy two was to improve the health center facilities and equipment. A basic list of equipment was prepared for procurement based on the assessment of the health facilities. The clinical and training equipment was procured from the US for 22 Health Centers and 60 health units, where community midwives would practice upon graduation. U.S. procurement took approximately one year. Furnishings such as desks, tables, etc. were purchased from local Yemeni manufacturers.

Thirty one facilities (Health Centers, MCH centers, HMIs and HMI hostels) were renovated. The purpose of the renovation was to provide adequate space to accommodate all basic MCH/FP services including prenatal care, family planning counseling and services, child health, delivery, pre- and post-delivery, health education, immunization, registration, and waiting. (Some health centers received additional renovation in order to function as training centers.) The process included an assessment and discussion of needed changes, preparation of plans and specifications, bidding, the physical renovations which included supervision, final inspection, and certification.

Clinical and management improvements were the third strategy used to improve the quality of care. OFC activities focused on priority problem areas of infection prevention, family planning, antenatal care, diarrheal diseases, immunization, record keeping, drug supply and user fee, and developing and introducing protocols. Technical assistance (TA) was provided in using protocols and problem solving, supervising and monitoring, and evaluating improvements at the health centers on an ongoing basis.

Protocols, checklists, and guidelines were developed and introduced for delivery, antenatal care, vaccination, diarrhea control/Oral Rehydration Salts (ORS), family planning, postpartum care, infection prevention, registration and record keeping. Technical assistance emphasized areas most in need of improvement and those which would have the largest impact on improving the quality of service. These areas included infection prevention, antenatal care, and family planning counseling. Technical assistance in outreach strategies was also provided, particularly during the final year of the contract, and had a positive impact on improving the providers' performance and increasing the quality of services.

Two checklists were developed to monitor and measure the quality of care. One was developed to monitor the facilities and furnishings and the second was used to monitor the quality of services. The latter used the clinical protocols and checklists to evaluate performance. Both checklists were useful in supervising performance and providing technical assistance.

Management improvements sought to support MOPH initiatives, establish teamwork, strengthen supervision, introduce guidelines, strengthen community involvement and improve the integrated management of MCH services. Attention was initially focused on establishing an improved MCH HMIS. The introduction of a reliable HMIS system was important to improve the monitoring and analysis of information by providers and decision makers and to establish the HMIS as a basis for health center planning and management decision-making.

Thereafter, management training was an important focus of activities. Training was targeted on those issues that most directly address the quality of services, and the organizational relationships that supported those services. Working with the Director Generals in each of the three OFC Governorates, lesson plans were developed for a five-day health center management workshop for health center directors, MCH directors, Health Office staff and community leaders. The workshop design was based on the findings of the original needs assessment and addressed roles and responsibilities of Health Centers, Health Center supervision and team building, job descriptions, problem solving, priority setting and planning. A management evaluation was conducted and a one page report was distributed to all centers identifying both strengths and areas requiring improvement.

A full cost sharing program was delayed pending the ROYG parliamentary approval of the MOPH cost sharing program. OFC therefore began a pilot user fee system. This began with a rapid, in-depth examination of fee collections at the Health Centers. Discussions were then held with the Director Generals of the Health Offices and based on these discussions a workshop was developed and conducted at each health center. This user fee system was subsequently implemented at 85% of the centers in Hajjah and Hodeidah. Implementation in Hadramaut was delayed pending the receipt of written approval from the Director General. This written authorization was requested by the seven Health Center Directors.

Increased Community Participation

Component three of the model included three objectives which were: 1) to identify methods and mechanisms for community support, 2) to develop, implement, and monitor Community Partnership Agreements which identified the roles and responsibilities of OFC, the community, the health center, and the governorate Health Office in improving the quality and quantity of MCH/FP services, and 3) to facilitate the establishment of local health committees to support Health Centers.

Activities undertaken included raising community awareness of the benefits of MCH/FP and soliciting support for MCH/FP activities, identifying the Health Center and the Health Office inputs, assisting communities in developing a plan for supporting MCH/FP, preparing and

signing Community Participation Agreements (CPAs), and monitoring the performance of all parties in fulfilling their commitments under the agreement

Contract Performance

Contract performance as measured by the contract indicators was very good. Fourteen of the contract indicators had one target for end of contract performance. An additional indicator (#2) had three sub-targets, for a total of seventeen targets. Fifteen of these seventeen indicator targets were met or exceeded. Of the two that were not met, one (Indicator #2 for Hajjah) reached 53% of the target value, and the other (Indicator #3 2) reached 55% of the target value.

Replication

Based on the experience gained in developing and implementing the MCH/FP Health Center Improvement Model in the OFC/JSI contract, we believe that the Model is generally replicable in Yemen (although best with certain modifications and provisos), and that the MOPH and other donor agencies and NGOs would be well served in adopting the basic Model as a guide for improving health care service delivery.

I Background

A. Health Sector Setting

The Republic of Yemen is a poor country in comparison to other Arab countries, and has relatively few resources to devote to health and other development issues. With a population of nearly 16 million, a Total Fertility Rate of 6.7¹, a growth rate of 3.7%, and current use of modern contraceptives at 8 - 9%¹, it has one of the world's fastest growing populations.

Yemen's dependency ratio is the highest in the Arab world and extremely unfavorable to economic development. This is especially true with the decline in the national economy that began in 1991 with the repatriation of close to a million Yemenis from the Gulf countries and the loss of associated remittance income. While education continues to expand, literacy remains low, especially among women (16%). The segregation and seclusion of women has greatly restricted their access to education, health care and other social services, generally impeding their development and that of the country.

The Republic of Yemen government (ROYG) and the current Ministry of Public Health (MOPH) administration have given high priority to improving the quality and quantity of basic curative and preventive health services. Particular attention has been given to improving maternal and child health care (MCH). Despite these policies, improved MCH care is hampered by a number of constraints, including lack of resources, and weak administrative and management capacities at central, governorate, and district levels.

The quantity and quality of health care is inadequate due to the lack of trained, qualified staff (especially female health care providers), a shortage of essential drugs, and inadequate clinical facilities and equipment. Only about 30 - 40% of the largely rural population is currently served by existing health facilities.

Between the 1991/92 and the 1997 DHS surveys, there have been a decline in total fertility, increased use of contraception, and increases in antenatal care and in trained attendance at deliveries. However, fertility remains high, family planning use low, and pregnancy and delivery continue to be risky. Child health indicators such as immunization rates are also especially troublesome. The percentage of children immunized actually declined between 1991/1992 and 1997.

On the other hand, new leadership in the Ministry of Public Health has committed itself to dramatic health sector reform, including the decentralization of a weak and highly centralized health bureaucracy, reforming the drug supply systems, introducing cost sharing, forging public/private partnerships, and pushing both authority and resources to the district level. These

¹ According to the preliminary April 1997 Demographic and Maternal and Child Health Survey

anticipated reforms offer hope that Yemen's health care system, now heavily dependent on donor resources, can begin to move toward greater self-sufficiency and higher quality

B Options for Family Care (OFC) Project Description

The focus of USAID/Yemen health care support for almost twenty years has been on strengthening ROYG capacity in effective delivery and management of maternal and child health and family planning. This began in 1980 with the Tihama Primary Health Project and was followed in 1986 with the Accelerated Cooperation for Child Survival (ACCS) Project.

The Options for Family Care (OFC) Project originally began in 1990 in response to the alarming population growth rate that was identified during studies undertaken with USAID assistance in the late 1980's. In response to major political, economic and social changes resulting from unification and the Gulf War, and political decisions in the U.S. to reduce assistance to Yemen, major administrative and technical modifications were made to the OFC Project in 1991 and 1992. During this period, bridging activities were implemented using buy-ins from centrally-funded projects for clinical renovations, awareness raising, and health education materials development. Late in 1992, USAID conducted a situation analysis which identified a number of weaknesses affecting the provision of family planning services. They included inadequate funding of the health sector, a lack of leadership, planning, coordination and management capacity, a lack of public awareness of the importance of MCH/FP, and a lack of trained (especially female) health care providers.

This review, and subsequent discussions with the MOPH, resulted in further modifications to the OFC Project in 1993, concentrating on the delivery of MCH/FP services and related MCH/FP policies. A subsequent 1994 Request for Proposals resulted in OFC contract number 279-C-00-95-00516-00 being awarded to a U.S. health care consulting firm, John Snow, Inc. (JSI), in January 1995. A second project paper supplement was authorized in 1995 which increased the funding level, focused on MCH service delivery, added emphasis on integrating MCH and FP, and authorized geographic expansion to five governorates.

The final substantive OFC modification was made in September 1996 when USAID closed the USAID/Yemen Mission. This resulted in a reduced JSI/OFC contract scope of work, as well as a shorter (3¾ year) contract duration.

The final re-designed project focused on improving maternal and child health services in four governorates: Hajjah, Hodeidah, Hadramaut, and Lahj. (Because of budget limitations, assistance to Lahj was not to be as extensive as assistance to the other three governorates. It consisted of limited training, facilities renovations, and providing clinical equipment and furnishings, and ended on September 30, 1997.) In Hajjah, Hodeidah and Hadramaut, project assistance concentrated on three principal areas:

- a Training of additional female providers, and promoting better and more sustainable training capability in the governorates This involved supporting the establishment of 11 decentralized training centers, supporting Health Manpower Institutes (HMI), supporting the training of new community midwives, and training of new female primary health care workers (*murshidat*) in areas where candidates did not meet the minimum requirements for midwife training
- b Improving the capacity of selected health centers to deliver higher quality MCH/FP services by renovating facilities, providing equipment, and providing a variety of technical assistance and short-term training activities
- c Forming partnerships among the MOPH (central and governorate health offices), health centers, communities, and JSI/OFC so that each party contributed specific inputs to improve MCH/FP services in the short term and sustain those improvements in the long term

Substantial achievements in these three areas combined to demonstrate a “MCH/FP Health Center Improvement Model” that can be adapted and applied to other parts of the country using MOPH, donor, and community resources

C USAID/Yemen Health Sector Special Objective

The Goal and Purpose of the USAID Options for Family Care Project (OFC) are

Goal "To improve Yemeni family health and welfare", and

Purpose "To increase use by Yemeni women and children of health services in up to five targeted governorates"

As mentioned above, the design, planning and procurement processes for this contract had been underway for some time and had been through a number of iterations By late 1995, USAID/Washington and USAID/Yemen had developed and agreed upon a Strategic Framework for the Mission The Strategic Objective of this Framework was “To improve maternal and child health and increase contraceptive prevalence ”

During this time period, USAID began to experience a world-wide funding crisis Project and operating expense budgets were cut, many USAID Missions around the world were closed, and plans were made to close additional Missions In April 1996, USAID announced plans to close the Mission in Yemen by September 30, 1996 In August 1996, USAID/Washington in consultation with USAID/Yemen and USAID/Cairo, decided to continue the OFC activity until September 1998 after closure of the Mission

The Strategic Framework and Objective were consequently modified in August 1996. The newly modified Strategic Framework was guided by the newly developed **Health Sector Special Objective**

“Improved quality and use of integrated MCH/FP services in 22 health centers in three governorates ”

Also part of the revised Strategic Framework, supporting the Special Objective, were the following intermediate and lower level results

Intermediate Result

“‘Health Center Improvement’ model in 22 Health Centers in three governorates established and documented”

Lower Level Results

- 1 “Sustainable female staffing established in centers in three governorates”
- 2 “Minimum quality standards for centers in place in four governorates”
- 3 “Community and individual participation increased in three governorates”

D Consistency with MOPH Priorities

The OFC Project was designed by USAID in collaboration with colleagues from the Ministry of Public Health, and was thus consistent with MOPH priorities for improving MCH/FP service delivery from the outset. These priorities included increased availability and training of female service providers, improved quality of facilities and equipment, improved clinical practices, better supervision, improved management practices, and increased community involvement in the overall effort to deliver health care services. While these MOPH priorities remained constant during the life of the OFC contract, the relative emphases and means of implementing priorities changed with time and changes in MOPH personnel. The OFC contract team made up of USAID, JSI, and MOPH staff worked to ensure that contract activities remained consistent with MOPH thinking as it evolved. For example, in 1995 the MOPH developed a decentralized midwife training strategy to increase the number of female health care providers available in underserved areas around the country. OFC became a major participant and funder of this strategy through the support and management of community midwife training at eleven training centers. Changes in the Ministry of Public Health key personnel after the April 1997 national elections resulted in increased interest and commitment to various areas of health care reform, including decentralization of authority and resources, and cost recovery schemes. This was entirely consistent with the original OFC contract scope of work and the OFC team was able to provide information, support, and some resources to the new MOPH leadership in these areas.

II. JSI Contract. Activities and Results

A Start-up, Planning and Initial Activities

Nearly all activities under the JSI contract were related to the demonstration of the MCH/FP Health Center Improvement Model, which is described fully in sections III - VI of this report. This section describes contract activities and results, how they were staffed and managed, and some early activities not directly related to the MCH/FP Health Center Improvement Model. As described in previous sections, the OFC project underwent a number of changes in 1995 and 1996, which in turn created some uncertainty for contract activities until the Health Sector Special Objective and the Strategic Framework were finalized and contract amendment number 2, focusing on the MCH/FP Health Center Improvement Model, was signed in September 1996.

Initially, the contract environment had been somewhat fluid. In January 1995, shortly after signing the contract, USAID and JSI had expected to amend the contract to reflect changes USAID was contemplating to its Strategic Framework. When this did not happen in a timely manner, the OFC team, made up of USAID, MOPH, NPC, and the JSI team, planned and implemented contract activities based on the likely nature of the anticipated contract amendment. After an initial team building process, which included the development of the first year's workplan, the OFC team focused on conducting a needs assessment and baseline data collection exercise in the governorates identified for OFC concentration.

One of the first contract tasks was to select target health facilities in collaboration with USAID and the MOPH. Criteria for this selection was developed by the OFC team (JSI, USAID, and MOPH) and included a center's need for OFC assistance, geographic distribution within the governorate, expressed willingness of center staff to collaborate with OFC, and (in some cases) history of USAID assistance. The following centers were selected:

Hadramaut	Mukulla Hospital MCH Center, Al Shahel Hospital MCH Center, As Shuheir Health Unit, Al Hami Health Center, Ghail Bawazir Health Center, Addis Al-Sharkiya Health Center, Seyoun Hospital MCH Center (added later as training site)
Hajjah	At Tur Health Center, Al Moharaq Health Center, Kuaydinah Health Center, Mabyan Health Center, Mahabisha Hospital MCH Center, Shagadirah Health Center, As Shahel Health Center, Hajjah Hospital MCH Center
Hodeidah	Bait Al Faqih Hospital MCH Center, Al Zohorah Health Center, Al Qutar Health Center, Marawa'a Health Center, Al Dahi Health Center, Bajil Health Center, Al Thowra Hospital (MCH referral center)
Lahj	Al Houta Health Center, Al Daleh MCH Center, Al Habilein Health Center, Tour Al Baha MCH Center, Al Waht MCH Center, Habil Gabr MCH Center

The assessments identified the particular needs and characteristics of each center which helped to determine the types of assistance that were needed, planned, and subsequently provided. Planning, scheduling, and implementation of this assistance was begun, including facility renovation, equipment procurement, clinical technical assistance, management technical assistance, and community liaison. At the same time, planning and implementation for the project's extensive training activities commenced. All of these activities are described in detail in sections III and IV of this report.

More broadly, the result of these efforts was the Contract Master Plan and the 1996 Annual Workplan. Both of these documents were developed in close collaboration with USAID, and MOPH colleagues, and guided contract implementation through the first half of 1996.

Fortunately, many contract activities, areas of geographic focus, and the project staffing pattern remained valid throughout this period. It was clear from the inception of the contract that work would concentrate on selected health facilities in Hadramaut, Haggah, and Hodeidah governorates. (Soon after the inception of the contract, USAID directed the OFC/JSI team to begin providing assistance to Lahj governorate as well. Lahj assistance continued through September 1997, and consisted of facility renovations, equipment provision, and more limited technical assistance and training - all aimed at improving the quality of clinical services.)

From the beginning, emphasis was placed on improving services in rural facilities, although the original contract called for the establishment of an urban MCH referral center in each governorate. The technical focus was to be on improving the quality and quantity of basic maternal/child health and family planning services clinically and managerially. It was recognized that a major element of improved service delivery would be to increase the number of female health care providers, thus requiring a strong training initiative. The progression from the original 1995 project design to that of the MCH/FP Health Center Improvement Model did not, therefore, require major conceptual changes. The most important change was to give more emphasis to increasing community participation, while continuing the existing emphasis on training and service quality improvement, and recognizing that integrating these three elements would, together, have a larger impact on improving the health of women and children.

Contract amendment number 2 was finalized and signed in October 1996 by JSI/Boston and the Regional Contracting Officer from USAID/Cairo. Although narrower and of shorter duration, the scope of work of the amended contract was largely consistent with the work that the OFC/JSI team had been implementing over the first eighteen months of the contract.

B The Amended Contract Scope of Work and Associated Performance Indicators

This section presents the special objective, intermediate result, and three lower level results with associated contract indicators used to measure OFC/JSI contract performance. Baseline measures were taken for 1995, largely from health center records, and targets were set for the year 1998. This established the basis for measuring progress and setting priorities throughout the remaining life of the project. The results of annual contract performance for each indicator is presented in Section VI.

Health Sector Special Objective Improved quality and use of integrated MCH/FP services in 22 Health Centers in three governorates

Indicator 1 Percentage of eligible children under *five* completing DPT/polio series at 22 Health Centers (*Target 6%*)

The MOPH immunization management/tracking system collects and monitors data on children under *one year old*, **not under five years old**. This fact was overlooked in August 1996, when this indicator was established. It was not possible to change the MOPH national HMIS standards for the convenience of the OFC contract, nor was it efficient or possible to ask 22 health centers to collect additional data only for one OFC contract indicator. Therefore, OFC established a proxy indicator in line with the MOPH policy and data collection standards, of tracking immunization of under one year olds. To account for the difference, the number of under ones was estimated in relation to the population of under fives to establish the percentage of under ones which would be equivalent to 6% of the under five year old population. A 6% increase in under fives was determined to be equivalent to 17.5% of under ones, therefore,

Proxy Indicator 1 Percentage of eligible children under *one* completing DPT/polio series at 22 Health Centers

Baseline 1995	Target 1998
13.60% (8,053 immunizations)	17.50%

Indicator 2 Number of antenatal visits per pregnant woman at 22 Health Centers

Baseline 1995	Target 1998
Hadramaut 3.65	Hadramaut 4.00
Hajjah 1.85	Hajjah 3.00
Hodeidah 2.13	Hodeidah 3.00

Indicator 3 Couple-years of protection (CYP) generated at 22 Health Centers

Baseline 1995	Target 1998
4,186	5,442

Intermediate Result

MCH/FP Health Center Improvement model in 22 Health Centers in three governorates established and documented

Indicator 1 Number of Health Centers implementing the model that have sustainable female staffing, minimum quality standards, and communities participating

Note In order for a center to meet this indicator it must meet the requirements of Indicator 2 1, Facilities and Equipment (achieving a rating of 60% or better), Indicator 2 2, Quality of Clinical Service (achieving a rating of 60% or better), Indicator 3 1 Community Participation (having a signed community participation agreement), and, LLR indicator 1 3, have female health care providers

Baseline 1995	Target 1998
0	12

Indicator 2 Detailed report/evaluation of the model prepared and distributed to MOPH and donor community

Baseline 1995	Target 1998
0	1

Lower Level Results

Lower Level Result 1 Sustainable female staffing established in centers in three governorates

Indicator 1 1 Number of decentralized training centers operating

Baseline 1995	Target 1998
0	9

Indicator 1 2 Number of trainees nominated by communities which will contribute to their support

Baseline 1995	Target 1998
0	400

Indicator 1 3 Number of trained female providers in place at 22 Health Centers

Baseline 1995	Target 1998
63	132

Lower Level Result 2. Minimum quality standards for centers in place in four governorates

Indicator 2 1 Number of centers passing inspection for minimum quality of facility and equipment

Baseline 1995	Target 1998
0	28

Indicator 2 2 Number of Health Centers following minimum clinical and management protocols

Baseline 1995	Target 1998
0	20

Indicator 2 3 Average number of months that ORS is out of stock at 22 HCs

Baseline 1995	Target 1998
3 36	1 00

Indicator 2 4 Average number of months that iron folate is out of stock at 22 HCs

Baseline 1995	Target 1998
6 80	2 00

Indicator 2 5 Average number of months that oral contraceptives are out of stock at 22 HCs

Baseline 1995	Target 1998
1 39	0 50

Lower Level Result 3 Community and individual participation increased in three governorates

Indicator 3 1 Number of Community Participation Agreements signed and operational

Baseline 1995	Target 1998
0	22

Indicator 3 2 Number of Health Centers adopting and implementing more effective user fee systems

Baseline 1995	Target 1998
0	22

C The Approved Workplan

The complete 27 month Workplan approved in September 1996 is provided as an attachment and covers the period from July 1996 to September 1998. A **summary of the approved workplan** follows below

Lower Level Result 1.1 Sustained female staffing established in centers in three governorates

Program Strategy	Outputs	Target	Activities
Improve decentralized training (pre-service)	Operating decentralized training centers	9 centers	<ul style="list-style-type: none"> a Renovate and equip training centers b Provide temporary supervisors/ trainers c Recruit trainees from community d Support training of local supervisor trainers e Support training of trainees f Assist MOPH/ Health Office in developing support of graduates g Assist HMIs to improve capacity to train and supervise training h Document this portion of the model how it works, what it costs, problem areas
Involve community in training	Communities at the district and subdistrict level actively nominating trainees	400	<ul style="list-style-type: none"> a Raise community awareness of importance of MCH/FP and solicit support b Develop and sign community partnership agreements c Assist communities in identifying and selecting trainees, developing support plans for training centers and trainees and in developing support plans for graduates

Lower Level Result 1 2 Minimum quality standards for centers in place in four governorates

Program Strategy	Outputs	Target	Activities
Improve Refresher training capacity and implementation	Trained in service teams	4 teams of 10 trainers each	a Train training teams b Assist training teams in developing lesson plans and training strategies c Support in-service training in the field
Improve health center facilities and equipment	Health centers meet minimum standards for facilities and equipment	28 centers	a Identify health center needs for renovation and equipment b Procure and distribute appropriate equipment c Conduct any needed training in the use of equipment d Renovate facilities e Inspect renovated facilities and use of new equipment
Improve clinical and management practices	Health centers following basic clinic and management protocols	22 centers	a Focus on priority problem areas for OFC intervention, Infection prevention, FP, ANC, CDD, Immunization, Record keeping, drug supply, user fees b Develop and introduce protocols as appropriate c Provide TA in use of protocols and in solving priority problems d Evaluate improvement at health centers

Lower Level Result 1 3 Community and individual participation increased in three governorates

Program Strategy	Outputs	Target	Activities
Promote community, health center, health office cooperation to improve MCH/FP services	Increased community contributions to MCH/FP services which is complementary to health center and health office inputs	22 communities	<ul style="list-style-type: none"> a Raise community awareness of improving MCH/FP and solicit support b Determine health center and health office inputs c Assist communities in developing a plan for MCH/FP support d Prepare CPAs and obtain signatures of parties e Monitor the performance of all parties in implementing their agreements f Document this portion of the model how it works, what it costs, problems areas
Promote the adoption of rational user fee system	Rational user fee system in use	22 centers	<ul style="list-style-type: none"> a Determine current user fee policies at the health office and health centers b Assist health office in developing rational user fee system c Assist health centers in adopting the health office system d Assist health centers in budgeting and managing user fee revenues

Section III Description of the Model, and Section IV Development and Implementation of the Model, provide a complete and detailed analysis of the workplan activities. The organization of these sections follows the workplan outline.

D Staffing and Organization

The original staffing pattern remained largely intact for the life of the contract. The Chief of Party, Clinical Advisor, Senior Nurse Midwife, and a number of locally-recruited technical, administrative, and support staff were based in and worked out of the Sana'a headquarters office. For the first eighteen months (March 1995 - September 1996) of the contract, the Sana'a staff also included a Senior Population Policy Advisor (expatriate), who provided technical assistance.

to the National Population Council (NPC) This assistance was designed to improve the policy environment for family planning and related issues, and to carry out specific activities to increase official and public awareness of population issues

Offices were also established in four target governorates, with a staff led by a senior advisor who had both overall responsibility for governorate activities, as well as responsibilities for specific technical areas, centrally and in all governorates Initially, the Training Advisor was assigned to Hadramaut governorate, the Management Advisor to Hajjah, and the Community Participation Advisor to Hodeidah Each governorate senior advisor was assisted by a locally-recruited staff consisting of 1) Governorate Coordinator, with general responsibilities for activities in the governorate and specific duties depending on training and experience, 2) Community Participation Coordinator, with responsibility for community liaison, 3) Nurse Midwife, with responsibility for clinical technical assistance, and 4) support staff Lahj governorate had a smaller staff, consisting of a locally-recruited senior advisor and a governorate coordinator (The Lahj senior advisor, an experienced female physician, later joined the Sana'a staff as Clinical Specialist, when assistance to Lahj ended in 1997) See attachments for an organization chart of the OFC contract

Physically, the Hajjah and Hodeidah governorate offices were located inside the governorate Health Office, in space provided by the MOPH The OFC Lahj office was located at the Lahj Health Manpower Institute The Hadramaut office had to be rented locally, since the MOPH did not have adequate office space in Mukulla to provide OFC an office The placement of offices in or near the Health Offices was deliberately designed to maximize the interaction and collaboration between MOPH and contract staff

Subcontractor Support

The principal subcontractors that assisted JSI in implementing the contract were AVSC International, International Health and Development Associates (IHDA), the Program for Appropriate Technology in Health (PATH), and World Education, Inc (WEI)

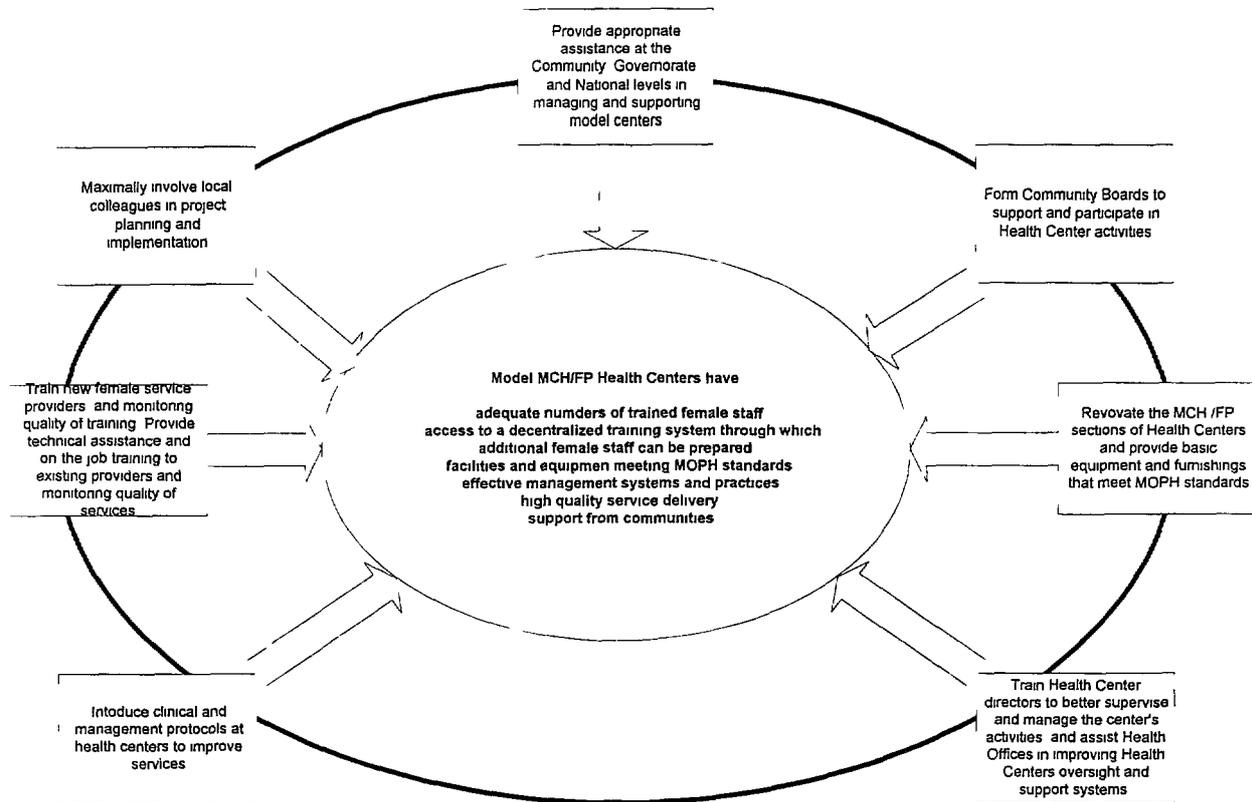
III Description of the MCH/FP Health Center Improvement Model

The following three sections describe the Model as developed and implemented under John Snow Incorporated's contract with USAID. A separate document, "The MCH/FP Health Center Improvement Model," was written, produced and disseminated as part of JSI's deliverable contract responsibilities. The description of the model in this final report differs from that described in the "Model" document. This narrative is more descriptive of the activities JSI undertook in implementing the 1996 - 1998 contract workplan. Conversely, "The Model" document is for a broader audience less interested in the details of the contractor's performance in implementing and fulfilling contract obligations, it provides a more generic overview of the model, what worked, constraints encountered, and lessons learned.

This MCH/FP Health Center Improvement Model was designed not only to improve quality and use of MCH services during the term of USAID assistance, but also to develop and demonstrate a Model that could be used by the MOPH in future efforts to continue to improve maternal and child health. The Model is a set of inter-related components, each composed of numerous sub-activities, that can result in higher quality and more sustainable MCH services at health centers. The Model was designed to address specific weaknesses in the health care delivery system in a synergistic fashion, recognizing that MCH/FP services in towns, villages, and rural areas can be improved in three areas: inadequate numbers of service providers (especially female providers), inadequate facilities, equipment, and clinical and management practices, and lack of community participation in the local health care system. Since these weaknesses are related, efforts to improve one of them in isolation from the others would not be effective. For example, newly trained providers must have adequate facilities in which to work, community support is required for maintenance of facilities, and higher quality services are required to generate community support and to achieve better utilization of the MCH/FP services by the clients.

Thus, the Model is a system in which the inputs reinforce one another so that the outputs and benefits are greater than the sum of their parts.

MCH/FP HEALTH CENTER IMPROVEMENT MODEL



The demonstration of the Model in the OFC contract consisted of three sets of activities, or components, designed to improve the delivery of MCH services

1 **Establish a sustainable training mechanism for increasing the number of female MCH service providers at eleven training centers in three governorates**

Eighty-five percent of the Yemeni population lives in rural areas where there is a general lack of female health care providers at a limited number of rural health centers. Given the cultural preference for females to seek services from female health care providers, increasing the number of such providers is essential to enhancing women's access to services. Thus, the first component of the Model is to establish a mechanism through which additional female providers can be trained. This component was designed so that the training could be done in decentralized training centers, consistent with the decentralized training approach of the MOPH National Midwifery Training Plan. Once established and equipped, these centers could then be used over time for additional training activities, such as to train additional providers for other nearby health centers or

health units, or to replace providers lost to attrition. The training centers must be supported by management and supervisory systems at the central and governorate MOPH and HMI, including the provision of adequately-prepared trainers and training materials, a standardized curriculum, and the close supervision and support of the training process. The community participation component of the Model is very important to the success of this training component, since communities are called upon to provide a variety of support to the training process.

2 Improve the quality of facilities, equipment, and standards of care at health centers

Except for the relatively few facilities that have enjoyed extended periods of donor support, the typical rural health care facility in Yemen requires improvements in the quality of the facilities, equipment and standards of care. The number of providers needs to be increased through quality pre-service training, and those that are present require quality in-service training and continuing education, motivation and supervision. Clearly, improving quality must be an essential element of any attempt to provide health care services. Thus, this component of the Model is concerned with quality improvement in a variety of important areas, including renovation of facilities, provision of basic equipment, and provision of a variety of short-term training, technical assistance and supervision to increase the quality and management of services.

Activities undertaken as part of this component included renovating facilities, providing clinical equipment and furnishings, and providing a variety of short-term training and technical assistance to improve the quality of clinical services and management.

3 Promote community and individual participation to improve and sustain health center training, clinical service, and management activities

The Government of Yemen, through the Ministry of Public Health, wishes to provide basic health care services to the people of Yemen. Since government resources are limited, the MOPH five year plan indicates that Yemeni communities must take much greater responsibility for, and contribute their own resources to the task of, improving their health. In this component of the Model, communities are requested to take on this responsibility and to contribute resources to support specific health center activities, such as the decentralized training component of the Model. Communities are provided with guidance and support during this process, but are ultimately expected to independently manage their inputs to the health care system with the assistance, guidance and coordination of MOPH. The Model utilizes a mechanism called the Community Partnership Agreement to formally establish a partnership among the MOPH (central and governorate health offices), health centers, communities, and the donor-funded project. This written agreement specifies how each party will contribute specific inputs to improve MCH/FP services in the short term and sustain those improvements in the long term.

Other important activities of this component include encouraging the formation of community health committees and conducting training workshops to enable committees to identify problems and needs, and develop plans to work with the health centers constructively over the long term

IV. Development and Implementation of the Model

A Implementation of the Model by Component

This section describes the detailed development and implementation of the activities for each of the three Model components. In most cases the activities noted, and the organization of this section, corresponds to the approved July 1996 - September 1998 workplan and the contract's three lower level results of

- 1 Sustainable female staffing established in centers in three governorates
- 2 Minimum quality standards for centers in place in four governorates
- 3 Community and individual participation increased in three governorates

Component 1 Sustainable female staffing established in centers in three governorates

Strategy **Improve decentralized pre-service training**

Objectives

The OFC project pursued the following objectives in supporting training for new female service providers

- to increase the number of trained female health care providers (midwives and primary health care workers) available in under-served areas
- to demonstrate a mechanism for the decentralized training of these providers, as part of the MOPH National Community Midwifery Training Plan
- to assist the MOPH and HMI in improving their institutional capacities to support training programs
- to deliver training of the highest quality possible in the Yemeni context

Implementation Activities

MOPH Midwifery Training Taskforce

The MOPH established a Midwifery Training Taskforce in 1995 to examine and determine how best to increase the number of female providers at service delivery sites. OFC actively participated in the Taskforce's work which resulted in the National Community Midwifery Training Plan and Community Midwife Training Program. This five-year national scheme

initially planned to train approximately 4,000 new community midwives. This number was later reduced to 2,500 after early training experiences, like that of OFC, demonstrated the complexity and cost of such training. Many of the training strategies developed by OFC were incorporated into the Ministry's plan, including a decentralized approach to training at selected Health Centers throughout the country, recruitment of trainees based not only on educational qualifications but also on their expressed commitment to complete the training and to work thereafter, and solicitation of community support for the training.

Preparing, renovating, and equipping decentralized training centers

Health centers within which to establish decentralized training centers were selected by representatives of the central MOPH, HMI, each governorate health office, USAID, and project staff. Criteria for selection included the geographic distribution of the centers, the capability of the centers to take on responsibility for managing the training, the ability of the governorate Health Offices and HMIs to support the training, and the extent to which communities offered to contribute in substantial ways to the training.

The selection of centers as training sites was also contingent upon each community's willingness to provide housing for the trainees and trainers who were not from the immediate area. According to the Partnership Agreement, preparation of the training sites was to be a joint effort of the community and the project. The project was responsible for renovating and equipping the health facilities (and in some cases the hostel) and providing furniture for the trainers, while the communities were responsible for providing and preparing the accommodations of the trainers and trainees. This included the housing itself, with basic kitchen and toilet facilities, and water and electricity. In many cases this was problematic and required intensive follow-up, especially in areas where water and electricity were not part of an existing community system.

All training centers required renovation of clinical facilities and the creation of space for theoretical classroom instruction, and practical clinical training. A full discussion of the renovation process is provided below.

Each of the training centers was provided with basic training tools and equipment. The equipment included slide and overhead projectors, TV/VCRs, anatomical models, and flip charts (see attachments for standard equipment list). A basic library of training and reference materials was also provided, with an emphasis on Arabic language references when available (see attachments for sample list).

The following **eleven** health centers were selected to be developed as **training centers**

- Hadramaut** 1 Seyoun MCH Center (located within Seyoun Hospital)
- 2 HMI in Mukulla (serving Mukulla and Al Shaher Districts)

- Hajah** *Community Midwife Training*
- 1 Shagadirah MCH Center
 - 2 Mabyan MCH Center
 - 3 Kuaydinah MCH Center
 - 4 Mahabisha MCH Center

- Female Primary Health Care Worker (murshidat) Training **
- 1 At Tur Health Center
 - 2 Al Moharaq Health Center

- Hodeidah** 1 Al Marawa'a MCH Center
- 2 Bait Al Faqih MCH Center
 - 3 Al Zohorah MCH

** Note Even though the MOPH and HMI wish to phase out of murshidat training areas of the country that lack female candidates who meet the minimum criteria to enter the community midwife program will continue to need lower-level providers for the foreseeable future The training in At Tur and Al Moharaq was therefore designed to meet this need The training program in Mahabisha was upgrading existing murshidat to become community midwives This was the first such course undertaken and provided experience for similar MOPH efforts in the future*

Providing, supporting, and monitoring trainers and training supervisors

Trainers were recruited through a combination of advertising within the Ministry of Public Health, personal contacts, and word-of-mouth referrals The MOPH guidelines (see attachments) for recruitment were followed, which stressed both educational qualifications and previous training experience In the interests of sustainability and of making use of local capabilities, preference was given to Yemeni candidates who possessed the appropriate midwifery certificate and training experience Because of the general shortage of qualified candidates, and the geographic relocation required, insufficient numbers of Yemeni candidates were found and some expatriate (i e Sudanese) trainers had to be utilized

Outside the scope of the OFC contract, the MOPH (with donor assistance) developed a mandatory three-month TOT course to familiarize trainers with the newly developed eighteen month Community Midwife training curriculum The OFC contract provided support for two of the TOT trainers and about twenty TOT participants during the three month course (Note that other participants were to become trainers at other, non-OFC, training sites) The TOT began at the HMI in Sana'a in December 1996 and ended in March 1997

At the end of the TOT, the twenty OFC participants were divided into teams of two trainers each and were assigned to the nine OFC supported community midwife training centers These twenty trainers were provided financial, technical, personal, and logistical support by the OFC team

Providing adequate support and supervision to long term decentralized training programs requires substantial time and effort and is crucial to ensure a quality training program This was generally done by OFC governorate staff in coordination with, and involvement of, governorate-

level MOPH and HMI staff Health Office and HMI personnel were encouraged to take on increasing responsibility for these critical tasks, particularly in resolving logistical and other problems In addition to OFC clinical staff, two training supervisors were hired as consultants to supervise and assist the Community Midwife trainers, augmenting the support provided by project clinical and governorate staff They played crucial roles supporting the practical clinical skills training, the theoretical classroom learning, and personally supporting, coaching and supervising the trainers and the training program One consultant took primary responsibility for the theoretical and training content while the second focused on practical MCH/FP training Additionally, an expatriate training consultant provided periodic assistance, supervision, and evaluation services which were useful both for OFC activities and to the wider MOPH National Midwifery program A mini-TOT was conducted later in 1997 to obtain trainers for the two *murshidat* training programs that started late in 1997 in Hajjah This mini-TOT also provided a means by which to select replacement trainers for those trainers lost through attrition at the community midwife training sites

Recruitment and selection of candidates for training

Identification and recruitment of community midwife candidates was a task assigned to communities and health centers as their first responsibility under the Community Partnership Agreements Numerous meetings were held with the community and health center staff to accomplish this (see Component 3 below) Candidates from both the immediate area of the training center and from the surrounding district were identified by health center staff, community members and local leaders Application forms, developed in cooperation with the HMI and the Health Office, were distributed to the center At the request of the health office, MCH supervisors were required to collect and submit the applications to the health office OFC/JSI's role in this process was to provide guidance on implementing MOPH and HMI policies and standards, and developing and coordinating the use of various forms, policies, procedures and systems

Governorate selection committees were established comprised of a Health Office administrator, MCH Director, HMI staff, and representatives of the central MOPH/ MCH section Having a specific application process and an objective selection committee proved to be very important in controlling what was often a highly competitive and political trainee selection process (see section IV B Successes, Constraints, and Lessons Learned for a discussion of the trainee selection process)

Candidates were required to take a written examination followed by individual interviews conducted by the selection committee It is important that the selection process be transparent, and that the MOPH and HMI be responsible for applying criteria and selecting the candidates (see attachments for the trainee selection criteria) Of the 699 candidates who applied and sought placement in the training program, 220 trainees were selected and began training between April 1997 and November 1997

Supporting the training of local supervisor trainers

OFC also provided assistance for the pre-service training of community midwife supervisors in Hadramaut province at the Hadramaut HMI. This one-year training course began in April 1997. The larger numbers of trained midwives and the lack of sufficient MCH supervisors led to the decision to strengthen Hadramaut MCH supervision, complementing the community midwife training in Seyoun and at the Mukulla HMI. Ten community midwives attended the course. At the end of the course there was an administrative dispute regarding authority to certify the graduates between HMI Hadramaut, HMI/Sana'a, and the Amin Nasher Training Institute in Aden, which had traditionally supervised the Hadramaut HMI. The Aden Training Institute refused to recognize the one year supervisory course which the Sana'a HMI had sanctioned in discussion in early 1997. Aden required that the course continue for another year. Due to limited OFC resources and the September 30 contract completion date, the training continued but without further OFC support.

Supporting the training of community midwife and murshidat trainees

Training at all OFC supported community midwife training centers began in April 1997 and the *murshidat* training (a nine-month course) began in December 1997 at two centers in Hajjah.

Two trainers were assigned to each training site and used the Community Midwife training syllabus to guide their teaching (see attachments for the curriculum outline). The syllabus included an outline of the topics to be covered in the didactic and practical parts of the training, and provided the sequence in which these topics were to be covered. Supplementary materials from a variety of sources were provided to the trainers to help them prepare and conduct the training (see attachments for the training materials list).

This required substantial effort, support, and resources from the OFC/JSI staff. (A discussion of some of the important problems encountered during the training is provided in the next section of this report.) During the last quarter of 1997, the MOPH decided to lengthen the community midwife training by an additional six months, and *murshidat* training by an additional three months. While this additional time allowed for more didactic and practical training, it meant that OFC/JSI team was not able to support the completion of training within the period of the OFC contract. As of the end of the OFC/JSI contract, USAID was working to identify a US training group through an indefinite quantities contract mechanism to support the continuation of the two local hire training supervisor/consultants until the expected end of the 24-month course in April 1999. Approximately 200 midwife and murshidat trainees were in training as of the end of the contract on September 30, 1998.

Practical training in deliveries

A vitally important (required by MOPH for certification) aspect of the Community Midwife training is the attendance by each trainee of at least twenty deliveries, and the concurrent training in the care of high risk cases and deliveries. Many decentralized training centers lack an adequate volume of deliveries to meet these certification requirements, since the typical class of twenty trainees would require 400 deliveries. Therefore, it was necessary to temporarily move groups of trainers and trainees to higher volume delivery facilities, such as urban hospitals. Each

group of trainees moved to temporary sites for this practical clinical training for periods ranging from one to three months, depending on the volume of deliveries

The trainees from each center were divided into two groups so that one group continued to provide MCH/FP services at their “home” center. This was necessary because, at many Hajjah and Hodeidah training centers, the trainers and trainees were the only MCH service providers

Assist MOPH/Health Office in developing support of graduates

In 1995, the MOPH had committed to hiring only about 25% of the expected CM graduates. By 1998, the new MOPH staff had increased their commitment to hire 100% of the graduates, demonstrating the priority they have placed on improving maternal and child health

Past experience has shown the importance of preparing well in advance of the end of training programs to arrange for the hiring of new government employees. In 1998, OFC staff worked with the MOPH and HMI/Sana’a personnel to plan for the certification and hiring of the new community midwife training participants scheduled to graduate in April 1999. MOPH representatives worked with the Civil Service Administration to determine the steps and procedures to be followed in certifying and hiring the new graduates. Armed with this information, the MOPH obtained the names of all community midwife trainees and submitted a list of their names to the Civil Service Administration before the end of August 1998. This allowed the Civil Service administration and MOPH to include sufficient resources and positions in the 1999 budget to allow for the immediate hiring of the new graduates. Past experience in Yemen has shown that it can take over one year for a certified graduate to be hired by ROYG after completing a training course if this hiring procedure is not started far in advance of the actual course completion

Assistance to Health Manpower Institutes (HMIs)

Assistance was provided to governorate HMIs, both to bolster their own training activities and to enhance their ability to supervise training governorate-wide. Under the new MOPH plan for Community Midwifery Training Plan, HMIs are assigned the essential task of supervising the decentralized training

Assistance varied from province to province. In Hadramaut, the HMI served as the OFC-supported training site for trainees from Mukulla and Al Shaher districts, and thus received all of the support described above for decentralized centers. At the Hajjah/HMI, OFC continued an earlier USAID program of support by funding the salaries of two midwife trainers, provided renovation and equipment, and provided stipend support for six trainees who came from OFC-supported districts. In Hodeidah, OFC supported renovations to the HMI facilities, and agreed to support the training stipends for trainees from OFC-supported districts. However, despite continual follow-up, the HMI in Hodeidah did not undertake a community midwife training program due to staff changes and a lack of resources from the central HMI/MOPH in Sana’a

Supervisory and support visits to decentralized training sites were made in coordination with

HMI staff⁷ OFC staff, especially the training supervisors, made a concerted effort to coordinate and involve governorate HMI staff in all their supervisory visits. This was done with varying, but increasing, degrees of success. A lack of funds for supervisory per diem and absence of a clear role in supervision of the decentralized training served as the main barrier for HMI supervisors to accompany OFC supported training supervisors on their site visits. In general, the same problems exist for MOPH staff.

Strategy 2 Involve the community in the training

This strategy overlaps and is inter-related to Component 3 “Increased Community and Individual Participation”. Please see Component 3 (Strategy 1, Promote community, health center, and health office cooperation to improve MCH/FP services) for a discussion about involving communities in the training program and for a description of activities carried out in implementing this strategy.

Component 2 Minimum quality standards for centers in place in four governorates

Strategy 1 Improve refresher training capacity and implementation

Objective

- **To increase provider skills and knowledge**

Implementation Activities

- Train governorate training teams**
- Assist training teams in developing lesson plans and training strategies**
- Support in-service training in the field**

Developing training teams and conducting in-service training

In June 1996, a four-week workshop was held in Sana’a for the purpose of forming and training a team of local trainers in each governorate. The concept was to create the capacity in each health office to provide refresher training and on-the-job training to health centers. Twenty-four participants completed the course, which included training in theoretical and practical training techniques, and the development of refresher training plans for each governorate. Following these refresher training plans, refresher training workshops were conducted in each governorate later in 1996. Three, two-week sessions were conducted in each governorate (including Lahj), with a total of 180 health care providers trained. The curricula and training were developed and conducted by each governorate team with the support and oversight of OFC/JSI staff. Trainee and Trainer workshop evaluations were consistently high, and trainee performance was also good, as measured by pre- and post-tests. Thus, the training was useful both in terms of the

formation of training teams and the provision of structured refresher training to governorate health care providers. However, both the training of trainers and the refresher training were entirely funded by OFC. Throughout the remainder of the OFC contract, it became clear that training teams such as these could only function as a part of donor-driven activities, since the resources do not exist within the MOPH system for sustaining them independently. Additionally, there was no apparent improvement in the quality of services available in the health centers, which was the purpose of the workshops. For the most part, these two factors led the OFC/JSI staff to refocus further skill training efforts to on-site and on-the-job training for the duration of the contract.

In-service training

Acute Respiratory Infections (ARI) management training

A short, five-day course in managing ARI, one of the most significant sources of morbidity and mortality among children under five, was conducted for forty-five doctors in 1996. This training, conducted in collaboration with UNICEF, trained groups of 12-15 doctors from each governorate (including Lahj). It was to have been the first of a series of such short courses on different topics. With the revision of the OFC contract in 1996, however, project resources were focused more specifically on training that directly contributed to successfully developing the MCH/FP Health Center Improvement Model.

Midwifery skills workshops

In 1998 two workshops were conducted to increase and improve the skills of midwives and community midwife trainers from targeted health centers. Twenty-nine participants in these two-week workshops were provided with theoretical and practical training in episiotomy, suturing, use of the partograph for monitoring labor, family planning counseling, and IUD insertion. The workshops resulted in improved and increased availability of family planning services and higher quality MCH care at OFC-supported health centers.

Health Management Information System (HMIS) workshop

A two-day TOT workshop was conducted for twenty participants from the four governorates (including Lahj) to introduce the health office staff to the new MCH HMIS system. Participants were then responsible for training health care providers at health sites in their governorates in the use of the new MCH HMIS system.

On-site and on-the-job training

As mentioned above, off-site workshops were not resulting in improved quality and services and off-site workshops require significantly more resources than on-site training. To elaborate, there are certain disadvantages to off-site workshops which include

- Participants are often unable to transfer what they have learned in an off-site classroom

setting to their health center work sites

- Providers and center directors who do not attend the off-site training workshop are often unwilling to practice and implement new skills either because they do not understand them, or are unwilling to because of their lack of involvement and ownership

On-site, in-service training which included both didactic classroom instruction (mini-workshops) and coaching during service delivery, was provided at the health centers. This approach was found to be more effective in improving provider skills and practices, and consequently the quality of services, than off-site training workshop. These were then followed up with regular technical assistance to providers and support to the trainers. In some cases, staff trained through these in-service training activities went on to provide on-the-job training to other staff.

Strategy 2 **Improve health center facilities and equipment**

Clinical equipment and furnishings

Objectives

In the MCH/FP Health Center Improvement Model, provision of new equipment and furnishings enables and motivates health center staff to provide higher quality services which tends to attract clients. Having functional clinical equipment and furnishings allows for work to proceed smoothly and efficiently. The following objectives were pursued in the provision of clinical equipment and furnishings.

- To provide a means by which to accomplish essential service delivery, by enhancing existing services, or by making services possible where there were none before. For example, prenatal visits become more thorough with an accurate scale and height measurement, and a nebulizer allows children with respiratory infections to be treated at the center rather than be referred to a hospital.
- To achieve higher quality of service, MOPH standards designed to improve the quality of services require that certain equipment and furnishings be available. For example, service quality is enhanced by a screen which provides privacy during an exam, and providing an autoclave or a dry oven allows equipment for delivery and IUD insertion to be sterilized, thus reducing the risk of infection.

Implementation and Activities

- a Identify health center needs for renovation and equipment**
- b Procure and distribute appropriate equipment**
- c Conduct any needed training in the use of the equipment**

For each OFC target site, an equipment needs assessment was conducted by comparing the equipment available on-site with the MOPH list of standard equipment for MCH centers.

In some cases, the OFC clinical staff identified additional and alternative equipment needs. A list was compiled, by center, of those items which were missing, in poor condition, or present in insufficient quantity. This formed the basis for the list of items to be procured. Selected items were also listed for health units associated with OFC target health centers, in order to assure that new community midwives or *murshudat* trained with project assistance would have appropriate equipment to work with. The list of equipment to be procured was then developed using standard medical equipment catalogs, such as the one used by UNICEF, and procurement initiated following USAID procurement regulations. The advertising, bid collection, ordering, delivery, and shipment process was quite time-consuming, lasting approximately ten months. Basic furnishings for health centers (e.g., desks, chairs, supply cabinets, file cabinets) were procured from local Yemeni manufacturers.)

U.S. and locally procured items were delivered to OFC facilities in Sana'a and then repacked and distributed to each health center. Packing lists were used to ensure that all items arrived and to obtain signatures to document the "hand-over" from OFC to each health center.

Following delivery of the equipment, OFC staff visited the centers to assist in assembly of some items and in training of staff in the use of equipment with which they may not have been familiar. Continuous follow-up training and oversight was provided, and was crucial to assure that equipment was being used and maintained properly.

Facility Upgrade

Objectives

Facility upgrades were done in all of the OFC sites, with the amount of renovation work carried out depending on the "baseline" condition and configuration of the site, the size of the site and need for additional space, and whether the site was to be a training facility. The objectives of facility renovation were:

- To create adequate space to accommodate all basic MCH/FP services including prenatal care, family planning counseling and services, child health, delivery, pre- and post-delivery, health education, immunization, registration, and waiting.
- To renovate/repair existing space so that service delivery areas met reasonable standards for appearance, functionality for services, and ease of cleaning/maintenance.

Typical renovation work included repair of walls and painting, creating partitions and/or removal of walls depending on the spatial configuration of the rooms, repair and/or replacement of windows, repair and/or placement of ceiling fans, repair of electric systems, repair of water and sewerage systems, repair of bathroom facilities including replacement/repair of fixtures, pipes, and tiling. At training sites, additional work included re-configuring space for didactic training rooms, and the renovation of hostel space in cases where communities were unable to independently provide adequate facilities.

Implementation Activities

- a Identify health center needs for renovation and equipment**
- b Renovate facilities**
- c Inspect renovated facilities and use of new equipment**

Assessment of facilities

The first task was developing a list of necessary MCH/FP services that should be included in the health center, using MOPH standards, and estimating the minimum square meters of space required for each service. Existing MCH/FP facilities in each health center were then assessed according to these standards by the Health Center Director, Health Office representative, OFC staff, and a Consulting Engineer contracted by OFC/JSI. In virtually all centers, current space was inadequate to accommodate basic services. Additionally, sites selected for decentralized training also required the identification of appropriate classroom space.

Each facility had to be assessed individually to determine how existing space needed to be repaired, reconfigured, and augmented in order to deliver the basic services, and to meet reasonable standards of service quality and efficiency. A variety of considerations had to be addressed, trade-offs considered, and compromises made in such variables as the location of bathrooms in relation to the delivery room and service areas, privacy for clients, and patient flow considerations. In the end, the parties sat together to sketch out and agree upon the renovations.

Preparation of specifications

Since the management of building renovations required special, non-health expertise and experience, a consulting engineer was contracted to provide advice on the feasibility of the renovations proposed (e.g. structural issues, cost considerations, alternative solutions), to prepare detailed specifications for bidding purposes, to review contracts for potential problems, to supervise work in progress, and to provide certifications of completed work. The local engineer contracted prepared specifications and drawings based on the assessments described above. (The engineer initially contracted was replaced with a more qualified and experienced engineer when it became apparent that the first engineer was not capable of fulfilling his contract responsibilities.) All documents were prepared in Arabic and English. This was done by the consulting engineer's office to ensure that the correct vocabulary and terminology was used.

Review of specifications, revisions, and approval

An essential aspect of the renovation process was that all parties agree on the work to be performed. Once specifications were prepared, they were distributed for review by OFC staff, Health Center Director, and Health Office staff (Director General, Engineer, Public Health Department). This was done to ensure that the space identified, the items and quantities required met those agreed upon during the facility assessment. Any modifications were then made by the consulting engineer and the specifications were translated and resubmitted to the above mentioned parties for final review.

In addition to the specifications and the associated drawings, the consulting engineer prepared a bill of quantities and set of bidding documents which were provided to the contractors. The bidding documents included standards by which the work identified in the specifications was to be performed, like for example, the manner in which cement was to be mixed, the type and quality of electrical wiring or sewerage pipes to be used.

Identification of contractors

Tenders for the renovations were advertised in local newspapers and health office staff were consulted in order to identify appropriate contractors to receive specifications and bidding documents. The Health Office administration and the Health Office engineer were given a final list of the contractors that would receive the specifications. This was to ensure that they had no objections to the contractors who would eventually be considered for the work. The Health Office itself had experience with some of the local contractors, which proved to be a valuable source of reference information on the prior work of potential contractors.

Potential contractors were contacted by the governorate office, notifying them that specifications and bidding documents were being distributed.

Preparation of bids by the contractors

Contractors were required to visit the sites in order to prepare their bids. Questions about the specifications were directed to the consulting engineer for clarification.

Bids were opened publicly in the governorate offices, with the Health Office engineer and OFC personnel attending. This process involved reading of the contractor's name and the total price of the bid for each facility. Thus each contractor knew the total of the bids by all other contractors. This transparent process served to reduce questions and charges of favoritism later on. The contractors were informed that all the documents submitted to the governorate office would be sent to Sana'a for review by the OFC office and the consulting engineer.

Selection of the contractors

The consultant engineer and OFC staff reviewed each bid. Criteria for selecting the contractor included completeness and presentation of the bid, price, relevant work history and references, and assurance that schedules would be met. Meetings were held to discuss the final selection and consensus was reached regarding the winning bids. The OFC Sana'a office wrote directly to the contractors informing them of OFC's decision on their bids. These letters were faxed to the governorate offices for distribution to the contractors. It was important that the governorate offices remain separated from the selection process due to the sensitive nature of contract selection in order to avoid any appearance of conflict of interest.

Standard contracts were prepared and used in all governorates. After selection of the contractor, an appointment was made by the consulting engineer to visit the site with the contractor before work began to ensure that the work and contract was clearly understood. Once the final details

were worked out, the contract (in English and Arabic) was sent to the governorate office for review and signature by the contractor. A health official, either the DG and/or the HO engineer, were asked to, and usually, signed as witnesses.

Supervision of the renovation work

Under contract terms, each contractor was to assign a supervisor to ensure that the work proceeded according to the schedule and the specifications. Progress was monitored routinely during site visits by OFC and Health Office staff. More formal supervision visits to the sites were made by the consulting engineer to inspect work completed and ensure the work was completed following the specifications, to indicate whether work required under the contract payment schedule was completed, and to review requests for additional work that was unforeseen but necessary to complete the renovation (e.g., the discovery of faulty wiring or blocked sewage pipes). These visits were generally attended by the Health Office Engineer, OFC staff, the Health Center Director, and the contractor.

Initial inspection certificates were issued to sites when the work was completed. After issuing the initial inspection certificate and verification by the consulting engineer, the contractors were paid all money due to them except for the 10% retained. Notes were made for minor items not fully addressed by the contractor. Once the contractor notified the local OFC office that these minor items were addressed, a visit was scheduled by the Sana'a Office to send the consulting engineer to conduct the final inspection. Final inspection certificates were issued when all work was completed and there were no outstanding items. Notes from the previous initial inspection were reviewed to ensure that the contractor fulfilled all commitments.

The final 10% retained was paid to the contractor approximately 90 days after the initial inspection. During this time period, if any faulty work was discovered (e.g., plumbing, fixtures, doors and windows) during normal use, the contractor would be sent back to rectify the problems at his expense. All contractors were required to issue one-year guarantees for the work they completed in the centers.

Strategy 3 Improve clinical and management practices

Clinical Standards Improvements

Objectives

The clinical technical assistance provided by OFC to support the MCH/FP Health Center Improvement Model was designed based on the following objectives:

- To upgrade the quality of service delivery by introducing or reinforcing clinical standards and guidelines
- To increase provider skills and knowledge

- To promote increased use of health facilities by clients

Implementation Activities

- a Focus on priority problem areas for OFC intervention Infection prevention, family planning, antenatal care, diarrheal diseases, immunization, record keeping drug supply and user fee**
- b Develop and introduce protocols as appropriate**
- c Provide Technical Assistance (TA) in use of protocols and in solving priority problems**
- d Evaluate improvements at the health centers**

An initial assessment of the targeted health centers confirmed the following general conditions providers were few in number and needed improved skills, greater motivation and improved supervision While all centers needed assistance, there was substantial variation from center to center and governorate to governorate Centers in Hadramaut tended to be better developed than those in either Hodeidah or Hajjah, but still needed improvements in the quality of care available Centers in Hajjah, at the other end of the spectrum, generally had few female providers and therefore offered virtually no MCH/FP services A variety of approaches were used to provide assistance to target centers

Protocols and guidelines

Protocols and checklists were designed and introduced to improve the quality of clinical practices in infection prevention, prenatal care, postnatal care, delivery, health education and rehydration, family planning, and HMIS These complemented and supplemented the MOPH booklet, “MCH/FP Standards”, which provides more detailed clinical information on a variety of interventions These tools were used during supervisory visits to monitor service delivery practices and as the basis for technical assistance to improve services Service providers were instructed to utilize them as reference and self-monitoring tools by posting them on the walls of the appropriate service delivery areas Based on experience, and to ensure that these protocols were used routinely by providers, a complementary set of step-by-step “guidelines” for clinical practice were developed in the areas of

- Delivery
- Antenatal Care
- Vaccination
- Diarrhea Control/Oral Rehydration Salts (ORS)
- Family Planning
- Postpartum Care
- Infection Prevention
- Registration and Record keeping

These guidelines (see attachments) were circulated to the MCH departments of governorate Health Office for comment, resulting in some minor modifications The guidelines were then

printed on brightly colored paper (a different color for each service area) and permanently laminated in plastic for posting in the appropriate service delivery area. These guidelines are meant to guide and remind experienced service providers of the step-by-step procedures in the particular area of service delivery.

Technical Assistance (TA)

While technical assistance and on-job training was provided for all MCH/FP interventions, more emphasis was given to those areas that would yield the greatest results in quality improvement and service utilization, and for which providers seemed to need repeated instruction. These areas included infection prevention, antenatal care, and family planning counseling. Infection prevention was identified as a clinical skill that requires frequent reinforcement, so it was emphasized frequently by both clinical staff and governorate teams. Technical assistance also focused on improving the quality of antenatal contacts, including encouraging clients to return for follow-up visits. In a society where many factors inhibit the use of family planning services, it is important that providers give clients good counseling and accurate information, and that they are able to provide appropriate methods. Technical assistance therefore focused on increasing and improving counseling and communication skills, and providing training in IUD insertion.

Outreach

The importance of outreach to increase contact with potential clients is clear, so project staff worked both with existing providers and community midwife trainees to encourage and facilitate home visiting. Outreach had a noteworthy effect on increasing OFC contract quality of service performance as measured by the number of antenatal visits, immunization rates, and couple years of protection. All indicators increased markedly as outreach activities intensified. It is important to emphasize with providers, center directors, and community members that outreach must be a part of the established routine of every health center.

Evaluating health center improvements

Health center improvements were monitored through regular field visits, tracking of MCH data through the MCH HMIS, and the use of two monitoring checklists (one monitoring the quality of clinical services, and one monitoring the furnishings, equipment and facilities) developed for this purpose.

Each center was usually visited twice a month by OFC staff together with Health Office staff. Site visit reports were written for future reference and follow-up. MCH/FP data was collected each month. The OFC contract identified four clinical and management areas in which to track health center improvements and contract performance: the number of antenatal visits per pregnant woman, the number of immunizations, family planning couple years of protection, and three areas of supply stock-outs (iron folate tablets, oral contraceptives, and ORS). These two checklists were used each quarter at each center to monitor the centers service and facilities performance. Based on the results of these checklists, each center was scored quarterly, with sixty percent determined to be a passing score.

Finally a comparative management assessment was conducted at the end of the contract using a more general checklist. This comparative assessment was conducted by a team of local Health Office staff and used to rank the OFC centers within each governorate. While no passing or failing grade was issued, each center earned points and were rated and compared to the other OFC-supported centers.

Management Improvements

Objectives

The MCH/FP Health Center Improvement Model could not be viewed as a stand-alone effort at the health center level, indeed, all initiatives had to be coordinated through all tiers of the health care system, including the central MOPH, Health Offices, health centers and other service facilities, and communities. Accordingly, the following basic management objectives were established:

- to support MOPH initiatives (e.g. cost sharing, community midwife training, decentralization) and to incorporate them into contract and health center management,
- to establish OFC Governorate Teams that work within existing Health Office structures to support District/Health Center MCH initiatives,
- to strengthen Health Office supervision and oversight of MCH/FP initiatives within the respective Governorates,
- to introduce guidelines, standards and systems for improving the management of MCH/FP services within a Health Center context,
- to strengthen community involvement in the management of District/Health Center health services,
- to improve the management and integration of MCH/FP services within District/Health Centers.

Implementation Activities

- a** Focus on priority problem areas for OFC intervention: infection prevention, family planning, antenatal care, diarrheal diseases, immunization, record keeping, drug supply and user fee
- b** Develop and introduce protocols as appropriate
- c** Provide TA in use of protocols and in solving priority problems
- d** Evaluate improvements at the health centers

The need for management improvements within MCH/FP service systems was identified in the design of the OFC/JSI contract and the Model. The on-site baseline assessments conducted at

each center identified specific areas requiring improvements, including

- supervision and monitoring systems
- health management information systems (HMIS)
- specification of employee job descriptions and responsibilities
- team work and communication
- integration of, and referral between, MCH and curative health services
- administrative and financial controls
- community involvement in management

Following initial assessment and baseline data collection, attention centered on assisting the MOPH in the design and introduction of a new HMIS system for MCH/FP through early 1997. Thereafter, emphasis was placed on management improvements through training the staff of Health Offices, health centers and community representatives. Technical assistance was also provided on a continuous basis to improve day-to-day management practices.

Health Management Information System (HMIS)

While health information pertaining to MCH services was generally available through the MOPH data collection system, most health officials (at all levels) questioned the accuracy and utility of this data. (This was confirmed when it took considerable time and work to determine and establish accurate baseline data for the workplan and indicators.) Therefore, the development of an information system was seen as one of the necessary first steps in improving management of MCH/FP services.

The OFC team assisted the MOPH MCH Division in developing an improved MCH/FP HMIS. New standardized forms, cards and registers were designed, data collection procedures were simplified and made more logical, and some information of dubious usefulness was eliminated from the system. Next, Health Office staff participated in a OFC sponsored Training of Trainers (TOT) in using the new system. Governorate teams comprised of OFC and Health Office officials subsequently provided practical training to health center personnel at sites in the governorate providing MCH/FP services. Attending the on-site training were MCH personnel, Health Center Directors and doctors at the health center training locations. A protocol and checklist (see attachments) for assessing the quality of data collection was developed and used by staff and Health Office personnel to ensure the accuracy of the record keeping and reporting.

The introduction of a reliable HMIS system was certainly a significant step, but it was only the first of several on-going actions taken to improve the monitoring and analysis of the HMIS by users and to establish the HMIS as a basis for health center planning and priority setting. These other actions included

- Routine on-site monitoring by OFC Governorate Teams (including Health Office officials and OFC/JSI staff),
- Monthly monitoring of health statistics by health center MCH staff. Graphs charting several important clinical indicators were utilized both to introduce the concept of

monthly monitoring for management purposes, as well as to ensure that staff were attending to those interventions which were more likely to improve performance and service utilization,

- Priority setting and planning initiatives established through OFC-sponsored Management Training Workshops

Management Training

As the project progressed, it became clear that management training should focus on those issues that most directly address the quality of services, and on the organizational relationships that support services. This is in contrast to the original training plan, which would have provided more general management training to senior personnel at the central MOPH and at each Health Office. The programmatic targets for MCH/FP contained in the Ministry's Five-Year Plan would have been used as the basis for forming broad management plans at the central and Health Office levels to meet those targets. While this type of training would certainly be useful, it would not have addressed the very specific, day-to-day operational problems which impede the quality of services at the health center level. Nor would it have focused on the relationships between the Health Offices, health centers, and communities which are vital to the present management and future improvement of services. Thus, the training focus was shifted to a more practical examination of the management problems that face health centers on a daily basis.

Working with the Director Generals in each of the three OFC Governorates, and using data from the original needs assessment of target centers, lesson plans were developed for a five-day health center management workshop for health center directors, MCH directors, Health Office staff and community leaders. The reason for this grouping of participants was to improve the integration of MCH within the health center setting, and also to reinforce the role of the community in health center decision-making. Health Office Directors were also invited to attend and participate in the training. The lesson plans addressed four major health center management needs:

- Roles and Responsibilities of a Health Center
- Health Center Supervision and Team Building
- Job Descriptions
- Problem Solving, Priority Setting and Planning

Key strategies within the training were to

- Work within existing MOPH guidelines,
- Improve the integration of MCH within other health center services,
- Clarify the community's role in health care improvement,
- Identify specific health center assignments following training,
- Involve the Health Office in monitoring and supervising workshop decisions

The five-day Management Training Workshops were held once in the Hajar, Hadramaut and Hodeidah Governorates respectively, with approximately 30 participants at each session. The fourth workshop in this series was a Health Office Director Generals' Meeting. The purpose of

this meeting was to

- review the results of the management training workshop and how the centers were implementing their action plans,
- review health center progress on key indicators and recommend plans of actions for continued MCH activities and support,
- review and prepare for the comparative health center management evaluations

In general, the importance and impact of follow-up support and supervision is a critical factor in improving the provision and management of services. Providers were motivated to improve their performance when supervisors provided serious support and follow-up, and cared about making improvements and achieving results. Providers were equally indifferent when supervisors were indifferent to performance.

Management Evaluation

The Management Workshops were followed up through bi-monthly, on-site review. A comparative management evaluation emphasizing overall MCH management was undertaken to review the progress made by each health center in implementing their plans. Accordingly the health centers undertook a re-examination of their services in order to adequately prepare for the process.

The primary objectives were to enable the Health Office to

- Identify and plan for future management support requirements,
- Provide each health facility with a quick analysis of their strengths and weaknesses in comparison to other locations,
- Enable government representative to recognize the achievements of health facilities in improving MCH service delivery

Major evaluation areas included

- Health facility team management (emphasizing integration of MCH into the facility decision making process)
- Interactions between community and the health facility
- Interviews with female health facility clients about MCH knowledge and opinions
- Examination of the MCH registration room and use of health statistics
- Management of MCH training
- Management of MCH clinical services and equipment
- Interaction between MCH and EPI, doctors, pharmacy, etc
- Cleanliness of the health facility and infection control systems
- Financial management

The result was a one-page report which was distributed to all centers identifying both strengths and areas requiring improvement, including a comparative matrix on how centers scored in

comparison to other locations in the Governorate

Fee Collection Training

Since the 1997 elections and subsequent ministerial reorganization, a major MOPH initiative has been to explore methods and systems for decentralizing programs and activities and empowering communities to share in the operation of traditional government institutions and programs. The MOPH developed a number of concept papers which led to the MOPH "Cost Sharing Program". The Cost Sharing Program has a number of components, one of which is the retention of fees collected at the district/health center for the purpose of providing incentives for health workers and for the purchase and maintenance of needed supplies, materials and equipment.

OFC's initial 1995 management assessment (see attachments) included an examination of user fees collected by health centers. The survey reported vastly different procedures for collecting fees in the health centers, with few controls for "non-government" fees (fees charged beyond the Government prescribed level).

To implement a pilot cost sharing program, a fee collection training program was designed that would be consistent with any initiative finally adopted by the MOPH. As a starting point, a rapid, in-depth examination of fee collections at the health centers was conducted. OFC staff then met jointly with the Director Generals in the Hodeidah and Hajjah Governorates to review the survey findings and to determine what corrective action was required. Based on these discussions and with the approval of the DGs, a three-day training workshop was developed for improving the book-keeping procedures and financial control mechanisms used in the Health Centers. This was then conducted on-site at each center by a Yemeni financial expert, with experience in the Hodeidah Health Office, who was selected to lead the training. A simplified financial record-keeping system was introduced which provided for improved management of both revenue (including any revenue increases which might result from the Cost Sharing Program) and expenses (including additional expense items, such as salary supplements or facility maintenance, that might become part of the Cost Sharing Program).

Component 3 Community and individual participation increased in three governorates

Strategy 1 Promote community, health center, and Health Office cooperation to improve MCH/FP services

Objectives

In order to achieve the contract indicator to increase the level of individual and community participation in Health Centers, the following objectives were pursued in this component of the Model:

- To identify methods and mechanisms for community support
- To develop, implement, and monitor Community Partnership Agreements which

identified the roles and responsibilities of OFC, the community, the health center, and the governorate Health Office in improving the quality and quantity of MCH/FP services

- To facilitate the establishment of local health committees to support Health Centers

Implementation Activities

- a Raise community awareness of the benefits of MCH/FP and solicit support for MCH/FP activities**
- b Determine the health center and the Health Office inputs**
- c Assist communities in developing a plan for supporting MCH/FP**
- d Prepare Community Participation Agreements (CPAs) and obtain signatures of parties**
- e Monitor the performance of all parties in implementing their agreement**
- f Document this portion of the model How it works, what is costs, problem areas**

Note The activities that were carried out in implementing this strategy overlapped with the implementation of Program Strategy 2, “Involving the community in the training,” under Component 1, “Sustained female staffing established in centers in three governorates”

Initial Assessment

Initial assessments revealed that community involvement in the Health Centers was generally limited, and in many cases non-existent. There was evidence at many centers of past support for building construction, equipment purchases, and drug donations. Unfortunately, the community leaders’ involvement in health center activities tended to be on occasions when conflicts arose between center management and local influential individuals.

Introductory Meetings with Communities

At each site the health center arranged an introductory meeting with the community to discuss the project’s objectives and planned activities for improving quality of MCH/FP services. In nearly every center the director took the lead role in organizing this community meeting. After numerous discussions in which the directors were encouraged to begin, it was suggested that they invite people that they knew and respected, people who use the health center, and those whom they knew were interested in health issues.

The focus of this initial meeting was to introduce the OFC project to the community, its objectives, and its emphasis on facilitating the improvement of MCH/FP services in the center (e.g., focus on prevention rather than curative). The project was described according to its major components of training, clinical/management improvements, and community participation, with explanations of the rationale for each component. Following the OFC presentation and overview, the community members and health center staff shared their thoughts about the project and community participation. Many men attended the meetings and, while the types of participants varied, they generally represented a cross-section of the community such as health

center staff, teachers, local merchants, farmers, pharmacists, local government representatives, leaders of political parties, and local community leaders (sheikhs) The most active participants in the meetings were usually the local community leaders Many reaffirmed the importance of community participation in improving the services at the health center and agreed that the government does not have adequate resources to meet the needs of the center and the community

Some common concerns raised by community members at the initial meetings were

- the lack of individual and community resources to support centers and participate in center or OFC activities,
- the need for services not being adequately provided by the centers -- among priorities identified were laboratory services and medical specialists,
- the lack of adequate government support to provide qualified staff, essential drugs, equipment, and continued maintenance of the centers,
- the perception that Health Centers had poor leadership, management, and lack of staff commitment,
- the perception that mismanagement of funds and potential corruption could result from charging patient fees,
- the perception that it is the government's responsibility to provide health services and the community does not have the resources to provide them on its own,
- the perception that community contributions to the centers would be mismanaged or misused,
- the perception that the Government (Health Office or central MOPH) would not honor its commitment under any agreement reached

Nearly all communities expressed the need for the project to contribute first and they would follow with necessary contributions from their side They also requested guidance concerning appropriate community contributions Accordingly, plans to support the MOPH community midwife training program were discussed, including ways the communities could support this effort

During these initial meetings, it was stressed that the project could not begin without firm commitments from the communities While this made good sense from an accountability standpoint, it did create difficulties with many communities that were reluctant to commit until they saw tangible evidence that the project and MOPH would provide the promised inputs

A minimum level for community contributions was established at these meetings, including

- Recruitment of candidates for community midwife training,
- Furnished accommodations for trainees and trainers in sites where community midwife training centers were to be established,
- Contribution toward stipends for trainees while in training (25% of the MOPH recommended stipend, equaling 500 Yemeni Rials (YR)/month/trainee),
- Establishment of health committees to finalize, approve, and follow-up community inputs identified in the partnership agreements and to act as a liaison between the

community and the Health Center. It was envisioned that the health committee would eventually take on the role of helping the center identify priorities, and develop plans and activities for the future (i.e. after completion of the contract).

Developing and signing Partnership Agreements

The concept of the Partnership Agreement (see attachments) was introduced in the initial meetings with the communities. Its purpose was to ensure that all parties -- Health Office, community, Health Center, and OFC -- would be clear about their roles and responsibilities. It was envisioned that getting clear commitments early on would increase community and Health Center ownership of the project and would eventually result in sustainable achievements beyond the project period.

It was necessary to draft, sign and implement these agreements quickly so that other sequenced activities (community midwife training, renovations and clinical and training equipment procurement) could begin or continue.

Draft partnership agreements were presented first to the Health Office, and then to the Health Center and the community. It was critical to get Health Office support of the agreement prior to presenting it to the community since the Health Office was the prime supporter of the Health Center, and would be there long after OFC ended. The Health Office also had many responsibilities under its section of the agreement and was critical to the success of the project.

The Partnership Agreements were usually signed at large community gatherings where the terms of the agreement were read aloud for all to hear. Representatives of each partner organization would then sign the document/agreement.

Introducing Health Committees

The importance of establishing health committees was stressed early on and was a key component of the Partnership Agreement. This was not only to serve the project's goals of establishing a mechanism to facilitate improved community and individual participation but also was consistent with the MOPH's decentralization approach under a District Health System. Each district was to have a health committee that would provide direction through needs assessments, priority setting, action-planning, resource management, and evaluation. Although the committees established for the Health Centers were less broad in purpose and were focused geographically on the area immediately surrounding the Health Center, it was envisioned that these could serve as models for, or components of, larger, district-wide committees.

It was consistently communicated that it was up to the community and the Health Center to decide on membership. Criteria for selecting committee members was developed and included items such as status as a respected member of the community, history of community service, interest and knowledge of health and health-related services, and time and willingness to attend meetings.

The importance of including local government representatives from the communities was noted early on. Although some were not necessarily supportive or interested in the activities of the center, it was important for them to keep informed about the Health Center and project activities for a variety of reasons, including their linkages with local government systems, leverage in dealing with local political problems, and official accountability for following up on community commitments.

Forming health committees prior to the drafting of the community participation agreements has advantages such as building community understanding, advocacy and support for preventative MCH services, building capacity and awareness of the community group from the outset, and making sure the community is committed to project activities and will take the ownership that is essential for sustainability. The major disadvantage is that this is a time-consuming process which must begin with the initial assessment. If it is not possible to first develop the committee, each partnership agreement should include a written commitment by the community to form a committee. This reinforces the emphasis on building trust between the Health Center and the community and improving accountability of the Health Center. In this case, almost all partnership agreements had to be signed before forming the health committee, due to time constraints.

Establishment of Health Committees

Throughout the processes of signing, implementing and monitoring Partnership Agreements, finalizing membership in the health committee remained a continuous challenge. Intensive intervention and assistance was needed to facilitate the formation of committees in the majority of centers in all three governorates. Community members and Health Center directors and staff expressed the need for additional assistance in guiding the health committees. They were not clear about their roles and responsibilities. Also, they had difficulty prioritizing the many problems faced by the Health Center.

As mentioned earlier, centers did not always form community boards before the partnership agreements were signed. However, forming the committee early on has distinct advantages which include

- An established board can develop priorities and an action plan as part of the agreement. This can result in a broader agreement that addresses a range of program and management issues.
- An established board can increase accountability in implementing and following up the commitments in the agreement.
- An established board has increased sense of ownership of an agreement that was drafted cooperatively by all partners.

While most of the centers had a list of names of frequent attendees of meetings, it was useful to ask them to finalize the membership in writing. This also gave OFC the opportunity to further guide committee selection, such as requests to include the names of female representatives that could serve on the committee.

Strengthening Health Committees

To enhance sustainability and the development of the community board structures, “board development” activities were conducted to assist the committees in defining their roles and responsibilities and setting priorities, which many of the committees found difficult to do. Therefore, OFC undertook health committee workshops which aimed to

- Raise the committee members’ awareness of local health problems, prevention of these problems, and the importance of defining roles for both the Health Center and community in addressing problems. Many of the committee members were focused on adding curative services to the centers and demonstrated limited understanding of the Health Centers’ role in prevention.
- Better define the health committee’s role and responsibilities in the community and to define operating procedures, such as when to hold regular meetings, how to formalize decisions and how to elect new members.
- Facilitate the development of a workplan for the remaining project period and beyond, making sure the workplan includes activities which address the community’s agreed-upon priorities. Most of the committees had identified many problems in the center, but had trouble prioritizing these problems and organizing activities to begin to solve them. The workshops helped them develop a workplan that would focus their work, assign responsibilities, and give them reasonable target dates for completion. In seeking future assistance this would also serve to demonstrate that they were well organized and were able to set priorities.
- Emphasize the importance of teamwork and problem-solving in developing and carrying out their workplan. It had become apparent that Health Centers and the committees tend to rely heavily on very few members rather than trying to distribute responsibilities and involve more individuals in the problem-solving process.

The workshops resulted in a series of health committee documents (see attachments) prepared by the committees themselves which will guide their future work. These include

- Overall goals of the Health Committee
- Responsibilities of the Health Committee
- Operating procedures of the Health Committee
- A list of needs and problems in priority order
- Objectives for addressing these priorities
- A workplan including activities, responsible parties and target dates for completion

The effectiveness of the health committees varied considerably and their sustainability is difficult to predict. Those most successful and with the greatest chances of sustaining themselves and their activities are those which are meeting on a regular basis, that have strong leadership, and who are working out problems and issues independent of outside intervention.

B Successes, Constraints, and Lessons Learned

This section describes achievements of the OFC project, as well as constraints encountered during implementation of the Health Center Improvement Model. With each constraint, possible solutions are also recommended. Successes, constraints, and lessons learned are organized and presented by each of the Lower Level Result components.

Contract achievements, as measured by the contract indicators, are summarized in section VI, "Progress Against Contract Performance and Special Objective Indicators"

Component 1 Sustainable female staffing established in centers in three governorates

Successes

- The decentralized training of female health care providers was carried out successfully in remote rural locations
- The training introduced MCH/FP services in some centers and communities for the first time, and substantially increased the amount and quality of services available at all centers
- Decentralized training of female health care providers increased the number of community midwives and murshidat by approximately 200, many of them in areas which were without previous MCH/FP services
- Community involvement and support of health care activities increased in many places where previously it had been minimal

Constraints Problems encountered and solutions used

Decentralized training of this magnitude and complexity had little precedent in Yemen. Dealing with the many challenges that arose required substantial project time, resources and energy from OFC, MOPH, Health Office staff and community members. Recognition of these problems and approaches to their solution will be important to the MOPH as it takes over more direct responsibility for training activities in the future.

- **Inadequate curriculum** It became apparent early in the training that the new curriculum for training community midwives was a syllabus with too little technical content (especially for inexperienced trainers) and that there was a lack of reference material available in Arabic to aid both trainers and trainees

Solution A variety of "stop-gap" measures to ameliorate these problems were used, including the provision of supplementary reference materials, and most significantly, the

provision of technical assistance and in-service training to trainers. While future training efforts will benefit from the supplementary materials, lesson plans, and testing materials, a worthwhile effort for a future donor would be completing, improving and expanding the curriculum. This would enhance the quality and consistency of the training. In addition, the need for frequent, skilled supervision of the training cannot be over-emphasized. In this demonstration of the Model, two experienced training consultants were hired to assist in developing lesson plans, improve didactic and practical training techniques, and to monitor and support the training to assure the highest possible quality standards.

The training consultants, like all OFC staff, maintained close working relationships with MOPH and HMI personnel in their supervisory activities. MOPH/HMI supervisors were given the opportunity to accompany staff and consultants on supervisory visits, were kept advised of problems and progress, and were invited to give their input on the content and management of these and other project activities. Time and resource constraints limited their ability to fully participate in these supervisory activities, however.

- **Need to replace trainers** There is a very short supply of qualified or experienced trainers for this type of training in Yemen. For a variety of reasons, trainers are not always able to remain at their assigned centers for the duration of training. Personal or family problems led to the resignation and/or reassignment of a number of OFC-supported trainers during the course.

Solution In the first instance efforts should be made to increase and improve the supply of qualified community midwife trainers. The demand is currently much greater than the supply. Trainers should be assigned to centers where they will be more likely to remain. Proximity to their homes and familiarity with the community are factors to be considered. Provision of ongoing support (both professionally and personally) also helps. Since some attrition is inevitable, however, it is important to continue the recruiting of trainers even after the commencement of training, and to conduct “mini-TOTs” to prepare new trainers to take over in mid-course. Trainers identified in this process can be held “in reserve” so that training is not disrupted by the abrupt departure of a trainer.

- **Trainee absenteeism and/or poor performance** While MOPH policy on these issues is clear (guidelines are written and specific), Health Offices and HMIs are often reluctant to enforce them strictly. In the experience of OFC, there were a few trainees that were frequently absent, or who had failed exams, but were not removed from the training in accordance with MOPH guidelines.

Solution Project or donor staff must properly defer to the MOPH/HMI supervisory system to make and enforce these types of decisions. When timely decisions were not made, frequent follow-up with written notification of all parties (including the central MOPH and HMI) was required to prevent absenteeism and poor performance from reducing the quality of training.

- **Follow-up with communities and logistical support** Follow-up with communities to assure their continuing contributions to the training according to the Community.

Partnership Agreements was a continuous and labor-intensive process. Similarly, the resolution of day-to-day problems (e.g., water and electricity availability) required substantial staff time.

Solution Strengthen communications between the trainers, community boards, and Health Center directors whenever possible to resolve these problems, since it will be their responsibility in the future.

- **Lack of deliveries for practical training** Few decentralized training centers have sufficient delivery caseloads to allow trainees to meet the minimum requirement of attending 20 deliveries.

Solution Trainees were taken to facilities with a higher volume of deliveries, and the number of on-site deliveries was maximized by increasing outreach/home visiting efforts. This requires additional resources, and like other training-related activities, requires substantial staff effort for planning and execution. It should also be part of the overall national planning for the decentralized midwifery training program.

Lessons Learned

- **Preparation, operation, and supervision of decentralized training centers is complex and labor-intensive** Managing the training centers proved to be one of the most time and energy consuming aspects of the Model. It required constant follow-up and all problems encountered, at least initially, were referred to project staff rather than handled by the centers or communities involved. Nevertheless, communicating and demonstrating problem-solving skills to the trainers, trainees and Health Center directors had begun to yield positive results by the end of the project.
- **Training site selection should take a variety of “success factors” into account** The training sites that operated with fewest logistical problems, and therefore with fewer distractions from training quality, tended to be those that
 - had previously been used as training sites,
 - had reliable supplies of water and electricity, better transport, more accessible markets, and more accessible sources of clinical supplies,
 - had more experienced and skilled directors who are able to solve problems and generate community support.
- **Candidates for midwifery are not available in all areas** The educational levels of women vary across geographic areas of Yemen, and some areas lack women with the educational qualification to enter midwifery training. This problem can be dealt with in at least three ways: 1) Training in such areas can be deferred until such time as the educational level of women rises, 2) Attempts can be made (including, perhaps, incentive systems) to find trained midwives willing to live and work in these areas, or 3) Lower-level providers which require lower educational levels (e.g., *murshidat*) can be trained.

- **Selection of trainees is subject to local politics** Participation in training programs is sometimes viewed as a prestige-conferring and/or economic benefit, rather than as an opportunity to gain skills or serve the community. Despite a rigorous, objective selection process, a few trainees were in the training for the prestige, and may never become midwives. In some instances, when these trainees' participation was challenged, the traditional local authorities intervened and made it difficult for training to continue.
- **Finding skilled trainers for decentralized community midwife training is difficult** For important capacity-building and sustainability reasons, this project consciously used as many Yemeni midwives as possible as trainers. The small numbers of skilled trainers available, and the reluctance of many of them to move to remote locations, made this decision difficult to implement. As a result, the trainers' midwifery and teaching skill levels varied considerably. It is unclear whether higher salary levels would motivate some additional highly skilled trainers to accept remote teaching jobs. Based on experience, having the right trainers was a key success factor, the right skills and personality can avoid many problems and more easily resolve others.
- **The MOPH-sponsored training of trainers (TOT) prior to the commencement of training was essential, but had some serious shortcomings** Given the variable skill levels of trainer candidates, the MOPH's insistence on a three-month TOT was well conceived. Many trainers gained valuable skills, the lack of which would have seriously compromised the community midwife training. However, the curriculum for midwifery training, assembled quickly in advance of the TOT, was little more than a syllabus. It did not provide the less experienced trainers with the detailed guidance (e.g. lesson plans) that they needed. Many trainers' clinical skills need to be improved. The next TOT should include midwifery skills training (MOPH plans now include a much longer (nine-month) TOT course, which, if well-executed, should address this problem.) In retrospect, the large number of participants in the TOT (50+) did not permit effective practical training and participatory learning.
- **Frequent, high-quality supervision of decentralized training is essential to providing training of acceptable quality** The technical and practical problems associated with decentralized training argue strongly for well-organized, regular supervision at training sites. Project governorate staff, clinical staff, and training consultants collectively spent a very high percentage of their time solving logistical problems, helping prepare lesson plans, giving on-the-job clinical training, supporting the trainers technically and personally, and evaluating trainer and trainee performance. This resulted in high quality training (by local standards) which could only have been realized with these supervisory efforts.
- **Housing for trainers and trainees is an important issue for both groups, and for the quality of training** One of the community contributions to the training was housing, but the quality of the housing and the on-going support provided by communities varied. Where housing problems occurred regularly, trainers, trainees, and staff were frequently distracted from the training to negotiate and resolve these problems.

A related issue is that common housing for trainees has the advantage of group participation in homework and shared use of resource materials. Trainees who had family in close proximity remained at home while trainees from distant villages lived in a hostel. Moving all trainees into the hostel would have been costly, and may have exacerbated logistical problems, but would have been advantageous in terms of group participation.

- **The need for practical training in deliveries and providing other client services needs to be emphasized.** Many Health Centers lack the volume of MCH/FP clients necessary to gain practical skills. Two options exist to address this problem: Organizing off-site training at sites with higher volumes, or seeking clients at the training/Health Center sites through outreach and home visits. Both worked in the case of the MCH/FP Health Center Improvement Model and both required substantial effort to organize and implement. The advantage of off-site training is that the needed experience can be gained quickly. The advantage of outreach and home visiting is that it develops closer links with clients and their families which increased use of services, in many cases by first time clients who began using and coming to the center. Both require additional resources, and if sufficient resources are available both are recommended. Future rounds of training need to coordinate off-site training on a nationwide basis, to minimize competition for placement at the few appropriate high-volume centers.

Component 2 Minimum quality standards for centers in place in four governorates

Successes

- Twenty-eight Health Centers were renovated, furnished, and equipped for MCH/FP service delivery. In some centers, this allowed for the delivery of these services for the first time. Basic equipment was also provided to 60 health units located in the catchment areas of target Health Centers.
- “Minimum quality standards” were introduced and established at centers for the first time.
- A streamlined health management information system (HMIS) was introduced and health care providers were introduced to the concept of using data for program and management decision-making.
- Health Office and HMI supervision and involvement in rural Health Center operations increased.
- Health Center supervision and management improved through greater definition of center responsibilities, staff roles, and community contacts. A team approach to Health Center management was introduced in which the curative and preventive services of the center are more closely linked.

Constraints Problems encountered and solutions used

- **Hidden problems in renovation work** Additional work was required at many centers when hidden problems were identified after the renovation began

Solution Contractors must be required to submit written requests for additional work. These can then be reviewed by the consulting engineer and approved or disapproved by the project staff. When dealing with building renovations, a substantial contingency reserve is needed to allow for repairing these hidden problems.

- **Inexperience of providers in using some equipment** The care and use of some new equipment was not understood by those using it (autoclave, dry oven, hemoglobinometer, nebulizer, Doppler)

Solution Incorporate on-job training, use of standards, and practical teaching about the equipment on clinical visits. Clinical staff must be prepared to spend time, and repeated follow-up, to demonstrate and ensure proper equipment use. Written operation and maintenance instructions in Arabic should be provided to sustain proper use and maintenance.

- **Clinical room and furnishing arrangements inappropriate** Following renovation and equipping, it was found that planned room and furnishing arrangements were not providing optimal client flow.

Solution Be aware of changing circumstances which may require changes in client flow, reorganization, and related issues.

- **Most providers needed continued follow-up and support when new material or practices are introduced** This was found to be the case with some providers at a number of centers.

Solution Repeated support needs to be provided to those who are identified as not following standards and procedures that have been established.

- **Supervision by central and governorate-level MOPH is infrequent** This is caused by many factors, including lack of staffing and insufficient transportation. When visits do occur, they are usually connected to a national initiative (e.g. immunization), to attend a ceremonial function, or to resolve substantial health issues that have been raised by senior community leaders. As a result, there is often a lack of understanding by the central level staff on the conditions which exist in the governorates, and by governorate staff on conditions at health facilities.

Solution While this difficult problem cannot be directly addressed by any donor project, supervision can be facilitated by providing central and governorate level MOPH staff with more opportunities to visit the field, and by involving them in decision-making related to project activities.

- **The drug distribution system is inadequate** The supply system is cumbersome and drugs are routinely in short supply. For example, iron folate was out-of-stock in many centers for long periods because of national procurement and distribution problems. Even more readily available commodities are frequently out-of-stock, a fact which contributes heavily to poor health facility utilization.

Solution Here again, the ultimate solution is beyond the scope of any time-limited donor project, although efforts to reform the national system and to improve governorate level supply systems are ongoing (including the efforts of OFC). Some improvement can be achieved by ensuring that Health Center staff give more attention to inventory, re-ordering, and supply issues.

- **Lack of outreach** While MOPH policies increasingly incorporate a community-based approach, most Health Centers provide few health services beyond the confines of the Health Center building. Centers are poorly equipped for outreach (e.g., few have vehicles), and staff are generally not encouraged or rewarded for outreach.

Solution Outreach can be encouraged by stressing its importance with providers, working with them to develop outreach strategies and plans, helping identify solutions to outreach barriers (e.g., enlisting community support for transportation), and by physically taking staff on outreach visits to demonstrate that it *can* be done. These activities were important to sensitize staff and to begin the process, but long-term follow-up and strategies to encourage outreach need to be pursued by the MOPH.

Lessons Learned

Clinical Improvements

- **The process of identifying and procuring clinical equipment is complex, time consuming, and needs to be approached with careful research** Within budgetary constraints, the project was careful to identify clinical equipment for MCH centers from international sources using standard catalogs. Despite this, some of the items procured were of poor quality, or were inappropriate for local conditions. One approach that might have helped would have been to investigate local Health Centers that were functioning well, and obtain detailed source information on their equipment. This may not have addressed issues of U.S. source and origin, however, so more detailed U.S. investigation of product quality should also have been undertaken. Longer lead time in procurement (a minimum of one year) would have allowed for more orderly distribution, with better training of staff in the use of equipment.
- **Care must be taken when procuring locally-manufactured furnishings for clinical sites** In order to conserve contract funds, shorten procurement time, and support the local economy, the project procured furnishings for clinical sites from local manufacturers. Some of the items procured turned out to be of poor general quality and construction. If local manufacturers are used, the purchaser must go to extra lengths to insure that items will be of acceptable quality and durability.

- **Follow-up of use and maintenance of equipment is required** Visits to the field by governorate and clinical staff to check equipment were valuable in assessing its use, care, and presence. One must be careful not to assume that all providers will immediately be able to utilize the skills taught. A few providers at some sites were unable to use or maintain the equipment properly. When this was discovered the project staff emphasized this by reinforcing it with follow-up training and technical assistance. One successful method was to maintain a training register at each site, identifying those trained, in what subject, and when. MOPH Governorate staff should make this part of their regular follow-up supervision and support.
- **Facility renovations require appropriate expertise and constant monitoring** Extensive renovation work requires supervision by an experienced professional from the outset -- someone with direct experience in supervising the type of work to be undertaken. Contract specifications must be clear and complete to avoid bids that are incomplete and subsequent cost overruns. Stringent time frames with penalty clauses should be built into all contracts.
- **Health Center and Health Office staff and community health committees must be in agreement with renovation work to be undertaken** Getting everyone's agreement (in writing) takes longer, but avoids longer-term problems of unfulfilled expectations. The involvement of the Health Office engineer is particularly important, since his job is oversight of construction/renovation and since he will have substantial contacts with contractors. As with most activities, local politics can be important, so it is crucial that the contractor selection process is objective and transparent. Within those limits, however, it is wise to give special consideration to any local contractors who are reputable and known to the community where work will be performed.
- **If possible, add some renovation benefits for non-MCH sections of the Health Center** Renovations should not be limited to the MCH section, as this may be seen as favoritism. If possible, the renovation of other service sections will maximize referral, promote team building and inter-departmental cooperation.
- **Careful planning and scheduling of clinical technical assistance increases effectiveness** Clinical technical assistance was improved by preparing a detailed plan and schedule for on-the-job training activities within clinical supervision and monitoring visits. This gave both trainers and Health Center staff a focus for each visit's activities. The scheduling also helped clinical staff and governorate-based staff organize follow-up and subsequent monitoring of skills introduced.
- **Clinical skills and expertise are needed and should be placed at the governorate or health service delivery level** While the clinical staff hired for the Sana'a office were all highly experienced, skilled professionals, this same level of talent was not available at the governorate level. Local governorate clinical staff were hired, in part, as a means of building governorate capacity for the future. Unfortunately, their lack of experience

limited their ability to contribute high quality technical assistance, and was a further demand on the time of Sana'-based clinical staff

- **On-site training has better results when it is participatory and practical** Providers must first understand the theory behind a practice, and then successfully carry out the practice as part of the training. This provides for more sustainable skills, where new methods immediately become a part of practiced procedure, and is thus preferable to purely theoretical training provided in a classroom or workshop setting. On-site training also allows for more providers at the site to receive the training directly, not just the few who might be selected for off-site training. Even when this practical method is used, however, continued follow-up and supervision are necessary to maintain the use of new skills. It is time consuming but necessary to check skills and standards maintenance on successive visits in order to establish the practice. Systematic evaluation is also required to indicate if more training is needed, and to revise training techniques.
- **Institutionalizing clinical training and supervisory capacity is a long-term effort** Project plans to establish governorate training teams which would be able to independently carry out both on-the-job and more structured training were not successful. We believe that this failure is symptomatic of a larger problem. Health Office staff have little incentive and resources to make routine field visits for training, supervision, or other purposes. Factors which contribute are lack of transport, lack of funds for per diem, the very short Yemeni work day, cultural/familial barriers to travel by some female supervisors, low salaries, and leadership which does not insist on the performance of specific job duties. Until these problems are solved, Health Centers outside of governorate capitals will continue to suffer from poor supervision and training, and service quality will suffer as a result.
- **Outreach to clients (especially women and children) is essential to improve and expand service coverage, but is difficult to provide and sustain in many cases** Poorly compensated and poorly motivated service providers, especially female providers who are culturally encouraged to remain "in the background," are understandably reluctant to leave Health Centers and make home visits. Conversely, and due to a host of factors, female clients are often reluctant to leave home to seek services. Verbally encouraging providers to do outreach -- and helping them make schedules and plans to do so -- had little effect. What was effective was having project staff, especially female staff, initiate outreach visits with providers, demonstrate that it was possible to do, and reinforce and encourage the practice. Whether this behavior can and will be continued after the project is uncertain, but when outreach is initiated in this way 1) Providers are more likely to continue the activity at least in the short run, and, 2) Women clients who established personal links to the center through home visits by female provider began visiting the center, some for the first time.

Management Systems Improvements

- **It is difficult to improve health services when critical health personnel (doctors, laboratory and x-ray technicians), equipment, drugs and supplies are missing**

Balancing resources between centers is important. Situations where one center has four doctors and another has none should be avoided. Centers that have a full complement of doctors and facilities attract clients. Minimum levels of staff should be provided at each center (e.g. at least one doctor per center).

- **Management improvement efforts should first focus on the service delivery point**
The OFC experience was that focusing at the Health Center level, with some support for management improvement at the Health Office level, produced improved quality of services. This approach also supported the MOPH's decentralization policy. Management improvements at the different levels are inter-related -- to some extent, all improvements at the local level require corresponding improvements in higher level support and supervision systems. Nevertheless, the purpose of the health care system is to provide services to clients, and the initial focus should therefore be on building capacity at the service delivery point. Additional support can then be directed to successively higher levels as time and resources permit.
- **Health Centers must be empowered and prepared to solve many of their own problems**
While assisting Health Offices to solve problems for Health Centers should be a major goal of any project, in reality Health Centers should be prepared and equipped to solve as many of their own problems as possible through decentralization of authority, responsibility and resources. Health Offices do not currently have the capacity to fully assist or supervise Health Centers, so self-reliance must be encouraged and developed.
- **Health workers are willing to make corrective changes**
While the management of health systems is weak throughout Yemen, Health Center personnel are generally capable and willing to make corrective changes when good ideas are suggested and they are given appropriate training. The challenge, in many cases, is to ensure that a support system is established to follow-up and assist these individuals after training. Support and follow-up should be provided by a combination of project-sponsored staff and Health Office personnel, since project involvement is in itself not sustainable.
- **MCH programs must be integrated into Health Center management**
Cultural and gender issues have tended to separate or marginalize MCH activities, which are largely preventive, from the mainstream of curative hospital/Health Center management. Accordingly, one goal of MCH-focused projects should be to pursue activities which facilitate the integration of MCH activities, such as assessing the degree of emphasis given to curative vs. preventive care by center management, and forging better relations (interpersonal and systemic) between MCH staff and other center staff. Without effective communication and management interaction within a Health Center, it is more difficult to pursue qualitative and quantitative improvements in health care delivery. Basic to this principle is the development of regular staff meetings among departments and a team approach to decision making and problem solving at each center.
- **Motivation is a key to making changes**
The problems faced by Yemeni health workers are substantial -- not the least of which is low pay and lack of recognition for improved work performance. Therefore, programs designed to introduce change must recognize

this reality and design reward systems that recognize improvement While increases in compensation would undoubtedly be useful, other mechanisms might be effective and more realistic, such as community-sponsored awards and recognition for good performance

Component 3 Community and individual participation increased in three governorates

Successes

- The Health Center Improvement Model demonstrated by example that policies and practices of decentralized training, decision-making, responsibility and resources allocation, together with community participation, can achieve improved MCH/FP care
- Community and MOPH partnership is an effective approach to improving MCH/FP service delivery and Health Center management
- Community health committees/boards were established and supported with training, and these committees helped resolve problems facing the Health Center and improved the delivery of health care services
- Health Office leaders began to interact with communities in positive, proactive ways to resolve problems locally
- Fee collection procedures were established or improved through on-site training in a manner consistent with MOPH guidelines and future plans for cost sharing Coordination and communication between the Health Office, Health Center and the community, with respect to financial issues, was improved

Constraints Problems encountered and solutions used

- **Communities did not necessarily view MCH as a high priority activity** The difficulty in developing an understanding and appreciation for preventive services is well known This was a particular challenge in some of the more traditional Yemeni communities that were very polite and appreciative of the project's desire to help them, but would have perhaps been happier with a water project or the provision of an x-ray machine Communities also tended to see health care as an entitlement, solely the responsibility of the government to provide

Solution Community meetings were and can be used as a platform to praise the virtues of preventive care, using examples that would be meaningful to the audience (e.g., asking how many knew of children who had died from preventable diseases) Messages about the inability of the government to meet all of the health care needs of the population were delivered bluntly Respected governorate officials and local leaders were also enlisted to deliver these messages

- **Trust is not automatically present between all parties** When entering a community for the first time all parties need to learn that the other parties are sincere. Past experience of the community with outside assistance may not have been positive.

Solution Taking the necessary time to build a community board and relations with it will pay dividends in the long run. Plan on conducting some smaller activities initially which will build trust between all parties.

- **Slow formation of committees** Despite constant follow-up and guidance, committees were slow to form, and once established, membership changed frequently in some communities. This delayed work with the health committees, such as facilitating the establishment of roles and responsibilities, priority setting, and planning.

Solution Staff must be patient, but also must intervene frequently by stressing the benefits of having an activist committee with stable membership. In the meantime, work should proceed with those community members who were most active and supportive.

- **Female representation on committees was difficult to obtain** When approached with the idea of having community meetings or forming community committees, the (male) leadership naturally assumed that males only should attend.

Solution Staff attending community meetings stressed the importance of female “input” into the planning for improving health care. (Sometimes, this was introduced slowly, for example, by asking men to consult their female relatives about their health care needs, priorities, and experiences with the health care system.) In communities more open initially to female involvement, and in all centers eventually, a variety of “woman-friendly” strategies were used. They included approaching school teachers or other women in the workforce, including midwives and *murshidat* in meetings to encourage other women to join, holding meetings in the Health Center during working hours, and finally, requiring female representation on committees before scheduling or beginning important activities.

- **Community politics played a major part of the community midwife training** Educational requirements were bypassed by some candidates with influential backing, relatives of community leaders demanded preferential treatment, and the interests of community leaders often took precedence over training quality.

Solution Problem cases were referred to the Health Office, HMI, and central MOPH to handle. The managers of training programs should insist on, and establish systems for, fair and transparent treatment of all trainees. In the case of a foreign agency, the Health Office, HMI and MOPH must be the enforcers of such policy.

- **Remote rural communities were in most need of community midwives but had the fewest candidates** These communities had few candidates who met the minimal education requirements. These also tended to be the more conservative communities, reluctant to send young women for training.

Solution Special efforts were, and must be, made to meet with these communities and to encourage them to consider allowing women to participate in the training. HMI/HO representatives were, and can be, recruited to talk to communities about identifying qualified candidates and the about the benefits to the community of the training.

- **Fulfilling agreed-upon commitments** Ensuring that all parties fulfilled their commitments was a major issue which required continuous follow-up in many communities. While OFC staff continued to make follow-up visits to ensure that the local communities lived up to their commitments, trainers, trainees, and Health Center staff need to be, and were, encouraged to solve problems on their own.

Solution During field visits trainees, trainers, and Center Directors should be, and were, encouraged to become better problem solvers. This can be done by helping them to identify the causes of the problems and to identify the individuals with the power and resources to assist them. They also can, and were, encouraged to resolve some of the problems on their own, where possible, without community assistance.

Lessons Learned

- **Community involvement is an important resource and must be included to improve health care delivery.** Until there is Health Center solicitation and acceptance of community interaction, the chances of improving community confidence in health care delivery, and in providing assistance to the Health Center, will be limited. Experience suggests that community interest in, and support of, preventive health activities can be generated through multiple contacts with community representatives, extensive negotiations of the specific inputs to be made by the communities, demonstration that community inputs result in specific benefits to the community, and frequent follow-up to assure that commitments are met.
- **The Community Partnership Agreement is an effective way of formalizing community participation,** as well as the inputs to be made by the Health Center, Health Office, and any outside group. It “gets everyone on the same page” in the beginning, and then provides an effective mechanism for follow-up. It is not a panacea, however. Staff spent enormous effort trying to ensure that signatories to the Agreements lived up to their promises. Occasionally, drastic action was required (such as stopping renovation activities) to ensure that commitments would be fulfilled.
- **Communities do not “automatically” perceive MCH services as a high priority.** Curative health services, water projects, road improvement, all are valued by communities presumably because of the immediate, tangible benefits they provide. Preventive health services, including midwife training programs, offer benefits of a more “conceptual” nature, and it therefore may be more difficult to persuade communities to devote scarce resources to supporting them. The universally male leadership may be insensitive to programs that can be seen as mostly benefitting women. Also, trainers and some trainees were outsiders in the community and leaders did not feel an immediate responsibility toward them.

- **The importance of sheikhs and parliamentarians in local health care programs cannot be minimized or ignored** Particularly in the more traditional areas of northern Yemen, leadership and power tends to be vested in a few men. What is called “community participation” in these areas often seems more like “sheikh participation.” It is certainly true that community-based activities in these regions absolutely must have the active support of these leaders, who often do not delegate much of their authority or decision-making.
- **Community leadership is critical, and the leaders must be identified** Even in less traditional areas, activism is often dependent on a few people who are very energetic and involved. Unfortunately, these people also tend to be very busy and/or frequently out of town, so leadership capacity-building is also important.
- **The history of poor services in Health Centers needs to be overcome** The Health Centers that serve many of these communities have provided such poor services for so long that people dismiss them. This project worked hard on motivational messages to community and Health Center alike, with the motivation that working together would yield tangible improvements. This approach was successful in large measure, but requires continuous follow-up to sustain improvements and community involvement.
- **Women can be active members of community health committees** Most communities at first discouraged the idea of inviting women to join health committees. But aggressive tactics to involve women paid off, with many committees including women in their membership by the end of the project. Some of the factors making it more likely or conducive for women to join committees are convenient meeting times, “neutral” meeting sites such as the Health Center or a local school, having more than one female participating, and the involvement of a well respected local community leader.
- **Health Center Directors generally support increased community involvement** Once initial community meetings took place, none of the center directors or staff objected to community involvement in the center activities. Not only were directors and staff pleased with the increased resources resulting from Partnership Agreements, but also community involvement seemed to please the director and staff by making the center a focal point of community attention.
- **Fee collection issues are very controversial subjects at Health Centers** Management improvement initiatives focussed on cost recovery revealed a deep sensitivity over fees collected in Health Centers. This reality is a clear indication that the MOPH-designed Cost Sharing Program may not be easily accepted or adopted at the local level. Therefore, extensive sensitization, community involvement and training will be required if the program is to achieve its objectives.

V. Potential for Replication

Based on the experience gained in developing and implementing the Health Center Improvement Model in the OFC contract, we believe that the Model is generally replicable in Yemen (although best with certain modifications and provisos), and that the MOPH and other donor agencies and NGOs would be well served in adopting the basic Model as a guide for improving health care service delivery. Although we refer specifically to the “Model”, it is not a rigid set of rules and prescriptions. Indeed, there are many opportunities to improve these approaches, to focus and emphasize various components of improving services, and to devote additional time to building capacities that will sustain better services in the long term.

Preceding sections of this report describe how the OFC Model approached each of the three components. There are other ways that these issues can be approached, and the descriptions provided about our experience, problems encountered and solutions used, as well as the lessons learned, should all be useful in helping program managers design their own approaches in the future. There may also be other components which would produce useful results, such as an information, education and communication (IEC) component.

In addition to issues raised in previous sections of this report, we emphasize the following points as particularly important for project design and implementation, however the Model may be replicated:

- Devote more resources to management training and leadership development at all levels starting from the Health Center, and working up to the Health Office and central levels as resources permit.
- To the degree possible, work with national authorities on a long term program to change the organizational culture which will permit greater individual accountability, motivational mechanisms, and rewards and sanctions based on merit.
- Make longer term commitments to provide assistance as long as all parties are meeting their responsibilities. Many of the changes and improvements in clinical practices and training systems, and *most* of the changes in management practices and community participation, cannot be fully implemented and institutionalized in periods of less than five years, with ten years being preferable. The expectations for institutionalization and sustainability vary in direct proportion to the amount of time invested, other factors being equal.
- Develop an equitable, transparent system for selecting the target service delivery sites based on need and demonstrated performance. One of the more important criteria should be demonstrated willingness and capacity to contribute in significant ways to the work to be performed, including contributions of staff time, funding, and/or in-kind contributions.
- We believe program planners need to adopt procedures where the partners in a project come together in the beginning, formalize and write down their plans and the inputs that each partner will make in a document resembling the Community Partnership Agreement.

- To the extent possible, include a system that recognizes and therefore motivates good performance. The OFC Model included a system of comparative assessment to evaluate performance from center to center.
- While funding limitations and donor priorities often require that projects focus on one or a limited number of health interventions, projects should be designed as much as possible with the entire system in mind. For example, Health Centers have a variety of preventive and curative functions. Improving some of them while neglecting others ignores the inter-related system in which the services are provided, and can be a disincentive for cooperation among these services.
- Health programs should also work to form linkages with other sectoral programs where problems may be related, or where economies of scale can be achieved by sharing resources. One natural linkage is with national and municipal authorities dealing with water, environmental, and sanitation issues, since so many of Yemen's health problems are environmentally based or related. The Dutch Government's experiment linking community health committees with garbage collection schemes is one model among many that could be used.
- The changing social and economic environment in Yemen makes it important that we regularly challenge our assumptions about what can and cannot work, and what practices are most appropriate to the situation. For example, the MOPH embraced the idea of decentralized community midwife training (with the enthusiastic support of a number of assistance agencies such as USAID's OFC) based on the assumption that young women could not travel far away from home for training. Undoubtedly, for many Yemeni families and for entire subcultures, this assumption is valid. But anecdotal evidence from some of our community meetings conducted after training was underway suggests that this attitude may be far from universal. The lesson is that Yemen is a changing society which must constantly respond to new challenges and conditions, and we need to be constantly aware that the validity of our assumptions may be changing as well.
- The Health Center Improvement Model, as described here, is not sustainable in the short term. That is, efforts such as this will continue to require donor support for the foreseeable future. The basic idea of the Community -- Health Center -- MOPH -- Donor Partnership which is at the heart of the Model assures that all parties share in the effort and cost of making it work, and similarly share in its success.

VI Progress Against Contract Performance/Special Objective Indicators

Contract performance as measured by the contract indicators was very good. Fourteen of the contract indicators had one target for end of contract performance. An additional indicator (#2) had three sub-targets, for a total of seventeen targets. Fifteen of these seventeen indicator targets were met or exceeded. Of the two that were not met, one (Indicator #2 for Haggah) reached 53% of the target value, and the other (Indicator #3 2) reached 55% of the target value.

Overall contract performance as measured by the contract indicators was very good. **The OFC/JSI team was able to meet or exceed 15 of the 17 contract indicator targets.** Performance against one of the two indicator targets not fully achieved was also good. In antenatal visits per pregnant woman (Indicator #2), the target was achieved in Hadramaut and Hodeidah, and 53% of the target value was achieved in Haggah (82% of the target value was achieved in Haggah during the last quarter of the contract).

The poorest performance was recorded in the number of Health Centers implementing a more effective user fee system. This was because none of the centers in Hadramaut were willing to implement the system without written authorization from the Health Office Director General. This was in spite of the fact that the Director General had given verbal approval for the centers to participate in the user fee training workshop which was implemented with the seven Hadramaut Health Centers.

Calculating and comparing 1998 annual performance

It was not possible to provide twelve months of performance data for calendar year 1998 due to the contract ending on September 30, 1998. In order to report annual figures for 1998 and compare 1998 performance with the annual performance reported in the baseline year (1995), 1996 and 1997, we have chosen two methods to calculate 1998 annual performance. Whenever an indicator is measured on an annual basis two figures are provided, e.g. 15.6%/18.5%. The first figure is the last four quarters (12 months) of the contract, from October 1, 1997 - September 30, 1998. The second figure is also for twelve months, from January 1, 1998 - December 30, 1998, and includes nine months of actual performance data (January - September) and 3 months (October - December) of estimated data. The fourth quarter estimate is an average of performance for the first three quarters of 1998.

This applies to the following indicators:

Special Objective Indicators 1, 2 and 3
Lower Level Results Indicators 2.3, 2.4, and 2.5

Results achieved

Special Objective Improved quality and use of integrated MCH/FP services in 22 Health Centers in three governorates

Indicator 1 Percentage of eligible children under five completing DPT/polio series at 22 Health Centers (Target 6%)

The MOPH immunization management/tracking system collects and monitors data on under children under one year old, not on children under five. This fact was overlooked in August 1996, when this indicator was established. It was not possible to change the MOPH national HMIS standards for the convenience of the OFC contract, nor was it efficient or possible to ask 22 Health Centers to collect additional data only for one OFC contract indicator. Therefore, a proxy indicator was established in line with the MOPH policy and data collection standards of tracking immunization of children under one year old. To account for the difference the number of under ones was estimated in relation to the population of under fives in order to establish a percentage of under ones equivalent to 6% of the under five year old population. A 6% rate of under fives was determined to be equivalent to 17.5% for children under one year old, therefore,

Proxy Indicator 1 Percentage of eligible children under one completing DPT/polio series at 22 Health Centers

This indicator was achieved

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
13.60%, 8,053 immunizations	14.73%, 9,018 immunizations	16.03%, 10,161 immunizations	24.9%/27.2%, 15,790/17,248 immunizations	17.50%

As of August 1998, this indicator was met and surpassed for 1998 when 18.54% (11,751 immunizations) was achieved in the first 8 months of 1998. The increase in coverage is even more noteworthy when comparing OFC figures with the 1997 Preliminary MCH DHS survey results released in April 1998, which showed a drop in national immunization rates from 47% to 39%. The most dramatic increases were achieved in Hajjah where 43% coverage was achieved during the 12 months from October 1997 - September 1998. This is attributable to the OFC-sponsored introduction of MCH services at centers which had not previously offered these services, and to outreach and home visits which were emphasized in the last nine months of the contract.

Indicator 2 Number of antenatal visits per pregnant woman at 22 Health Centers

This indicator was achieved in two (Hadramaut and Hodeidah) of the three OFC governorates

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
Hadramaut 3.65	Hadramaut 3.52	Hadramaut 3.57	Hadramaut 4.16	Hadramaut 4.00
Hajjah 1.85	Hajjah 2.30	Hajjah 1.74	Hajjah 2.46	Hajjah 3.00
Hodeidah 2.13	Hodeidah 2.12	Hodeidah 2.19	Hodeidah 3.07	Hodeidah 3.00

At various times since the fourth quarter of 1997 this indicator has been achieved monthly or quarterly. The number of antenatal visits has been increasing steadily in all three governorates. In the fourth quarter of 1997 Hadramaut exceeded the target when it achieved 4.27 visits per

pregnant woman Antenatal visits per pregnant woman in Hodeidah have been rising quarterly since the second quarter of 1997, exceeding the target in the last quarter of the contract, 3.07 visits per pregnant woman Hajjah figures are also at their highest level ever, reaching 2.63 in the second quarter of 1998 and 2.46 in the third and final quarter of the contract, but falling short of the target

Another important measure of antenatal services usage is the volume of antenatal visits (i.e., all initial visits plus all follow-up visits (Note that the number of antenatal visits per pregnant woman (all visits divided by initial visits) tends to decrease when large numbers of new clients receive services for the first time) Dramatic increases were seen in the total volume of visits For example, total visits in the first quarter 1997 were about 3,100, as compared with 8,000 visits in the third quarter of 1998 Improvements in the number of providers, the quality of services, and outreach from the centers are all contributing factors to the increase in the volume of visits and the number of visits per pregnant woman

Indicator 3 Couple years of protection (CYP) generated at 22 Health Centers

This indicator was exceeded using both the 12 month period from October 1997 to September 1998 and the first three quarters of 1998 and a projection for the fourth quarter based on performance from January through September 1998 Factors contributing to the increase in CYP were fewer stock-outs of contraceptives and enhanced skills of providers related to family planning

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
4,186	4,990	4,543	5,588 / 5,812	5,442

Intermediate Result Health Center Improvement model in 22 Health Centers in three governorates established and documented

Indicator 1 Number of Health Centers implementing the model that have sustainable female staffing, minimum quality standards, and communities participating

This indicator was exceeded with 21 centers having achieved the minimum rating for quality of facilities and equipment and quality of services, signed community participation agreements and female providers

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
0	0	12	21	12

In order for a center to meet this indicator it must meet the requirements of Indicator 2.1, Facilities and Equipment (achieving a rating of 60% or better), Indicator 2.2, Quality of Clinical

Service (achieving a rating of 60% or better), Indicator 3 1 Community Participation (having a signed community participation agreement), and, LLR Indicator 1 3, (have female health care providers on-site and/or participating in the decentralized training program)

The centers meeting this indicator were

Hodeidah Bayt Al Faqih, Bajil, Dhahí, Marawa, Al Qutai, Zoharah
 Hajjah Hajjah MCH, Mohabisha, Shagadirah, Kuaydinah, As Shahel, Mabyan, Moharraq, At Tur
 Hadramaut Mukulla MCH, Shaher, Ghail Ba Wazir, Adeis As Sharkiya, Al Hami, Shuheir, Seyoun

Indicator 2 Detailed report/evaluation of the model prepared and distributed to MOPH and donor community

This indicator was achieved

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
0	0	0	1	1

A report on the MCH/FP Health Center Improvement Model was written and presented to the Ministry of Public Health at a meeting on October 3, 1998. The report was distributed within MOPH and distribution to the donor community is expected before the end of 1998.

Lower Level Results

Lower Level Result 1 Sustainable female staffing established in centers in three governorates

Indicator 1 1 Number of decentralized training centers operating

This indicator was achieved and exceeded

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
0	0	11	11	9

Decentralized training centers were established at the following locations

Hodeidah Bayt Al Faqih, Marawa, Zoharah
 Hajjah Mahabisha, Shagadirah, Kuaydinah, Mabyan, Moharraq, At Tur

Indicator 1 2 Number of trainees nominated by communities which will contribute to their support

This indicator was achieved and exceeded

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
0	699	699	699	400

Indicator 1 3 Number of trained female providers in place at 22 Health Centers

This indicator was met and exceeded by 119 %

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
63	93	94	290	132

As of September 30, 1998 there were 93 female service providers working and 197 midwife and murshidat trainees in training (totaling 290), receiving practical, on-site training and providing services at the OFC supported Health Centers. Since the training program was extended beyond the completion date of the OFC contract, it was not possible to assess how many of the trainees would actually graduate and subsequently work at OFC target Health Centers and associated health units

Lower Level Result 2 Minimum quality standards for centers in place in four governorates

Indicator 2 1 Number of centers passing inspection for minimum quality of facility and equipment

This indicator was met

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
0	0	27	28	28

The centers passing the quality standards checklist for facilities and furnishings included

Hodeidah	Bayt Al Faqih, Bajil, Dhahi, Marawa, Al Qutai, Zoharah, At Thowra Hospital Referral Center
Hajjah	Hajjah MCH, Mahabisha, Shagadurah, Kuaydinah, As Shahel, Mabyan, Moharraq, At Tur
Hadramaut	Mukulla MCH, Shaher, Ghail Ba Wazir, Adeis As Sharkiya, Al Hami, Shuheir, Seyoun
Lahj	Al Houta, Al Daleh, Al Habilein, Tour Al Baha, Al Waht, Habil Gabr

Indicator 2 2 Number of Health Centers following minimum clinical and management protocols

This indicator was met and surpassed

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
0	0	18	21	20

A minimum rating of 60% on the clinical services checklist was required to meet this indicator
The following centers met this requirement during the final quarter

Hodeidah	Bayt Al Faqih - 82%, Bajil - 65%, Dhahi - 72%, Marawa - 84%, Al Qutai - 61%, Zoharah - 81%
Hajjah	Hajjah MCH - 79%, Mahabisha - 81%, Shagadurah - 77%, Kuaydinah - 76%, As Shahel - 78%, Mabyan - 88%, Moharraq - 75%, At Tur - 74%
Hadramaut	Mukulla MCH - 64%, Shaher - 67%, Ghail Ba Wazir - 80%, Adeis As Sharkiya - 85%, Al Hami - 95%, Shuheir - 90%, Seyoun - 92%

Indicator 2 3 Average number of months that ORS is out of stock at 22 Health Centers

This indicator was met

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998

3 36	1 32	2 20	99/ 85	1 00
------	------	------	--------	------

Using the last four quarters of the contract the stock out rate was 0 99 Using the last three quarters of the contract and estimating a figure for the last quarter of 1998, based on the average of the first three quarters of 1998, the number is 0 85 This was achieved by OFC staff being mindful of the stock levels of ORS and making sure that center directors and governorate staff responsible for supplies followed up in a timely fashion

Indicator 2 4 Average number of months that iron folate is out of stock at 22 HCs

Depending on which figure is used the indicator is achieved, or not During the last four quarters of the contract, the target was not met, with iron folate being out of stock for an average of 2 39 months On the other hand, the target is exceeded if the first three quarters of 1998 are used and averaged to determine a 1998 fourth quarter figure Using this method the number of stock-outs is 1 38 which exceeds the 2 00 target

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
6 80	8 95	7 50	2 39/1 38	2 00

As indicated by the figures above, stockouts of iron folate was a major problem throughout the period of the OFC contract, primarily because of national-level supply shortages Performance on this indicator improved dramatically in 1998 due to better national supply, and to the efforts of the OFC staff to track stock supplies and ensure center directors and governorate supply staff followed up when supplies were low In cases when MOPH supplies were low other sources were sought, such as the Yemen Family Care Association

Indicator 2 5 Average number of months that oral contraceptives are out of stock at 22 Health Centers

This indicator was achieved and surpassed

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
1 39	0 33	0 370	082 / 084	0 50

Lower Level Result 3 Community and individual participation increased in three governorates

Indicator 3 1 Number of Community Participation Agreements signed and operational

This indicator was met and surpassed. The number of Agreements is greater than the number of target health centers, because two similar Agreements were signed and implemented with the HMIs in Hadramaut and Hajjah.

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
0	0	24	24	22

Indicator 3 2 Number of Health Centers adopting and implementing more effective user fee systems

Fifty-seven percent (12 of 21) of this indicator was achieved.

Baseline 1995	Annual 1996	Annual 1997	Annual 1998	Target 1998
0	0	0	12	22

The poor performance here is attributable to the fact that none of the centers in Hadramaut were willing to implement an improved user fee system without written authorization from the Health Office Director General, though he had previously given verbal approval for the centers to be trained in implementing the new system. In the northern provinces of Hajjah and Hodeidah, 12 of 14 (86%) centers implemented the system that was developed with OFC support and training. As of the end of the contract, each of the six centers in Hadramaut had written to the Director General requesting approval to implement the system in which they had received OFC assistance and training, and were awaiting the Health Office response.

The centers implementing the user fee system were

Hodeidah Bayt Al Faqih, Dhahī, Marawa, Al Qutai, Zoharah
Hajjah Mahabisha, Shagadīrah, Kuaydinah, As Shahel, Mabyan, Moharraaq, At Tur

VII. Contract Expenditures

In August 1998, the contract budget was modified (Amendment 4) in order to revise the contract budget and increase the total estimated cost of the contract to \$6,836,326

Column I Budget below shows the budgeted figures as per the contract, and Column II Cumulative shows total cumulative invoiced costs over the life of the project

	I BUDGET	II CUMULATIVE
Subtotal	\$6,457,338 00	\$6,431,439 09
Fee @ 6%	<u>\$378,988 00</u>	<u>\$322,139 80 *</u>
Total	\$6,836,326 00	\$6,753,578 89 **

* \$322,139 80 represents billed 85% of the fee Remaining 15% fee billable upon completion of all contract requirements

** \$6,753,578 89 billed to date

Sample Community Partnership Agreement

PARTNERSHIP AGREEMENT

AL MARAWA'A HEALTH CENTER, COMMUNITY OF AL MARAWA'A, HODEIDAH HEALTH OFFICE, AND THE OPTIONS FOR FAMILY CARE PROJECT/USAID

This Partnership Agreement (CPA) is agreed to among Al Marawa'a Health Center, Community of Al Marawa'a, Hodeidah Governorate Health Office, and The Options for Family Care Project/USAID in order to

- Identify major center activities to be accomplished
- Clarify division of responsibilities among the above parties to accomplish the activities
- Ensure that the commitments are fulfilled as agreed by the above parties

Summary of Major Activities

- Establish a training center for pre-service training of Community Midwives
- Renovate space allocated for delivery of integrated MCH services
- Improve the quality of Maternal and Child Health /Family Planning (MCH/FP) services being provided by the health center
- Provide necessary training and clinical equipment, training in the use of the equipment, and technical assistance to the health center
- Support refresher training courses for the health center's FPHCWs
- Support pre-service training for community midwives
- Provide on-the-job training to enhance management, recordkeeping, and cost-recovery systems, facilitate the implementation of the MOPH's Health Management Information System (HMIS)

Division of Responsibilities

Implementation of these activities and the sustainability of staffing and services will require coordination, cooperation, and specific resources from the above mentioned parties. The division of responsibility will be as follows

- **Al Marawa'a Health Center**
 - Works with Al Marawa'a Community to establish a Health Advisory Board.

x

- Coordinates with Al Marawa'a Community to contribute to living costs and transportation for the trainees
- Allocates adequate space for the provision of integrated MCH services and training to be renovated by OFC See attached drawing indicating designated space
- Ensures a regular supply of running water and electricity
- Provides ongoing maintenance of the MCH/FP center and its equipment, including regular, thorough cleaning and minor repairs
- Implements the MOPH's Health Management Information System (HMIS) and serves as a test site for the enhancement of this system, submitting reports to the Hodeidah Health Office in a timely manner Reports any difficulties in completing these reports
- Participates in activities to improve the quality of care and to improve the management of the MCH services such as refresher training, on-the-job training, implementation of an internal system of supervision, planning, budgeting, and cost-recovery activities, use of data for decision-making, in-patient care and internal management of patient flow
- Holds regular weekly staff meetings aimed at organizing and coordinating the work of employees, resolving internal problems, and improving quality of service
- Ensures that necessary statistics are collected, compiled, and submitted to the Governorate Health Office for the purposes of internal management and to ensure that a constant supply of drugs, vaccines, and contraceptives are available
- Retrieves cleaning supplies, vaccines, drugs, contraceptives as well as associated client cards and record books from the Health Office on a regular basis in order to maintain a regular stock
- Facilitates the recruitment and selection of candidates for midwifery training
- **Al Marawa'a Community**
 - Establishes a Health Advisory Committee for the purpose of supporting health service delivery at Marawa'a Center
 - Through the Health Advisory Committee, manage selected community and other

resources which support the training of Community Midwives at Marawa'a Center This shall include, but may not be limited to, managing the funds and goods required for food for the trainees

- Coordinates with Al Marawa'a Center to support the living accommodations of the trainers and trainees for the community midwife training
- Employs a guard for the center
- Brings forth appropriate candidates to be trained as midwives
- Contributes toward the daily living expenses of the trainees
- Provides all transportation and furnished lodging for the trainees

- **Hodeidah Governorate Health Office**
 - Designates a representative(s) to serve on the Joint Selection Committee (Health Office, Health Manpower Institute, Ministry of Public Health, and the OFC Project) for the selection of trainees for the Community Midwife Training Program at the Al Marawa'a Training Center
 - Provides government employment to all trainees after graduation
 - Provides basic cadre of staff for the MCH section
 - Coordinates with Al Marawa'a and OFC in designating space for implementation of integrated MCH services as indicated in the attached sketch
 - Facilitates and participates in activities to improve the quality of care and to improve the management of the MCH services such as refresher training, on-the-job training, implementation of an internal system of supervision, planning, budgeting, and cost-recovery activities, use of data for decision-making in-patient care and internal management of patient flow
 - Ensures that the center maintains a regular stock of MCH/FP cards, registers, and other record keeping supplies, family planning supplies, vaccines and drugs as available, and cleaning supplies
 - Provides financial support for the maintenance of the center, including building maintenance, equipment, and cleaning supplies

- Works in coordination with OFC in the development and implementation of an on-site system of supervision for the training center and for MCH services
- Coordinates with the MOPH to develop a plan for supporting midwives after training
- With support from OFC, works to improve logistical and management systems to ensure the disbursement of drugs, vaccines, and contraceptives and associated record keeping forms to the health center staff in a timely manner, provides training and follow-up supervision on the Ministry of Public Health's new Health Management Information System (HMIS), and develops a system for the distribution of HMIS record keeping forms
- Brings forth appropriate candidates to be trained as trainers in MCH record keeping systems
- Supports, facilitates, and supervises the trainers in conducting training in record keeping for MCH staff in health centers
- Establishes and maintains a Training Advisory Board for overseeing training activities, assisting in the selection of trainees, and establishing and maintaining a training documentation system
- Provides emergency and essential drugs, supported by the MOPH, to support the cost-recovery system
- Employs trained Lab Technician to be assigned to Marawa'a Health Center
- **Options for Family Care (OFC)**
 - Renovates the designated MCH section as indicated in the attached drawing and specifications (see attached) and contract in the amount of \$21,835 or 2,751,210 Yemeni Rials
 - Provides management and field support, as needed, through its local staff and resident advisor to facilitate implementation of OFC contract activities
 - Provides basic furnishings, equipment, and instruments for training of community midwives and MCH/FP service delivery in the amount of \$18,250 or 2,299,500 Yemeni Rials
 - Provides or supports in-service training (on-the-job, refresher training, and

training of trainers) for the MCH staff

- Recruits two community midwife trainers to conduct training of community midwives
- Supports training of trainers course to prepare trainers for community midwife training in the amount \$2400 or 302,400 Yemeni Rials
- Provides salaries for the two community midwife trainers for approximately \$17,000 or 2,142,000 Yemeni Rials
- Provides stipends for community midwife trainees in the amount of \$3900 or 491,400 Yemeni Rials
- Supports refresher training for female primary health care workers in the amount of \$2404 and 302,932 Yemeni Rials
- Provides support and technical assistance to the health center to improve the quality and timeliness of their MCH data collection and reporting, using the newly developed Health Management Information System developed by the MOPH
- Provides lab equipment for Marawa'a Health Center if the center maintains a regular stock of MCH/FP cards, registers, and other record keeping supplies, family planning supplies, vaccines and drugs as available, and cleaning supplies. The center must also work with the Health Office to develop a written fee schedule for all the lab services that will be offered by the center

Addendums to this Agreement

All parties will work cooperatively and continue to explore areas of future support during the OFC contract period and beyond. Therefore, it is expected that this agreement will include several addendums.

At a minimum, these should include agreements with Primary Health Care Units associated with Al Marawa'a Center and their communities for the support of community midwives who will attend training at Al Marawa'a Center, including Al Mahad, Al Khalifa, and Koshuba.

Agreement

By signing below, the following parties have agreed to the implementation of above activities and have agreed to the assigned responsibilities as outlined. Modifications to this agreement will

be made in writing and are subject to approval of all parties

Al Marawa'a Center
Director

Signature

Date

Al Marawa'a Community
Representative

Signature

Date

Options for Family Care
Representative

Signature

Date

Hodeidah Governorate
Health Office General Director

Signature

Date

MOPH guidelines for Community Midwife Trainee Selection Criteria

Community Midwife Trainee Selection Criteria

- 1 Ninth grade general education certificate
- 2 Willing to participate in, and commit to a 2 year training course
- 3 The trainee should be free of responsibilities which will hinder participation The trainees family , husband and father was be willing
- 4 No more than 10 days of continuous absences or 15 total days of absences
- 5 The community must select them
- 6 Must pass a written entrance examination and be interviewed and selected by the selection committee
- 7 No more than 20 trainees per class or training center

**List of Equipment and Instruments Needed for
the Selected Health Centers (including Training Centers)**

List of Equipment & Instruments Needed for the Selected Health Centers

Item No	Stock No	Description	Quantity	Unit Price	Total Price
1-	101000	Bed Labor and Delivery W / two - Piece Mattress	40	\$250	\$10,000
2-	184500	Examination Table Folding,2-section 180 cm Long, 60 cm W x 76 Height	100	150	\$15,000
3-	100800	Bassinet (Baby's Cot) W/Canvas basket 880 x 580x860 mm	30	70	2,100
4-	101605	Carrage, Dressing W / 2 Shelves 910 x 460 mm ("36 x 18") 800mmH	35 ←	325	\$11,375
5-	216000	Basin wash 4 Litre S S Approx 315mm Dia x 90 deep	50 ←	20	\$1,000
6-	214000	Basin Solution 6 litre SS Approx 315mm Dia x 127 deep	40	25	\$1,000
7-	210000	Basin Kidney 475ml,18/ 8,0 8mm Stainless Steel	150	8	\$1,200
8-	270000	Tray Instrument W/Cover,225x125x50mm St Steel	160	32	\$5,120
9-	727500	Forceps Hemostat Rochester-Pean 16cm(6 25") Long	120	10	\$1,200
10-	724500	Surgical Scissors Straight 14cm (5,5") Long	120	8	\$960

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Serial No	Stock No	Description	Quantity	Unit Price	Total Price
11-	735200	Forceps Sterilizer Cheatle 270mm(10 75) Long S S	150	\$30	\$4,500
12-	333000	Jar Forceps 114mm(4 5) deep Dia 54mm	150	25	\$3,750
13-	334200	Jar Thermometer Approx Dia 25mmx105mm deep	190	3	\$570
14-	481050	Thermometer Clinical Oral Dual Cells/FAHR Scale	500	3	\$1,500
15-	683000	Sphygmomanometer 300mg Hg with Cuff	200	26	\$5,200
16-	686000	Stethoscope Binaural Unit Complete	200	6	\$1,200
17-	686500	Stethoscope Foetal Pinard m (1429)	150	8	\$1,200
18-		Doppler w/ battery charger and regargeable battery	30	575	\$17,250
19-	319000	Mucus Extractor 12CH Catheter W/20ml Container	200	6	\$1,200
20-	305000	Apron Utility Opaque Plastic 0 9 m widex1m Long	200	7	\$1,400
21-		→ ARI Timer	380	5	\$1,900
22-	514000	Brush Hand, Approx 90x40mm("3 5x1 5")	300	1	\$300
23-		ENT Set	15	200	\$3,000
24-	14000	Scale Physician adult Metric 140KG x100G	120	25	\$3,000

Serial No	Stock No	Description	Quantity	Unit Price	Total Price
25-	114400	Height measure Instrument up to 2 metres	30	\$20	\$600
26-	145520	Scale Infant Clinic Metric 15 5Kgx5G	75	250	\$18,750
27-	557000	Scale Spring Baby 5Kg,25G Graduations W/Throusers	250	30	\$7,500
28-	156000	Sterilizer Dressing Pressure Type 350x380mm/39L Fuel	75	160	\$12,000
29-		Autoclave	30	\$675	\$20,250
30-	107700	Drum, Sterilizing, Cylindrical 240mm Dia	80	40	\$3,200
31-	169000	Stool Revolving Adjustable Height 360mm(14") Dia	80	55	\$4,400
32-	950000	Hemoglobinometer Set Sahli Type complete	5	20	\$100
33-	1183000	Thermometer Dial Vaccine, Storage Vapur Pressure	2	4	\$8
34-		Vaginal Specula	100	25	\$2,500
35-		Midwifery Kit (content inclosed)	400	260	\$104,000
36-		Vacuum Extraction	10	700	\$7,000
37-		Episiotomy Set (Content inclosed)	10	113	\$1,130

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Item No	Stock No	Description	Quantity	Unit Price	Total Price
38		Projector Screen	1512	\$120	\$1,800
39		Slide Projectors	1512	400	\$6,000
40		Overhead Projectors	1512	400	\$6,000
41		TV/VCR Combination Sets	10	600	\$6,000
42		Eva Gynological Model	1512	350	\$5,250
43		Breast Examination Model	10	50	\$500
44		Female Pelvic Organs Model	15	200	\$3,000
45	local	5 -9 KVA Generators	4	4,000	\$16,000
46	Local	Chairs for Waiting Rooms/Training Centers	1000	25	\$25,000
47	local	Metal Shelf Files	50	250	\$12,500
48	Local	Patient Screen	200	50	\$10,000
49		IUD Kits	30	250	\$7,500
50		Refrigerator w/ freezer	10	600	\$6,000
51		Dial Thermometer	130	5	\$650
52		Pediatric Bed	60	100	\$6,000
53		Nasogastric Tube	100	15	\$150

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Item No	Stock No	Description	Quantity	Unit Price	Total Price
54		Nasal Catheter/Cannula	60	1	\$60
55		Nebulizer	40	20	\$800
56		Ambu Bag with face mask (infant)	60	10	\$600
57		Airway Guedal Rubber	20	1	\$20
58		Adult Ventilator bag and mask	20	50	\$1,000
59		Infant Resusitator tool	250	5	\$1,250
60		D&C Set	10	300	\$3,000
61		Infant Syphgamomanomater	30	20	\$600
62		Infant Stetscope	30	5	\$150
63		Portable Stand Light	210	50	\$10,500
64		Baby Cots	30	50	\$1,500
TOTAL					\$408,193

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TEACHING AIDS AND MATERIALS
PROCUREMENT FOR TRAINING CENTERS

ITEM	QUANTITY	COST	TOTAL COST
Models			
1 —PC Manikin w/ male and female genetata, 35lbs	12	520 00	\$6,240 00
2 Obstetnc Manikin w/ carrying case	12	565 00	6 780 00
3 Eva Gynelological Exam Model**	12	465 00	5,580 00
4 Breast Examination Model**	12	345 00	4,140 00
5. Pelvic Normal and Abnormal	12	795 00	795 00
6 Family Planning Educator (SIMA 60-36 FPE)	12		
7 Normal and Abnormal Uter (SIMA 60-36 Axa)	12		
8 Cervical Set (SIMA 60-37 C-S)	12		
9 Female Pelvic Organs (SIMA 60-27 CS)**	12		
Audio Visual Equipment			
1 TV/VCR Combination Sets (one unit)**, 220V	10	600 00	\$6,000 00
2 Slide Projectors w/ 2 extra lamps*, 220V	12	400 00	4,800 00
3 Overhead Projectors w/ 2 extra lamps* 220V	12	400 00	4,800 00
Classroom Equipment			
1 Bulletin Boards, 36 x 48'	12	35 00	\$420 00
2 Bulletin Boards, 24" x 36"	6	20 00	180 00
2 Chalk Boards, 48" x 72'	12	90 00	1080 00
4 Write On Transparency Film	24 boxes	20 00	480 00
5 Chalk, white and colored	24 boxes	30 00	720 00
6 Erasers	12	24 00	288 00
7 Overhead transparency markers	12 boxes	8 00	96 00
Other			
1 Wall Pockets legal size, single unit	200	10 00	\$2000 00

*This items were on the original procurement list sent to AMEG (4 of each) I do not know if they have been purchased or not

**These items are on the comprehensive list of equipment sent later

Prices quoted are estimates or from information in catalogs Please check into quantity discounts Most preferably under \$500 00 All electronics should be 220/240V, 50Hz, low technology, easy maintenance We do not need anything very expensive with latest technological gadgets These will be used out in the field by the training centers and HMIs

Please ship via air freight Thanks

Training Materials Provided to Community Midwife Trainers

Training Materials Provided to Community Midwife Trainers

Books

- 1 Anatomy
- 2 Physiology
- 3 Public Health
- 4 First Aid
- 5 The situation of Women and Children in Yemen

Copied and provided

- 1 Obstetrics and medicine
- 2 Family Planning for midwives in Yemen
- 3 Primary health Care for MCH
- 4 Rules and regulations for Home deliveries
- 5 Illustrated Childbirth
- 6 Child care in Primary health care
- 7 Basic Medicine in Primary health care
- 8 Family Health Care (2 volumes)
- 9 Guidelines for primary health care trainees
- 10 On being in charge
- 11 Participatory training techniques
- 12 Partograph
- 13 Standardized tests
- 14 Trainee evaluation
- 15 Home visiting
- 16 Sexually transmitted diseases
- 17 Mechanics of Labor and delivery
- 18 Physiological changes during pregnancy
- 19 Reproductive growth and health
- 20 Child development
- 21 Caring for the newborn baby
- 22 ORS Therapy
- 23 Complications of pregnancy
- 24 Using teaching equipment
- 25 Communicating
- 26 The status of women
- 27 Management
- 28 Demographic s and statistics of Yemen
- 29 Breast-feeding
- 30 Diarrheal Control
- 31 Guidelines for health unit practices

The Community Midwife Curriculum Content

The Community Midwifery Curriculum Content

Unit 1 Basic Training

- 1 Anatomy and Physiology
- 2 First Aid
- 3 Fundamentals of Nursing
- 4 Public health
- 5 Nutrition
- 6 Personal health
- 7 Women's health
- 8 Environmental health
- 9 Communications skills
- 10 Health Information System in Yemen

Unit 2 Antenatal care

Antenatal care from ovulation through delivery

Unit 3 Delivery and Labor

- 1 Evaluating the prognosis of labor,
- 2 Caring for the mother through labor
- 3 Identifying normal and abnormal labor
- 4 Managing normal labor
- 5 Caring and managing the neonatal

Unit 4 Post delivery care

- 1 Care of the puerperium for mother and child
- 2 Family Planning
- 3 Common gynecological and obstetric conditions and their management

Unit 5 Child care

- 1 Growth and development of the child from 0 - 5
- 2 Breast feeding and child nutrition
- 3 Common health problems of the child and their management

Unit 6 Management and Supervision

- 1 Basic management and supervision skills
- 6 Providing first aid during emergencies for the mother and neonatal

MCH/FP Standard Equipment and Furniture in a Referral Hospital

MCH/FP Standard Equipment and Furniture in a Referral Hospital

<i>S No</i>	<i>Item</i>	<i>Quantity</i>	<i>Prerequisites</i>
OUTPATIENT			
CLIENT REGISTRATION ROOM/AREA			
	Table with chair	1	
	Client Seating	2	
	Shelves (1m)	30	
	Telephone line	1	
WAITING ROOM/AREA			
	Table with Chair	1	
	Client Seating/benches	20-25	Depend on the No of clients served
	Bulletin Board 100x70cm	1	
	Video and TV	1	
	Educational Videos, Flip charts, Posters etc		
MATERNAL CARE			
COUNSELING ROOM			
	Table & Chair	1	
	Client Seating	2	
	Adult Weighing Scale	1	
	Height Measurement	1	
	Sphygmomanometer	1	

	Stethoscope	1	
	Supply Cupboard	1	
	Demonstration Models		
	Waste Bin	1	
ANTENATAL ROOM			
	Table & Chair	1	
	Client Seating	1	
	Examination Table	1	
	Stool	1	
	Patient Drapes	6	
	Screen	1	
	Sphygmomanometer	1	
	Portable Light	1	
	Stethoscope	1	
	Fetal Stethoscope	1	
	Tray	1	
	Doppler	1	
	Thermometer	3	
	Thermometer Jar	1	
	Waste Bin	1	
FAMILY PLANNING ROOM			
	Table & Chair	1	
	Client Seat	2	
	Gyn Examination Table	1	
	Stand Lamp	1	
	Screen	1	

	Equipment Cupboard	1	
	Sphygmomanometer	1	
	Stethoscope	1	
	Stool	1	
	Instrument Cart	1	
	Thermometer	3	
	Thermometer Jar	1	
	Gloves		
	Solution Bowl	2	
	Speculum (diff Sizes)	12	
	Sponge Forceps	10	
	Sterilizer (Autoclave)	1	
	Instrument Tray Covered	1	
	<u>IUD Insertion Pack</u> Speculum (1) sponge Forceps (1) Long Artery Forceps (1) Uterine Tenaculum (1) Uterine Sound (1) Scissors (1)	4	Included in IUD Kit #2
	Hook IUD Removal	4	
	Small Bowl	1	
	Forceps IUD Removal "Aligator Jaw"	4	
	Surgical Contraception Equipment to be used with laparotomy/ caesarian section facility for HOSPITAL only		
PRE-DELIVERY ROOM			
	Bed	10	

	Sheet		
	Pillow		
	Blanket		
	Bedside desk		
	Stand w/hook		Near each bed
	Waste Bin		
DELIVERY ROOM			
	Table & Chair	1	
	Delivery Bed	4	
	Patient Drapes		
	Stand Light	4	
	Sphygmomanometer	1	
	Stethoscope	2	
	Fetal Stethoscope/Doppler	1	
	Screen	4	
	Supply Cupboard	1	
	Stand w/hook	4	
	Instruments Cupboard	1	
	Scrubbing Brush	5	
	Gloves		
	Instrument Trolley	4	
	Stand Double Bowl	4	
	Padded Table for dressing newborn	3	
	Basin Solution		
	Inst Tray with Cover		

	Infant weighing Scale	1	
	Plastic Sheet	8	
	<u>Delivery Pack.</u> Artery Forceps (2) Cord-cutting Scissors (1) Cord Ties Urinary Catheter (1) Gauze Swabs or Cotton Mucus Extractor (1) Episiotomy Scissors (1) 3 Dressing Baby Towels	10	
	Apron	6	
	Urinary Catheters Metal	4	
	Adult Ventilator	4	
	Oxygen Cylinder	4	
	Waste Receptacle	4	
	Vacuum Extractor	1	
	Syringes & Needles		
	Wall Clock	1	
	D&E or D&C Set	3	
	<u>Perineal Repair Pack</u> Sponge Forceps (1) Needle Holder (1) Scissors (1) Tissue Forceps (2) 1 toothed+1 non-toothed Sterile Suture Materials Gauze Swabs/Cotton	5	
	Local Anaesthesia		
	Sterile Gloves		

POST-DELIVERY ROOM/AREA			
	Bed	16	
	Sheet		
	Blanket		
	Pillow		
	Baby cot		
	Baby Blanket		
	Beside bed Desk		
CHILD CARE			
RECEPTION/EXAMINATION ROOM			
	Table & Chair	1	
	Client Seating	1	
	Thermometer	3	
	Thermometer Jar	1	
	Infant Weighing Scale	1	
	Stethoscope for infants	1	
	Sphygmomanometer infant	1	
	ARI Timer	1	
	Waste Bin	1	
	Examination Bed	1	
	ENT Set	1	
IMMUNIZATION ROOM			
	Table & Chair	1	
	Client Seating	2	
	Supply Cupboard	1	

	Refrigerator with Freezer	1	
	Gas Cylinder	2	
	Dial Thermometer	1	
	Vaccine Carrier Daily	3	
	Vaccine Carrier Monthly	1	
	Ice Pack	8	
	Kidney Basin	1	
	Ampule Cutter	2	
	Waste Bin	1	
	“Sharps” Disposable Unit	1	
	Syrings & Needles		
	Tray	1	

REHYDRATION/NUTRITION/GROWTH MONITORING ROOM

	Table & Chair	1	
	Client Seating	10	
	Infant weighing Scale	1	
	Thermometer	3	
	Thermometer Jar	1	
	Demonstration Table	1	
	Cup	20	
	Spoon	20	
	Droppers 10 ml	10	
	Supply Cupboard	1	
	Waste Bin	1	
	ORS Package		
	Thermus Jar (5 liters)	1	

	Tissues		
	Treatment Chart	1	
	Flipchart	1	
	Food for Display	1	
INTENSIVE CARE UNIT FOR ARI/REHYDRATION			
	Table & Chair	1	
	Client Seating	10	
	Infant weighing Scale	1	
	Thermometer	5	
	Thermometer Jar	1	
	Demonstration Table	1	
	Cup	10	
	Spoon	10	
	Droppers 10 ml	10	
	Supply Cupboard	1	
	Waste Bin	1	
	ORS Package		
	Thermus Jar (5 liters)	1	
	Tissues		
	Pediatric bed	10	
	Stand w/hook	10	
	Scalp needle (butterfly)		
	Infusion Sets		
	Nasogastric Tube	20	
	Empty IV Bottles for Nasogastric Admin	15	
	Syrings & Needles		

	Sheet	20	
	Oxygen Cylinder	3	
	Nasal Catheter/Cannula	6	
	Nebulizer	6	
	Ambue Bag	6	
	Infant face mask	6	
STERILIZING ROOM			
	Autoclave	2	
	Autoclave drum	8	
	Boiler	1	
	Stove		
	Equipment for boiling		
	Instrument Trolley	1	
	Cheatle Forceps	1	
	Cheatle Stand	1	
	Supply Cupboard	1	
	Washing Machine		
MEETING/REST ROOM			
	Large Table	1	
	Staff Chairs	15	
	Shelves/Cupboard for books etc		
	Bulletin Board	1	
	Waste Bin	1	
	Kettle Electric/Normal	1	

Protocols and Checklists

INTRODUCTION TO
OPTIONS FOR FAMILY CARE
MCH FACILITY AND EQUIPMENT SUMMARY CHECKLIST
AND
MCH SERVICE QUALITY SUMMARY CHECKLIST

Objectives

The two checklists have been designed primarily to measure results in the Maternal and Child Health Centers in the three project governorates. Specifically, the Facility and Equipment Summary Checklist is designed to measure the presence and functioning of the equipment in the MCH Center. The MCH Service and Quality Summary Checklist is designed to measure the use of the equipment and the standard skills of the providers rendering MCH services. These checklists are used by the OFC Project to evaluate progress toward these two indicators.

Use of the Checklists

Quarterly results for MCH services and facility are summarized within these two checklists. Ideally, these checklists should be used on regularly scheduled visits to the MCH Centers. The checklist will carry greater validity if the evaluation is done more than once. A monthly evaluation would be ideal. Scores of all visits to a MCH center can be averaged for the quarter. The Facility and Equipment Summary Checklist can be conducted by any OFC staff in the governorate or by those doing clinical or training visits. The MCH Service Quality Summary Checklist should be carried out by an observer who has a clinical background, and a good understanding of the local dialect. For Maternal services, it is preferable that the evaluator is female.

Scoring on the Checklists

Scoring consists of following the simple instructions for each section, explained for each item. Equipment and furnishings are scored according to its presence or absence/dysfunction. Services are graded according to the total score from a checklist based on a standard clinical protocol. In addition, the provider's use and maintenance of the facility, and its equipment is scored according to a graded description. A minimum standard is reached with a total score of 60% for each checklist.

OPTIONS FOR FAMILY CARE
MCH FACILITY AND EQUIPMENT SUMMARY CHECKLIST

Lower Level Result 2 Indicator 2

Governor/State _____ Health Center _____ Date of Appraisal _____ Evaluator _____

ITEM NO	CRITERION	Registration	Prenatal Care	Delivery	Pre-Post Delivery	ORT Health Educ	Family Planning	Vaccination	Score	NOTES/COMMENTS
1	Appropriate equipment furniture supplies available in each room (Refer to attached standards)									
2	Storage in each room is sufficient (Refer to attached standards)									
3	Furnishings present which provide environmental conditions conducive to the work area (Refer to attached standards)									
4	Facility structures are in working condition (Refer to attached standards)									
5	Seating is sufficient for the number of waiting clients outside of rooms (Refer to attached standards)									
6	Infection prevention equipment available and functional (Refer to attached standards)									
7	Two bathrooms are available clean and functional (Refer to attached standards)									
8	Number of rooms available and used for MCH service (Refer to attached standards)									
9	Rooms are clearly and correctly marked according to service provided (Refer to attached standards)									
TOTAL SCORE										

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**MCH FACILITY AND EQUIPMENT SUMMARY CHECKLIST
DESCRIPTION AND SCORING CRITERIA**

Instructions In each room, check if the listed items are present or missing/dysfunctional then add all missing items and score according to the scale given below each service)

1 Appropriate equipment, furniture, supplies available in each room

REGISTRATION ROOM

ITEM	PRESENT	MISSING/DYSFUNCTIONAL
chair		
desk		
file cabinets		
index holder		
waste bin		
Renewable supplies		
index cards		
antenatal cards		
child growth cards		
small client cards		
registration book		
family planning cards		
SCORE (from 11 possible)		

SCORE

- 5= no missing items
- 4= 1-2 missing items
- 3= 3 missing items
- 2= 4 missing items
- 1= 5 missing items
- 0= 6 or more missing items

PRENATAL ROOM

ITEM	PRESENT	MISSING/DYSFUNCTIONAL
chairs (2)		
desk		
exam bed		
step to exam bed		
screen		
cabinet		
waste bin		
adult scale		
health education materials		
fetoscope		
stethoscope		
tape measure		
blood pressure set		
SCORE (from 13 possible)		

SCORE

- | | | | |
|----|-------------------|----|-------------------------|
| 5= | 0-1 items missing | 2= | 5 items missing |
| 4= | 2-3 items missing | 1= | 6 items missing |
| 3= | 4 items missing | 0= | 7 or more items missing |

DELIVERY ROOM

ITEM	PRESENT	MISSING/DYSFUNCTIONAL
Chair		
revolving stool chair		
Delivery bed with basin & IV pole		
screen		
cabinet		
drums for sterilization (2)		
trolley		
episiotomy set		
thermometer		
fetoscope		
stethoscope		
tape measure		
blood pressure set		
doppler (or prenatal room)		
lamp on a stand		
baby scale		
delivery sets (2)		
Oxygen tubing/mask		
flow meter for oxygen tank		
ambu-bag		
manual mucus extractor		
cheatle forceps in jar		
waste bin		
SCORE (from 23 possible)		

SCORE

- 5= 0-2 items missing
- 4= 3 items missing
- 3= 4-7 items missing
- 2= 8-10 items missing
- 1= 11-12 items missing
- 0= 13 or more items missing

PRE/POST DELIVERY

ITEM	PRESENT	MISSING/DYSFUNCTIONAL
Beds (2)		
bed cover (sheet/blanket per bed)		
pillow for each bed		
bed side cabinet		
baby cot		
stethoscope		
blood pressure set		
waste bin		
SCORE (from 8 possible)		

SCORE

- 5= 0-1 items missing
- 4= 2 items missing
- 2= 3 items missing
- 1= 4 items missing
- 0= 5 or more items missing

ORT/HEALTH EDUCATION

ITEM	PRESENT	MISSING/DYSFUNCTIONAL
Cabinet		
8-12 cups		
8-12 spoons		
750 ml bottles for measuring/making ORS		
thermos		
waste bin		
infant scale		
health education materials		
cushions or chairs for sitting		
TV with video		
SCORE (from 10 possible)		

SCORE

- 5= 0-1 items missing
- 4= 2 items missing
- 3= 3 items missing
- 2= 4 items missing
- 1= 5 items missing
- 0= 6 or more items missing

FAMILY PLANNING

ITEM	PRESENT	MISSING/DYSFUNCTIONAL
cabinet		
desk		
chairs (2)		
exam bed		
screen		
health education materials		
IUD equipment complete set		
waste bin		
SCORE (from 8 possible)		

SCORE

- 5= 0-1 items missing
- 4= 2 items missing
- 2= 3 items missing
- 1= 4 items missing
- 0= 5 or more items missing

VACCINATION

ITEM	PRESENT	MISSING/DYSFUNCTIONAL or Expired (Vaccines)
cabinet		
desk		
chairs (2)		
refrigerator		
vaccine carrier		
ice packs		
waste bin		
thermometer on/in refrigerator		
SCORE (from 8 possible)		

SCORE

- 5= 0-1 items missing
- 4= 2 items missing
- 2= 3 items missing
- 1= 4 items missing
- 0= 5 or more items missing

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For the following items, give the score which most closely describes your observation

2 **Storage in each room is sufficient**

SCORE

2= Supply cabinet present with all parts intact
Cabinet easily opens to access equipment If locked key is present within the room
All storable items fit within storage area provided

1= Cabinet present but lock is broken or key is inaccessible
Cabinet cannot contain all storable materials and allow accessibility

0= Cabinet is absent or unusable

3 **Furnishings present which provide environmental conditions conducive to the work area**

1= Fan or air conditioner is present and working if needed
Windows open and close and can be locked are not cracked or broken

0= Fan or air conditioner is not present but needed
Windows are broken unable to open or close and lock

4 **Facility structures are in working condition**

SCORE

2= Doors open and close and can be secured or locked
Sinks and related fixtures are functional provide water and allow for drainage are not broken
Lights turn off and on as needed

1= The door opens but doesn't lock
Sinks have water only some of the time and/or drain drips onto floor
Lights work sometimes or some of the bulbs are needing replacing

0= Doors cannot be opened or closed or are missing pieces
Sinks cannot be used due to lack of water or blocked/broken drainage
Lack of electricity impedes services (night delivery IUD insertion)

5 **Seating is sufficient for the number of waiting clients outside of rooms**

SCORE

2= Clients are seated on benches or chairs in the hallway without having to stand or sit on the floor while waiting

1= Some clients must stand or sit on the floor because of the lack of seating in waiting areas

0= The majority of clients waiting are sitting on the floor waiting for services blocking the walking area

6 INFECTION PREVENTION AREA (Check if the listed items are present or missing/dysfunctional then add all missing items and score according to the scale below)

ITEM	PRESENT	MISSING/DYSFUNCTIONAL
Dry oven with thermometer		
Autoclave		
brush		
boiler		
burner		
attachments to burner		
2 plastic basins for infection prevention (disinfection and cleaning procedures)		
cheatle forceps in jar of disinfectant		
gas bottle		
SCORE (from 9 possible)		

SCORE

- 5= 0-1 missing item
- 4= 2 missing items
- 3= 3 missing items
- 2= 4 missing items
- 0= 5 or more missing items

7 2 Bathrooms are available, clean and functional

SCORE

- 2= 2 Bathrooms available
water is present from tap and for flushing toilet
drain is open
surroundings are clean without waste products visible within the bathroom
- 1= only one bathroom available and functional
water is not sufficient
drain is open but flushing is only partial
waste matter is visible in places in the room
only one bathroom is available or functional
- 0= No bathroom available
no water in bathroom
drain is clogged or unable to flush toilet
waste matter is obvious

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OPTIONS FOR FAMILY CARE
MCH SERVICE QUALITY SUMMARY CHECKLIST
 Lower Level Result 2 Indicator 2.2

Governorate _____ Health Center _____ Date of Appraisal _____ Evaluator _____

ITEM NO	CRITERION	Registration	Facility	Delivery	Pre-test Delivery	ORI Health Educ	Family Financing	Vaccination	NOTES COMMENTS
1	Score from protocol checklist for service								
2	Provider facilitates patient flow in and out of room (Refer to attached standards)								
3	All equipment is neatly organized in storage and accessible for service (Refer to attached standards)								
4	Room is clean and cleanliness is maintained as needed between patients (Refer to attached standards)								
5	Provider maintains room environment conducive to work (light ventilation privacy noise level number of people in the room) (Refer to attached standards)								
6	Provider treats clients with respect and facilitates communication (Refer to attached standards)								
TOTAL SCORE									

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**MCH QUALITY OF SERVICES SUMMARY CHECKLIST
DESCRIPTION OF CRITERIA AND SCORING**

SCORING FOR CLINICAL PROTOCOL CHECKLISTS

- 1 Observe one staff person giving the service from beginning to end
- 2 Mark “yes” in the column for each step of a service rendered correctly
- 3 Mark “no” in the column for each step of a service rendered incorrectly or incompletely
- 4 Add all of the “yes” marks in each column on each page
- 5 Refer to the scoring for that service (below) and record the score (0 1 2 or 3) on the Quality of Services Summary Checklist

REGISTRATION

less than 11	=0
11-12	=1
13-14	=2
above 15	=3

DELIVERY (total number of “yes” marked)

less than 60	= 0
61-71	= 1
72-81	=2
above 81	=3

FAMILY PLANNING (total number of “yes” marked)

less than 17	=0
18-20	=1
21-23	=2
above 23	=3

PRENATAL (total number of “yes” marked)

less than 19	=0
19-22	=1
23-26	=2
above 27	=3

VACCINATION (total number of "yes" marked)

less than 22	=0
22-26	=1
27-30	=2
above 30	=3

ORS/HEALTH EDUCATION (total number of "yes" marked)

Average all services observed and give one score on the quality services list

Weight and growth card

less than 9	=0
9-11	=1
12-13	=2
above 13	=3

Administering ORS fluids

less than 3	=0
4-5	=2
6-7	=3

Health Education

less than 7	=0
7-8	=1
9-10	=2
above 10	=3

POSTPARTUM (total number of "yes" marked)

less than 16	=0
16-19	=1
20-22	=2
above 22	=3

INFECTION PREVENTION (total number of "yes" marked)

Boiler

less than 7	=0
7-10	=1
11-13	=2
above 13	=3

If more than one service is observed average the scores for each piece of equipment

Autoclave

less than 13	=0
13-15	=1
16-18	=2
above 18	=3

Dry Oven

less than 11	=0
11-13	=1
14-15	=2
above 15	=3

For the following items, give the score which most closely describes the service

2 Provider facilitates patient flow into and out of the service area

SCORE

- 2= Clients are courteously directed to the room for services
Clients are directed in and out of the service room in an orderly manner which does not interrupt services
Door of services is not blocked
- 1= Provider is interrupted several times during an exam to answer the door
Clients must ask where services are because they have not been directed from the registration room or their question has not been answered
It is sometimes difficult to get into the service area because of crowds or confusion
- 0= Door to service area is open and never shut
3 or more clients crowd the service provider
Waiting area is not used

3 All equipment is neatly organized in storage and accessible for service

SCORE

- 2= Stored sterile instruments are covered or wrapped and dated
Necessary equipment is within the work area or stored and easily viewed while in storage
Emergency equipment is within site and not locked during work hours (ambu-bag, mucus extractor, Oxygen tubing, delivery instruments)
- 1= Sterile instruments are not dated or have expired past one week since sterilization
Room's equipment is not easily accessible or visible when needed (requested)
Emergency equipment is present but not readily visible or locked
- 0= No sterile instruments are stored and ready for use (nor are found in the process of preparation)
Necessary equipment to carry out the work is missing
Emergency equipment is not found when needed/requested

4 Room is clean and cleanliness is maintained as needed between patients

SCORE

- 2= No papers litter the floor
Cabinets are without visible dust outside or inside
Baby scale exam and delivery beds contain no body fluids or dirt marks
Linens are washed after single use
Rocks sand and dirt are not visible on the floors
Walls show no visible marks of dirt
- 1= Some papers on the floor or small pieces of dirt
Scale has residue on it from previous children patients
Walls have some visible dirt marks in places
Exam bed screens delivery bed baby cot or desk have stains or dirt marks
- 0= Floor has papers dirt rocks and/or mud clearly visible
Walls are full of dirt marks stains or bodily fluids
Room equipment is stained marked dusty throughout
Linens are stained and unsuitable for use contain dirt

5 Provider maintains room environmental which is conducive to work

SCORE

- 2= Room is vented or has a fan/air conditioning running when needed
Light is sufficient for patient exams and writing
Noise level is low enough to carry on a conversation without raising voice
- 1= Room is vented but it is not sufficient to make patients or workers comfortable
Light is present but dim
Noise makes it difficult to hear the patient without raising voice
- 0= Room is not vented nor is a fan/air condition on when needed
Light is dim so that writing is difficult and patient's skin cannot be easily examined

6 Provider treats clients with respect and facilitates communication

SCORE

- 2= Provider listens to client and answers all questions
Provider greets clients upon arrival to service room
Provider asks questions of the client and shares information about client's condition throughout the exam and giving health advice pertaining to the area of service
- 1= Provider does not hear client the first time a question is asked
Provider does not greet client directly or clearly
Provider does not share information and provider doesn't ask sufficient questions to gather needed information
- 0= Provider doesn't listen to client
Provider doesn't greet client
Provider speaks roughly and does not offer information or direction to the client

SCORING

Add total points on the summary checklist and grade accordingly. If more than one assessment was done during the quarter, average the results of each evaluation and produce one score for the quarter.

MCH FACILITY AND EQUIPMENT SUMMARY CHECKLIST (total 105)

63 POINTS = Meets minimum standards (60%) passing

74 POINTS= Slightly above minimum standards (70%)

84 POINTS= Well above minimum standards (80%)

95 POINTS= Standards are excellent (90%)

MCH SERVICE QUALITY SUMMARY CHECKLIST (total 81)*

49 POINTS = Meets minimum standards (60 %) passing

57 POINTS= Slightly above minimum standards (70%)

65 POINTS= Well above minimum standards (80 %)

73 POINTS= Standards are excellent (90%)

* If a service is not observed, subtract from the total number of points and calculate 60% from the total possible to determine the passing score.

Note When scoring on the summary sheets, mark scores in columns provided. Shaded areas are not to contain a score.

Scores for equipment and facility items are based on the following scale:

presence of items

90-100% = 5

80-89% = 4

70-79% = 3

60-69% = 2

50-59% = 1

less than 50% = 0

Performance checklist for postpartum care

Health facility _____ District _____
 Governorate _____

Name of service provider _____ Date _____

S N	Duties , functions	✓ x	Remarks, Actions
1	The room was tidy and clean		
2	Privacy secured by using curtains		
3	Asked mother about hers & her baby's health and if there is any complaint		
4	<p>Assessed general medical condition.</p> <ul style="list-style-type: none"> • Blood pressure, pulse, temperature • examined mother's breasts • abdominal exam • palpated fundus of uterus to make sure the uterus was shrinking gradually to normal size • asked if there were strong cramps or persistent abdominal pain • examined the amount of blood, its color and noted any unusual odor • inspected the perineum for cleanliness • provided care/instruction to the mother for cleaning the perineum /episiotomy 		

S N	Duties , functions	✓ x	Remarks, Actions
6	<p>Examined the newborn and explained the exam to the mother</p> <ul style="list-style-type: none"> • assessed color and respiration rate • cleared the airway by suction if needed • cleaned the newborn • checked that the cord tie was secure and the cord was clean • kept the baby warm and wrapped as much as possible during exam • weighed the baby and measured head circumference • gave vaccinations if available BCG and polio • put the baby on the mother's breast and made sure the position was correct 		
7	Encouraged mother to continue breastfeeding the baby Explained to mother the advantages of breastfeeding		
8	Excluded any probable complications for mother or child		
10	Called for a doctor in case of complications or referred the mother		
11	Explained to mother the reason for referring		
12	Followed up the case after referral by appointment to the center or by home visit		
13	Registered all data related to mother and her baby on the appropriate card or file		

S N	Duties , functions	✓ x Remarks, Actions
14	<p>Gave health education and advice before the mother departs</p> <ul style="list-style-type: none"> • nutrition and fluid intake • discourage harmful customs and health practices for the baby • personal hygiene • family planning • signs and symptoms of complications and how to manage them • care of the newborn return for vaccinations and weight monitoring 	
15	<p>Gave the mother an appointment (home visit or at the center) after one week or two to follow the health of her and her child and explained the importance of the visit</p>	

Name of supervisor _____

Performance Checklist regarding Weighing Children, ORS and Health Education

Health facility _____ District _____

Governorate _____

Name of MCH-service provider _____ Date _____

Steps for weighing				
1	The room was tidy and clean	.	.	.
2	Growth cards were available	.	.	.
3	The scale was adjusted & fit for use	.	.	.
4	Child & mother (or parents) were well received	.	.	.
5	Data on the health status of the child were systematically entered on his examination card	.	.	.
6	Asked the mother or father if there is any health problem with the child	.	.	.
7	Removed any heavy clothes	.	.	.
8	Put the child on the scale gently and didn't touch the child or scale basin during weighing	.	.	.
9	Moved the weights to appropriate numbers on the balance	.	.	.
10	Read the weight correctly	.	.	.
11	Registered the weight in kilograms on the child's card by plotting weight and age	.	.	.
12	Requested the mother to dress the child	.	.	.
13	The mother was briefed on the importance of the Growth Monitoring card	.	.	.

S N	Duties , functions	✓	x	Remarks, Actions
	<ul style="list-style-type: none"> • If the weight was increased, the mother was encouraged • The mother was told to return and take care for the child's nutrition if there was no change in the weight from the previous month • If the weight was decreased, the provider investigated the cause, such as illness and nutritional intake, and mother was advised accordingly 			
14	The mother/father was briefed on the health status of her child			
15	The child was referred to the doctor if needed			
16	The mother and father were briefed on the importance of follow up			
17	The next appointment was made			
18	Arrangements were made for follow up of the referred child either by home visit or appointment in the MCH center			
Administration of Oral Rehydration Solution				
1	Preparation of the solution as follows <ul style="list-style-type: none"> • Water bottle (750 ml), cups, spoons • ORS packets 			
2	Explain the method of preparing ORS <ul style="list-style-type: none"> • washed hands with soap and water • put the ORS powder in the bottled water or in 750 ml boiled, cool water • closed the bottle and shook until contents 			

	are dissolved		
	<ul style="list-style-type: none"> • requested the mother to give the solution to her child by spoonfuls 		
3	Helped the mother to give the solution		
S N	Duties , functions	✓	x Remarks, Actions
Health Education			
1	<p>Health advice was given to the mother as follows</p> <ul style="list-style-type: none"> • If the ORS packets are not available instruction was given for making it at home by one of the following methods <p><u>First method</u></p> <ul style="list-style-type: none"> • 4 cups water boiled and cooled (750 ml) • 2 table spoons sugar • two teaspoons salt <p><u>Second method</u></p> <ul style="list-style-type: none"> • 2 cups boiled water cooled • 3 pinches of sugar 1 pinch of salt <ul style="list-style-type: none"> • continue with breast feeding • continue to increase fluid intake with the presence of diarrhea • continue to give easily digested foods 		
	<ul style="list-style-type: none"> • Personal hygiene • Discontinue harmful health practices • Don t give antibiotics to the child unless under a doctor's supervision 		
2	<ul style="list-style-type: none"> • Encouraged the mother to ask questions and participate in discussion 		

S N	Duties , functions	✓ x	Remarks, Actions
3	• Explained instructions clearly to the mother		
4	• Used simple language appropriate to mother s understanding		
5	Used available health educational materials (pictures, film)		

Name and signature of the supervisor

Performance Checklist on Family Planning Services
(including counseling & medical check up)

Health facility _____ District _____

Governorate _____

Name of service provider _____ Date _____

Name of counseling provider (if different) _____

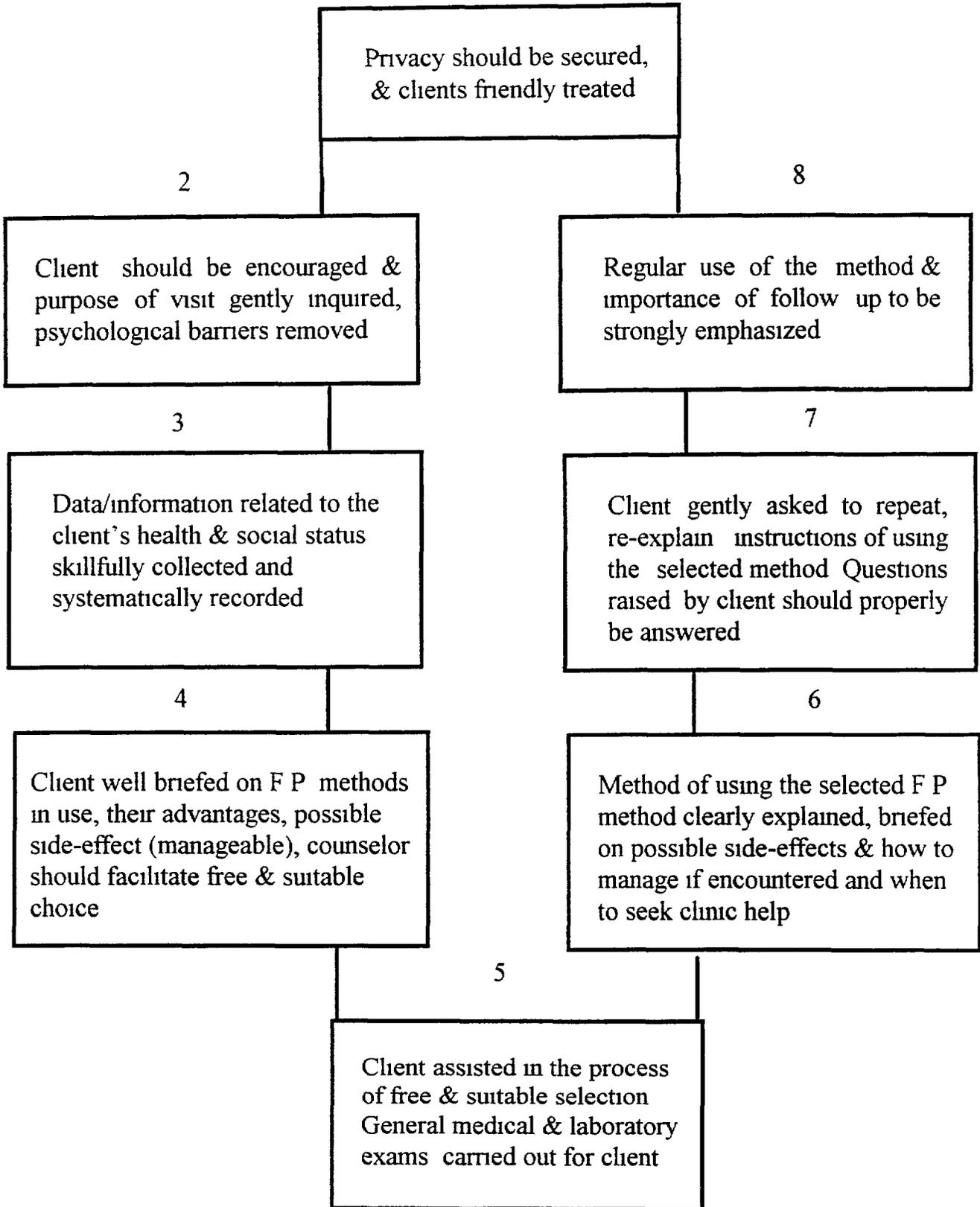
S N	Duties functions , roles	✓	x	Remarks, Actions
1	Room tidy & clean			
2	Contraceptives & illustrations for health education are available			
3	Privacy for the patient is followed			
4	Greets the clients with kindness and respect			
5	Asks the client her purpose in the visit			
6	Took necessary information <ul style="list-style-type: none"> • personal history • reproductive history • medical history 			
7	Clearly explained all available methods including the advantages & possible side effects for each method			
8	Asked the client which method she prefers			
9	Medical exam. <ul style="list-style-type: none"> • Blood pressure • weight • thyroid gland • breasts • abdomen 			

S N.	Duties , functions , roles	✓	x	Remarks, Actions
	<ul style="list-style-type: none"> • bimanual pelvic exam (for IUD only) • vaginal exam with speculum (for IUD only) 			
10	<p>Included necessary laboratory tests:</p> <ul style="list-style-type: none"> • urine for albumin & sugar, (pregnancy test if & when needed) • blood Hb 			
11	Explained to client the outcome of medical and laboratory exams & tests			
12	Recorded all information and tests			
	Counseling after medical exam			
13	Explained the method of choice to the client			Answered any raised questions
14	Explained how to use the method			
15	Made sure the patient understands the use of the method by asking the client to re-explain instructions for use			
16	Informed the client about specific side effects and how to manage			
17	Explained the importance of follow up			
18	Made an appointment for the next visit			
19	Recorded all necessary information on the card and register			
20	Gave the contraceptive to the client			
21	Referred clients that desired contraception which was not available in the center and registered it			

Name & signature of supervisor

Steps followed in F.P. Counseling

1



Performance Checklist for Registration Services

Health Facility _____ District _____
 Governorate _____ Date _____
 Name of service provider _____

S.N.	Duties, Functions	yes	no	Remarks, Actions
1	PREPARING SUPPLIES			
	• Room is clean and arranged			
	• New file folders with fasteners			
	• Index registration book and index cards			
	• Cards large and small prenatal family planning child growth			
	• pens for writing and correction hole puncher			
2	OPENING A NEW FAMILY FILE			
	• Greet the mother and father			
	• Explain the use and importance of the family file			
	• Ask the parent to buy the file folder			
Note	• If unable to pay for the file folder register the number on the large service card			
3	REGISTRATION PROCESS			
	• Ask the full family name (4 names)			
	• Assign a number and record the name and all needed information in the registration book and index card			
	• Recorded the number and the names of the children under 5 years on the family file			
	• Asked which services the family is requesting • Filled out all necessary information on the large and small card for that service • Checked that all information is filled in correctly			
	• Fastened the large card to the file folder and give the small card to the parents			
	• Gave the large file folder with large card to the parent and explain where the service room			
	• Put the registered index card in a specific drawer for counting against the returned folders at the end of work			
	• Counted returned file folders with the index cards			
	• Put file folders and index cards in numerical order and store them in their proper place in registration room			

Name of Supervisor _____

**Performance checklist on prevention of infection
and aseptic techniques**

Health facility _____ District _____

Governorate _____

Name of service provider _____ Date _____

S N	Duties , Functions, Procedures	✓ x	Remarks, Actions
1	Worker washed hands with soap & water before procedure and put on gloves		
2	Properly carried out <u>decontamination procedure</u> <ul style="list-style-type: none"> • cleaned the plastic containers which hold the solution • prepared disinfectant solution one part of chlorox concentrate in 9 parts of water • immersed all used instruments in the prepared disinfectant solution for 10 minutes • removed gloves after washing them and put them in the solution 		
3	Properly carried out <u>cleaning procedure</u> <ul style="list-style-type: none"> • put on household gloves • Cleaned the joints and teeth of all instruments with a hard brush while instruments were immersed in soapy water • rinsed cleaned instruments with cool clean water • dried rinsed instruments 		

S N	Duties , Functions, Procedures	✓	x	Remarks, Actions
	<ul style="list-style-type: none"> • After decontamination and cleaning, chooses one of the following methods of high-level disinfection or sterilization (dry oven, autoclave, chemicals or boiling) 			
4	BOILER (High-level disinfection)			
	<ul style="list-style-type: none"> • checked that the boiler is functional • put instruments in boiler, filled boiler with water until all instruments were immersed completely • turned boiler on, recorded the time when boiling started • boiled instruments without putting in anything else during 30 minutes of continuous boiling • turned boiler off • using a sterilized forceps, picked up the disinfected instruments, and put them in sterilized container with a cover • Note wrapped instruments can be kept in the container up to one week & can be used within that week otherwise unwrapped instruments should be used during the same day 			

S N	Duties , Functions, Procedures	✓ x Remarks, Actions
5	AUTOCLAVE (Sterilization) <ul style="list-style-type: none"> • made sure the autoclave is working, and the water level inside was optimal (covered the electric element, or was 3-4 cm deep for non-electric) • opened disassembled all instruments to be sterilized • wrapped instruments in cotton wrapper or put them in an opened sterilization tray • put the tray with instruments in the autoclave, and closed it properly • turn on the autoclave (electric) or light the burner and proceed as follows • once boiling starts, keep the steam valve open 4 minutes to release steam and air • close the steam release valve and watch until the pressure reaches 15 lbs /sq in and 121 degrees C or 250 degrees F <ul style="list-style-type: none"> • marked the time when pressure and temperature are reached and allow it to remain at this level for 30 minutes (20 minutes if all instruments are not wrapped) • turned off the autoclave and opened the steam release valve after the time for sterilization was completed • waited until the arrow indicated that all pressure was released and opened the lid 	

S N	Duties , Functions, Procedures	✓ x	Remarks, Actions
6	<p>DRY OVEN (High-level disinfection)</p> <ul style="list-style-type: none"> • made sure the oven was in order • previously cleaned and disinfected instruments were opened and put in oven • trays with instruments were left uncovered • turned oven on till temperature rose to required level, and time was recorded at 170 C, the instruments were left in oven for <u>one</u> hour at 160 C, the instruments were left in oven for <u>two</u> hours • after time allotted, turned oven off • used sterile forceps to pick up instruments and placed into a sterile container with cover • (Ask) time limit for using wrapped and unwrapped instruments • instruments are covered or wrapped and labeled with sterilization date 	.	

Name & signature of supervisor

Infection Preventing Techniques

- Decontamination

Instruments, tools reusable items are immersed in a 0.5 % chlorine solution for 10 minutes prior to cleaning

- Cleaning

With gloved hands, the mentioned items are cleanly washed with soap (or a detergent) and water. Using a brush is much desired.

Then properly rinsed with clean water.

- High - Level Disinfection (acceptable methods)

a- Boiling in a covered container for 30 minutes

b- chemical solutions by immersion for 20 minutes in

- 8 % formaldehyde solution
- 0.1 % chlorine solution
- 2 % (cidex) solution

- sterilization (preferable methods)

a- autoclave at a pressure of 15 lb/sq in (or 20 kg /cm) & at a temperature of 121 C for 20 minutes (30 minutes when wrapped)

b- dry heat at 170 C for one hour, or 160 C for 2 hrs

c- chemicals immersing in 8 % formaldehyde for 24 hours or in 2 % (cidex) for 10 hrs

NB Instruments sterilized by heat can be used as soon as they cool. Wrapped instruments can be stored up to one week & can be used during a period of one week.

Step one in Infection Prevention Process**Decontamination****Decontamination Procedure**

- 1 A pair of gloves to be worn for protection
- 2 A 0.5 % chlorine solution is newly prepared (on the same day)
- 3 Used instruments are immersed in the 0.5 % chlorine solution, in a plastic container, for 10 minutes
- 4 Instruments are then rinsed and put in a clean container, ready for cleaning (the next step)

Decontaminating examination bed/table

- 1 The same 0.5 % chlorine solution in a plastic container is put beside the bed
- 2 With a piece of sponge or a cloth the bed surface is thoroughly wiped off after each examination

How to prepare the proper chlorine solution CONCENTRATION

$$\left[\frac{\% \text{ of chlorine solution concentrate}}{\% \text{ of desired chlorine solution concentration}} \right] - 1 = \text{ratio of water parts to be added} \\ \text{one part of chlorine soln. conc.}$$

An example to prepare a 0.5 % chlorine solution out of 5 % chlorine concentrate

$$\left[\frac{5\%}{0.5\%} \right] - 1 = (10 - 1) = 9 \quad \text{ie 9 parts of water to one part of chlorine concentrate}$$

ie ratio of water to chlorine concentrate is 9 to 1

step 2

cleaning

cleaning procedure

- 1 A pair of gloves are worn for protection against contaminated organic matter like blood & pus
- 2 Items are washed with soap (or detergent) and water and rubbed with hard brush until thoroughly cleaned
- 3 Items are rinsed with cool clean water
- 4 Dry by oil towel

step 3

I High - level disinfection by boiling

Procedure

- 1 Items are decontaminated and cleaned according to procedures described above
- 2 Thoroughly rinse instruments until soap or detergent is completely washed away before placing items into boiler
- 3 Completely immerse items into the clean water in the boiler
- 4 Boiler is turned on until boiling starts
- 5 Time is noted and items are left in the boiling water for 30 minutes
No additional items should be put in the boiler during the 30 minutes

- 6 The boiler is turned off and articles are picked up with a sterilized forceps and placed into a sterilized (or high - level disinfected) container with a firm cover. Wrapped items can be kept sterilized for one week.

II High - level Disinfection by chemicals

Procedure

- 1 Items are decontaminated, cleaned thoroughly, rinsed and air or towel dried.
- 2 Completely immerse items (for 30 minutes) in either
 - 8 % formaldehyde (formaline) solution
 - OR
 - 2 % cidex solution
- 3 Each piece is placed in a disinfected container with a firm lid.
- 4 Items are rinsed with boiled -&- cooled water.
- 5 Disinfectant solution is discarded after work , or any time during working hours if contaminated.

step 3 continued

**III Sterilization by high - pressure
steam, dry heat , and
long - duration immersion in disinfectants .**

A- High - pressure steam

- 1 Items are decontaminated, cleaned, rinsed and dried as usual
- 2 Instruments articles are dismantled/opened to let steam reach all surfaces
- 3 Put on a tray as such in the autoclave if intended to be used after sterilization or properly wrapped if not going to be used immediately ie for later use In this case a sterilized container & cover should be prepared and available
- 4 Autoclaved for 20 minutes after reaching 121 C, and pressure of 15 lbs sq in and (30 minutes if wrapped) keeping the same temperature and pressure

(121 C = 250 F)

B- Dry heat

- 1 Decontamination, cleaning, rinsing and drying as usual
- 2 Leave cover off so heat can reach all parts of items to be sterilized
- 3 Instrument tray is then put inside the oven and left for one hour at 70 C or 2 hrs at 160 C
- 4 Using sterilized forceps, items are picked up and collected into a sterile container with a cover
- 5 Items should be wrapped as soon as they cool and they can be stored for one week

c- Chemical**Sterilization by long - duration immersion in chemical disinfectants**

- 1 Items are decontaminated, cleaned rinsed and dried as usual
- 2 Items are then immersed either in
2 % iodex solution for 10 hours
or
8 % formaline for 24 hours
- 3 Items are picked up by a sterile forceps & put in a sterile container with a cover
- 4 Items are rinsed by boiled & cooled water

Performance Checklist on Immunization

Health facility _____ District _____
 Governorate _____
 Name of MCH-service provider _____ Date _____

S N	Duties , functions	✓ x	Remarks, Actions
1	The room was tidy and clean		-
2	Educational audio-visuals were available		
3	Needed supplies were prepared		
4	Immunization cards & registers were available		
5	Privacy was accounted for		
6	An electric (or gas) refrigerator was working & in place <ul style="list-style-type: none"> • kept clean (inside outside & at the back) • the inside temperature was kept at 2 C to 8 C • the daily refrig temperatures were plotted on the specific chart • ice thickness did not exceed 0 5 cm • ice-boxes were not less than four • only vaccine (& sera) were kept inside • bottles filled with coloured water were put on the bottom surface & the inside shelves of refrig door to sustain the inside coolness while being repeatedly opened all vaccines were potent		.

S N	Duties functions	✓ x Remarks, Actions
7	Vaccines in the refrig were put in an orderly way as follows	
	<ul style="list-style-type: none"> • BCG, measles & OPV on the first shelf below the freezer • DPT & tetanus toxoid on the 2nd shelf below the freezer • all vaccine ampoules were labeled, showing the type of vaccine & its expiry date • vaccines approaching their expiry date were put at the front of each shelf ie to be used first ‘ first in first out’ • solvent ampoules for measles & BCG were equivalent to the number of vaccine ampoules • a dial thermometer was in place on the second shelf below the freezer • amount of vaccines & related items in refrig did not exceed one-month supply and was not less than one-week supply as compared to the average vaccination-workload in the health facility 	
8	Needles & syringes were sufficient in number ie not less than 70% of the total number of vaccine doses	
9	A vaccine carrier, in good condition was available for use	

S N	Duties , functions	✓ x	Remarks, Actions
10	A spare cylinder filled with gas was available		-
11	Mothers/fathers were well-received at the unit		
12	Related data were systematically taken, by questioning the mother/parents, and were recorded on the vaccination card		-
13	The importance of fully vaccinating a child according to schedule (as well as vaccinating women of child-bearing age against tetanus) was explained and emphasized to clients		
14	The type of vaccines and their expiration dates were carefully noted		
15	Prepares the mother/ baby before giving vaccine		
16	The service provider washed her hands with soap & water before and after the session		-
17	The service provider skillfully and correctly performed vaccinations		
18	Used needles, syringes & other disposables were collected in a basket		
19	Mothers /parents were informed about possible side-effects and how to deal with them		
20	Related data were recorded in the daily register and on clients cards		
21	Mothers/parents were briefed on the importance of fully vaccinating their children and according to the schedule		

S N	Duties , functions	✓ x	Remarks, Actions
22	They were informed on the fixed date of next visit	. . .	
22	Related daily statistics were recorded on the specific form		
23	At the end of vaccination session, all disposables in the basket were emptied into a barrel or special hole and were incinerated		

Name and signature of the supervisor

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Performance Checklist on Antenatal Service Delivery

Health facility _____ District _____
 Governorate _____

Name of MCH-services provider _____ Date _____

S N	Duties , functions	✓ x	Remarks, Actions
1	The room was tidy and clean	✓	
2	Needed equipments in good condition , supplies and instruments for antenatal care were available	✓	
3	Register and client s cards were available	✓	
4	Privacy was accounted for	✓	
5	A N C clients (pregnant women) were well received	✓	
6	Data on their health status & pregnancy were systematically taken and correctly recorded in the clients card/ file /& the daily register <ul style="list-style-type: none"> • personal history • reproductive history • history of present pregnancy • approximate date of conception • client was asked whether she is complaining of any health problem the service provider examined the client and was able to exclude any pregnancy risk factors	✓	

S N	Duties , functions	✓ x Remarks, Actions
7	Provider carried out the routine general checking - <ul style="list-style-type: none"> • blood pressure • weight • height • eyes • thyroid gland • heart and lungs • the breasts • legs 	
8	Abdominal exam <ul style="list-style-type: none"> • the height of the uterine fundus to determine duration of pregnancy in weeks • foetal presentation, lie & position • foetal heart sounds • inquired about foetal movement • pelvic measurement for primipara 	
9	Analysed if there was any abnormality and referred as necessary	

S N	Duties , functions	✓	x	Remarks, Actions
10	Laboratory exams requested for the following			
	<ul style="list-style-type: none"> • urine analysis for glucose and protein (pregnancy test if necessary) • blood for haemoglobin, blood group and Rh- factor 			
11	Explained to client about her health status and pregnancy progress			
12	Gave tetanus vaccine if needed or referred to the room for this			
13	Recorded all necessary information			
14	Iron & folic acid preparations / tabs dispensed			
15	Gave advice & instruction according to client's condition			
16	Explained the importance of nutrition in pregnancy			
17	Referred abnormal cases to the doctor			
18	Explained to client the reason for referral and emphasized the importance of a specialist opinion & his care and advices			
19	Explained the importance of regular follow up according to scheduled visits and fixed a date for the next visit			

Name & signature of the supervisor

Performance checklist on labour & delivery services

Health facility _____ District _____

Governorate _____

Name of MCH-service provider _____

Date _____

S N	Duties , functions	✓	x	Remarks, Actions
1	The room was tidy and clean	.	.	.
2	Equipments/instruments were sterilized & made ready for use			
3	Instruments needed for delivery as well as for resuscitation of a newborn were secured			
4	Privacy was accounted for			
5	Mothers in labour were well received, put under observation in the room			
6	Mother was effectively reassured			
7	Antenatal card was requested from the mother and was collected if available			
8	Ask the mother for the prenatal card if any and collected data from it and from the mother & relatives It included <ul style="list-style-type: none"> • personal & family history • reproductive history • current pregnancy history • duration of contractions and any health problem • explained any necessary examination 			

S N	Duties functions	✓ x	Remarks, Actions
9	Provider then briefly explained the routine general check up she is going to carry out which included <ul style="list-style-type: none"> • blood pressure, pulse, temperature • assess heart and lungs • assess thyroid gland • assess legs 		
10	General Medical Exam <ul style="list-style-type: none"> • blood pressure, pulse, temperature • listened to heart and lungs • checked the thyroid gland • checked the legs • fetal size for estimation of weeks of pregnancy • fetal position and lie • fetal heart rate • asked the mother about fetal movement • observed the length, intensity and duration of contractions • measured the pelvis size of primigravida • took pelvic measurements for primipara 		
11	Pelvic exam <ul style="list-style-type: none"> • determined the cervical dilatation and effacement • determined the presenting part flexion of the head determined if the bag of water was intact or broken 		

S N	Duties , functions	✓ x	Remarks, Actions
12	Ordered necessary laboratory tests <ul style="list-style-type: none"> • Urine for glucose and protein 		
	<ul style="list-style-type: none"> • Blood for hemoglobin, blood type and Rh 		
13	Records all information from exams		
14	Care of the mother in the first phase of labor <ul style="list-style-type: none"> • administered an enema if needed • catheterized the bladder if unable to void • shaved the perineum if necessary • encouraged the mother to drink clear fluids as desired • encouraged the mother to walk and change position • encouraged the mother to take deep breaths during contractions 		
15	Observes the mother in the second stage of labor and makes notes according to the use of the partograph <ul style="list-style-type: none"> • time of admission • descent of the fetal head into the pelvis • listened and records fetal heart rate every half hour or more as needed • assessed contractions strength, duration and frequency every 10 minutes • assessed dilatation and cervical effacement every 4 hours or more as needed • assessed the normality of the position of the presenting part and its progression • took blood pressure every 4 hours or more according to necessity • took the temperature every 4 hours 		

S N	Duties , functions	✓ x	Remarks, Actions
16	Transfeted the woman to the delivery room and explained this to her		
17	Analysed the case for any complications during the first and second stage and referred to the doctor as needed		
18	<p>Observation and care of the woman during the third stage of labor</p> <ul style="list-style-type: none"> ● Ananged the delivery room and prepared the sterile instruments on the first level of the trolley, and the unsterile instruments on the lower shelf ● prepared the equipment for resuscitation and the oxygen ● prepared the mucus extractor ● put on an apron and mask if available ● washed hands with soap and water ● listened to the fetal heart after contractions ● ananysed the information on the pattograph and referred the patient as needed ● put on gloves ● washed the permeal area ● encouraged the mother to push with contractions ● made an episiotomy if needed ● checked if there was a nuchal cord after the delivery of the head and reduced it ● delivered the baby and placed him/her on the mother's abdomen and dried him/her ● suctioned mucus from the mouth and nose of the infant and assessed respiratory efforts 		

S N	Duties , functions	✓ x	Remarks, Actions
	<ul style="list-style-type: none"> • assessed the one minute apgar score cut the umbilical cord when pulsations stopped 		
19	<p>Care/observation of the newborn</p> <ul style="list-style-type: none"> • dried and warmed the baby • wiped the eyes with clean gauze • tied the cord securely • assessed the infant for any malformations • weighed the baby and measured the head • gave vaccination against TB and polio if available • assessed the 5 minute apgar score • put identifying band on the baby • recorded all information • called the doctor or referred any abnormal case 		
20	<p>Observations/care of the mother in the fourth stage</p> <ul style="list-style-type: none"> • ascertained progress of uterine contraction and checked firmness and bleeding at least every 15 minutes or more if needed • inspect the integrity of perineum & vaginal wall etc and absence of any lacerations • sutured any lacerations , tears etc as well as the episiotomy cut (had it been carried out) • cleaned mother as well as delivery bed • helped the mother dress in clean clothes • took blood pressure and pulse every 15 minutes for the first hour postpartum <p>assured the mother of the baby's condition</p>		

S N	Duties , functions	✓	x	Remarks, Actions
21	Assisted the mother with breast feeding			
22	Explained to the mother the importance of breast feeding			
23	Transferred the mother to the post delivery room			

Name & signature of supervisor

Step-by-Step Guidelines

**FAMILY PLANNING
PERFORMANCE STEPS**

#	STEPS
1	Greet the client nicely
2	Ask the client about the reason for the visit
3	Gather the required information and register it on the card correctly * Personal history * Reproductive history * Medical history
4	Present the available methods to the client and explain clearly, the advantages and disadvantages of each method
5	Ask the client what method he/she desires
MEDICAL EXAM	
1	Check the following to further confirm or rule out selected method * blood pressure * weight * thyroid gland * breasts * abdomen * bimanual vaginal exam (for IUD) * vaginal speculum exam (for IUD)
2	Laboratory tests * urine albumin & sugar, (pregnancy test if needed) * blood hemoglobin
3	Explain to the client the results of laboratory tests

**FAMILY PLANNING
PERFORMANCE STEPS**

#	COUNSELING AFTER MEDICAL EXAM
1	Discuss with the client all information about the method of choice
2	Explain how to use the method
3	Ask the client to explain how to use the method, in order to check her understanding
4	Warn the client about the possible side effects and how to manage them
5	Tell the client about the importance of follow-up
6	Give the client a return appointment
7	Register all necessary information on the card and register
8	Dispense the appropriate contraceptive method to the client
9	Refer clients which request a method that is not available or which needs special care and register this on client's card and register

**HEALTH EDUCATION AND TREATMENT OF DEHYDRATION
PERFORMANCE STEPS**

#	HEALTH EDUCATION
1	ADVICE AND GUIDANCE FOR THE MOTHERS:
	<p>If the ORS packet is not provided, prepare it from water, sugar and salt as follows</p> <ul style="list-style-type: none"> * 4 cups of boiled or bottled water * 2 tablespoons of sugar * one teaspoon of salt <ul style="list-style-type: none"> - Continue to breastfeed the child - Give extra fluids by mouth if diarrhea continues - Continue to feed the child with foods easy to digest - Emphasize the importance of personal hygiene for the child - Refrain from giving the child medicines for diarrhea unless by physician s order
2	Use appropriate health education materials for conveying messages (films pictures)
3	Encourage the mother to participate and ask questions
4	Answer the mother with clear, appropriate explanations
5	Convey health education messages that are simple and plain

**HEALTH EDUCATION AND TREATMENT OF DEHYDRATION
PERFORMANCE STEPS**

#	STEPS
1	Receive the child and parents well
2	Take information about the child according to the card
3	Ask the mother about the present problems with the child
4	Explain to the mother the importance of the growth card
5	Weigh the child
6	Record all the necessary information on the child's card
7	Explain to the mother about the child's condition
8	Explain to the mother the importance of continual follow-up
9	Give appropriate health education and advice to the mother
10	Give an appointment for the next follow-up visit
11	Refer the child to the physician if it is needed
12	Follow-up any referred child
GIVING ORAL REHYDRATION	
1	Prepare the rehydration solution * 750ml water container, a cup and a spoon for each child * a packet of oral rehydration salts * Explain to the mother how to prepare the solution * Wash hands with soap and water * Put the contents of the packet in the water bottle -or cooled boiled water * Secure the lid on the bottle and shake it until the solution is dissolved
2	Ask the mother to prepare the solution
3	Ask the mother to give the solution to her child with a spoon
4	Help the mother to give the solution

**POSTPARTUM CARE
PERFORMANCE STEPS**

#	EXAMINATION AFTER DELIVERY
1	Ask the mother about her health and the baby's health and if there is any problem
2	<p>Examination</p> <p>Take blood pressure, pulse and temperature</p> <p>Examine the breasts</p> <p>Palpate position of the fundus to be sure it is involuting normally according to the time and ask the mother if she feels cramps, pain or bloating in the area</p> <p>Examine the amount of vaginal discharge, noting the color, amount and smell</p> <p>Clean the perineum as needed</p>
3	Give nursing care in cleaning the sutured perineum and total area and explain the importance of continuing this at home

NEWBORN CARE	
1	<p>Explain to the mother the care of the newborn as you examine the baby</p> <ul style="list-style-type: none"> * Check the color and the respiration rate of the newborn (between 40-60 resp /min) * Suction mucus from nose and mouth if needed * Clean the baby * Check that the cord is securely clamped or tied and cleaned
2	Put the baby to the mother's breast and be sure the position is good for nursing
3	Advise the mother to continue with breast feeding and explain its importance

POSTPARTUM CARE
PERFORMANCE STEPS

#	BEFORE DISCHARGE
1	Check if there is any complication of mother or child
2	Notify the doctor if there is any complication or if referral is necessary
3	Inform the mother of the importance of referral and the reason
4	Follow instructions of the doctor for referral
5	Dispensed and explained postpartum medications to the mother such as iron/folic acid and methergine tablets to be taken after leaving the facility
6	Records information in registers and cards
7	Advice and health education for the mother * Nutritional foods and importance of drinking enough fluids * To avoid unhealthy practices for her and her baby * Observe personal hygiene * Advantages of family planning and child spacing * The importance of fully immunizing the baby
8	Fix a date within one month for a postpartum follow-up visit

STEPS FOR PERFORMING VACCINATION

#	VACCINATION SETTING
1	EQUIPMENT AND SUPPLIES
	GAS OR ELECTRIC REFRIGERATOR
A	Refrigerator is clean from inside outside and behind it
B	The refrigerator temperature is between +2 to +8 degrees Celsius
C	Registration of the temperature is recorded accurately on the specific chart
D	Ice thickness is not in more than 0.5 cm
E	At least four ice packs are present
F	Only vaccine and sera are kept inside the refrigerator
G	All vaccines are potent

2	Items in the refrigerator are in order as follows
A	First shelf below the freezer BCG, measles & OPV
B	Second shelf below the freezer BCG measles and OPV
C	All vaccine ampoules are labeled with type of vaccine and expiry date
D	Vaccines approaching their expiry date are at the front of each shelf in order to be used first
E	Number of solvent ampoules for measles and BCG equal the number of vaccine ampoules
F	A dial thermometer is in place on the second shelf below the freezer
G	The amount of vaccines and sera is not more than one month supply and not less than one week's supply according to the average vaccination use in the health center
H	Bottles filled with colored water were put on the bottom surface and on the inside shelves of the refrigerator door to maintain coolness while being repeatedly opened
3	Needles and syringes are sufficient (not less than 70% of the total number of vaccine doses)
4	A vaccine carrier in good condition is available and used
5	A spare cylinder filled with gas, is available

#	SKILLED STEPS FOR VACCINATION
1	Receive the parents well
2	Be sure of the child's health status and take necessary information and record it on the vaccination card, and the vaccination register
3	Explain the importance of fully vaccinating a child (on schedule) and women of childbearing age
4	Check the type of vaccine and the expiry date
5	Prepare the woman or child for vaccination
6	Wash hands with soap and water
7	Give the vaccination correctly
8	Dispose used needles and syringes in a waste bin
9	Explain possible side effects and how to deal with them
10	Record remaining information on the register and the vaccination card
11	Explain the importance of completing all the vaccinations
12	Give the date for return appointment if needed
13	Record in the daily record
14	In the designated place, burn used syringes and items in waste bin at the end of the clinic hours

STEPS FOR REGISTRATION SERVICES

1	PREPARING SUPPLIES
	New file folders with fasteners
	Index registration book
	Index cards
	Cards large and small prenatal family planning, child growth
	pens for writing and correction, hole puncher
2	OPENING A NEW FAMILY FILE
	Greet the mother and father
	Explain the use and importance of the family file
Note	If unable to pay for the file folder, register the number on the large service card
3	REGISTRATION PROCESS
	Ask the full family name (4 names)
	Assign a number and record the name and all needed information in the registration book and index card
	Assign a number and record the name and all needed information in the registration book and index card
	Recorded the number and the names of the children under 5 years on the family file
	Asked which services the family is requesting, and fill out all necessary information on the large and small card for that service and checked that all information is filled in correctly
	Fastened the large card to the file folder and give the small card to the parents
	Gave the large file folder with large card to the parent and explain where the service room
	Put the registered index card in a specific drawer for counting against the returned folders at the end of work
	Counted returned file folders with the index cards
	Put file folders and index cards in numerical order and store them in their proper place in registration room

STEPS FOR CARE DURING CHILDBIRTH

TAKING INFORMATION	
1	Greet the mother and help her to the exam room
2	Assure the mother about her condition
3	Ask the mother if she has a pregnancy card
4	Take the necessary information
A	*Personal and family history
B	*Reproductive history
C	*Present pregnancy history
D	Inquire when contractions started
E	Explain to the mother about her progress in labor
5	General Medical Examination
A	Blood pressure
B	Heart and lungs
C	Examine thyroid gland
D	Examine breasts
E	Examine legs
6	Abdominal Exam
A	Check the size of the baby and if it agrees with the dates
B	Check the lie and position of the baby
C	Listen to the fetal heart rate
D	Ask the mother about the baby's movements
E	Note the strength, frequency and duration of contractions
F	Measure the pelvis (for primipara)
7	Vaginal Exam
A	Position the mother for the exam and explain it before beginning
B	Put on an apron
C	Wash hands with soap and water
D	Put on an exam glove
E	Clean the perineum
F	Check the dilatation and effacement of the cervix
G	Confirm the presenting part, flexion and measure the pelvis
H	Check if the bag of water is present (note time, and color if broken)
8	Laboratory Tests
	* Urine for sugar and protein
	* Blood for hemoglobin and type Rh

STEPS FOR CARE DURING CHILDBIRTH
(continued)

9	CARE DURING THE FIRST STAGE OF LABOR
A	Give an enema if it is necessary
B	Catheterize if it is necessary
C	Shave the perineum if it is necessary
D	Encourage the mother to drink
E	Encourage the mother to walk
F	Encourage the mother to breathe deeply with contractions
10	Observation of the mother as she approaches the second stage as recorded on the partograph and delivery record
A	Time of mother's arrival to the center
B	Progression of baby's descent into the pelvis (abdominally)
C	Fetal heart tones every half hour (120-160 beats is within norm)
D	Duration frequency and strength of contractions every half hour
E	Vaginal exam of dilatation and effacement of cervix every 4 hours or more frequently if warranted
F	Check the position of the fetal head
G	Take blood pressure every 4 hours and more frequently if needed
H	Take the temperature every 4 hours and more frequently if needed
I	Record any medications given and the time
Note. Refer any complicated cases to the Doctor, or referral center	

STEPS FOR CARE DURING CHILDBIRTH

(continued)

11	CARE DURING THE SECOND STAGE OF LABOR
A	Take the mother to the delivery room and explain this to her
B	Arrange equipment and materials for delivery
C	Set up delivery room Ambu-bag, suction, vacuum, oxygen, etc
D	Put on apron and if present, mask
E	Wash hands with soap and water
F	Listen to fetal heart tones after contractions
G	Request the doctor to attend if there are any complications
H	Put on gloves
I	Clean the perineum
J	Encourage the mother to push with contractions only
K	Cut an episiotomy if it is necessary
L	Check for a nuchal cord after delivery of the head
M	Help the mother deliver the baby in correct way
N	Put the baby on the mother's abdomen and dry and cover him

12	CARE OF THE NEWBORN
A	Suction secretions from nose and mouth Check breathing and assist if necessary
B	Evaluate the baby's condition for the one minute apgar score
C	Cut the umbilical cord when pulsations stop
D	Warm and dry the baby
E	Clean the eyes
F	Tie the cord correctly and remove forceps
G	Examine the baby for any deformities
H	Weigh the baby and measure head circumference
I	Evaluate the baby's condition for the 5 minute apgar score
J	Give the baby identification tag
K	Call the doctor or refer the baby if complications arise
L	Put the baby on the mother's breast for feeding

STEPS FOR CARE DURING CHILDBIRTH
(continued)

CARE OF THE MOTHER DURING THE THIRD STAGE	
1	Make sure the placenta is detached
2	Catheterize the bladder if necessary
3	If there is any abnormality, stabilize the patient and refer to a doctor
4	Help expel the placenta by pulling slowly and gently on the cord
5	Examine the placenta and note any abnormalities or incompleteness
6	Massage the uterus and be sure it is contracted
7	Measure the amount of blood loss
8	Give methergine IM
9	Continue to observe the uterus every 15 minutes for firmness
10	Examine the perineum for tears and if stitching is needed, inform the mother of its importance
11	Repair the episiotomy or tear with suturing
12	Clean the perineum and the mother, and the bed
13	Help the mother dress in clean clothes
14	Measure the blood pressure and pulse every 15 minutes postdelivery
15	Assure the mother of her health status and that of the newborn
16	Put the used instruments in the clorox solution
17	Help position the mother for breast feeding and place the newborn on the breast while telling the mother the importance of breast feeding
18	Transfer the mother to the post partum room for continued observation

STEPS FOR PRENATAL CARE

(1)

ACTIONS	
1	Receive the mother with kindness
2	Take the following information and record on the card
	A- Personal history
	B- Reproductive history
	C- Present pregnancy
	D- Estimate the due date for delivery
	E- Ask the patient about any present complaints
	F- Analyse the information and look for risk factors
3	General Medical Exam
	A- Blood pressure
	B- Weight
	C- Height
	D- Eyes for evidence of anemia
	E- Thyroid gland
	F- Heart and lungs
	G- Breasts
	H- Legs

STEPS FOR PRENATAL CARE

(2)

4	Abdominal Exam
	A- Define the number of weeks of pregnancy
	B- Define the position and lie of the fetus (35 weeks and up)
	C- Take fetal heart tones
	D- Ask the woman about the baby's movement
5	Measure the pelvis for the primigravida
6	Analyse any risk factors and consult the doctor if needed
7	Request laboratory tests
	A- Urine for protein and glucose
	B- Urine if needed to confirm pregnancy
	C- Blood for hemoglobin, blood type and Rh factor
8	Explain the tests results to the woman and assure her of her health status
9	Give tetanus vaccine if needed
10	Record all tests and exam results
11	Explain the importance of nutrition during pregnancy and taking iron and folic acid supplements
12	Explain the importance of coming regularly for follow up
13	Refer any cases to the doctor that need it
14	Convince the woman about the need to return especially to be checked
15	Set a time for the next appointment and record it on the card

STEPS FOR INFECTION PREVENTION

Decontamination and Cleaning	
1	Wash hands with soap and water before procedure and wear gloves
2	Decontamination Procedure
	A- Clean the plastic containers used for Clorox solution
	B- Prepare the Clorox solution 1 part Clorox to 9 parts water
	C- Put used instruments directly in the solution for 10 minutes
	D- Wash gloves in the solution, remove them and put them in
3	Cleaning procedure following decontamination
	A- Wear utility gloves
	B- Wash the instruments immersed in the water with a brush, cleaning teeth and joints completely
	C- Rinse instruments with water
	D- Dry the instruments

After decontamination and cleaning, follow one of the steps below

- (A) Boiling (high level disinfection)
- (B) Autoclave (sterilization)
- (C) Dry oven

(A)

Boiling High Level Disinfection	
1	Check the boiler for any malfunction
2	Put the cleaned instruments in the boiler and completely cover with water
3	Turn on the boiler (or burner) and note the time boiling began
4	Leave the instruments to boil for 30 minutes without adding any other instruments
5	Turn off the boiler (burner) after 30 minutes of boiling
6	Remove the instruments from the water with sterile forceps
7	Place instruments in a sterile container to be used that day or wrapped/covered with a lid and marked to be used within a week
Note store sterile instruments one week without removing the cover.	

(B)

Sterilization by Autoclave (steam and pressure)	
1	Check that the autoclave is in working order and put in water (for electric model, cover the element, for other, put in 3-6 cm water)
2	Open all the instruments
3	Place items in open container, or wrap in cotton cloth
4	Place items with space between them, and secure the lid
5	Turn on the autoclave, or light the burner and observe the following
	A- Open the steam release valve and keep it open for a full four minutes after the steam starts to escape, then close it
	B- Observe until the arrow reaches 15 lbs sq in and 250 degrees F or 121 degrees C and mark the time
	C- Keep at this pressure and temperature for 30 minutes (20 minutes if all instruments are unwrapped. The burner may need to be adjusted lower so pressure doesn't increase)
	D- Turn off the burner or electric autoclave after the appropriate time
	E- Open the steam release valve and observe until pressure is zero
6	Open the lid
7	Remove items with sterile forceps and place in sterile containers if unwrapped
8	Mark each item to be stored with the date of sterilization
9	Uncovered instruments should be used the same day. Covered or wrapped instruments are sterile for a week if unopened
10	Clean the autoclave if not used immediately and empty the water

Note: Items suitable for the autoclave are metal, glass, cotton and rubber such as: cotton, gauze, gloves, catheters, cotton wraps and instruments

(G)

Dry Oven	
1	Check that the oven is in working condition
2	Open all of the instruments
3	Place open, cleaned instruments in the oven, and in their <u>open</u> containers that they will be stored in later
4	Securely shut the oven door and set dial for temperature
5	Turn on the oven and notice when the temperature reaches sterilization point and note the time * 170 degrees C for 1 hour or *160 degrees C for 2 hours
6	Turn off the oven when the time is completed
7	Use sterile forceps to remove instruments
8	Cover instruments to be stored and mark the date Or wrap cooled instruments in sterile cotton cloth and mark the date
9	Unwrapped and uncovered instruments must be used the same day or re-sterilized for use the following day
Note Items suitable for the dry oven include those made from metal and heat treated glass only	

HMIS Supervisory Protocol and Checklist

HMIS SUPERVISORY PROTOCOL

Service Delivery Site _____

Date _____

Name of Supervisor _____

INDEX REGISTER

	YES	NO	Comments
1 1 Are the file numbers assigned in correct serial order?			
2 1 Are all of the addresses sufficient to physically locate the patient on an outreach visit?			

INDEX CARDS

	YES	NO	Comments
1 1 Does the number of index cards counted equal the last number in the Index Register?			
2 1 Select an index card at random Look at the next 20 cards Are <u>all cards</u> in the correct alphabetical order?			
2 2 Locate the Family File of the first 10 cards drawn Are <u>all 10</u> Family Files found and correctly filed in the archive?			

FAMILY FILE

	YES	NO	Comments
1 1 Were the Index Cards corresponding to each of the 10 Family Files found and in correct alphabetical order?			
1 2 Are the names of all the family members listed on the Index Card also listed on the outside of the Family File?			
1 3 Is there a Growth Monitoring Card for each of the children under 3 years of age listed on the Index Card in <u>all 10</u> Family Files?			

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INDIVIDUAL RECORD CARDS

Review all records in the 10 select Family Files (Monthly)	YES	NO	Comments
3 1 If current Antenatal Card, is all required data entered?			
3 2 (If any high risk conditions indicated on Antenatal Card locate corresponding entry in Antenatal Register) Is a referral marked for all records indicating a high risk condition?			
3 3 If current Family Planning Card has all required data has been entered?			
3 4 If any Medical History indicated contraindication to pills was an alternate method or no method was prescribed?			
3 5 (If any weight is below the curve on Child Health Card locate corresponding entry in Child Health Register) Is a referral marked for all records indicating a weight less than normal?			
3 6 (If any weight is above the curve on Child Health Card) Has the date of birth or age of the child been entered in the correct column of the chart?			

ANTENATAL CARE REGISTER

In the antenatal Register, review entries for the previous month	YES	NO	Comments
1 1 All appropriate columns have data entered?			
1 2 Is the first visit of the month recorded on a new page?			
1 3 Are visits numbered sequentially beginning with #1?			
1 4 Are all of the addresses sufficient to physically locate the patient on an outreach visit?			
1 5 Is tetanus immunization being properly recorded?			
1 6 If any referral or other action are meaningful remarks always entered in the final column?			
1 7 Are column totals entered at the bottom of each page?			
1 8 Are column totals correct?			
1 9 Are monthly total recorded at the end of the month?			
1 10 Are monthly totals correct?			

FAMILY PLANNING REGISTER

In the Family Planning Register, review entries for the previous month	YES	NO	Comments
1 1 Do all appropriate columns have data entered?			
1 2 Is the first visit of the month recorded on a new page?			
1 3 Are visits numbered sequentially beginning with #1?			
1 4 Are the names of the pills written in the same columns on each page?			
1 5 Ask "Are you registering each patient who comes for family planning even if they don't receive supplies?" (Note If no supplies are taken, "0" should be registered and the reason entered in the column for "remarks")			
1 6 Are column totals entered at the bottom of each page?			
1 7 Are column totals correct?			
1 8 Are monthly totals recorded at the end of the month?			
1 9 Are monthly totals correct?			

DELIVERY REGISTER

In the Delivery Register, review entries for the previous month	YES	NO	Comments
1 1 Do all appropriate columns have data entered?			
1 2 Is the first visit of the month recorded on a new page?			
1 3 Are visits numbered sequentially beginning with #1?			
1 4 (If any complication marked or low birth weight indicated see Outreach Register) Are all deliveries with a complication/low birth weight followed with an outreach visit within 2 days of delivery?			
1 5 Are column totals entered at the bottom of each page?			
1 6 Are column totals correct?			
1 7 Are monthly totals recorded at the end of the month?			
1 8 Are monthly totals correct?			

CHILD HEALTH REGISTER

In the Child Health Register, review entries for the previous month	YES	NO	Comments
1 1 Do all appropriate columns have data entered?			
1 2 Is the first visit of the month recorded on a new page?			
1 3 Are visits numbered sequentially beginning with #1?			
1 4 Are all of the addresses sufficient to physically locate the patient on an outreach visit?			
1 5 If any weight is less than normal, is referral or other action also marked?			
1 6 If any referral or other action are meaningful remarks always entered in final column?			
1 7 (If weight is more that normal locate the Family File and review the child s Card) Is the date of birth or age correctly entered on the Child Health Card?			
1 8 Are column totals entered at the bottom of each page?			
1 9 Are column totals correct?			
1 10 Are monthly totals recorded at the end of the month?			
1 11 Are monthly totals correct?			

OUTREACH REGISTER

In the Outreach Register, review entries for the previous month	YES	NO	Comments
1 1 Do all appropriate columns have data entered?			
1 2 Are outreach visits conducted and recorded on the Outreach Register?			
1 3 Is the first visit of the month recorded on a new page?			
1 4 Are visits numbered sequentially beginning with #1?			
1 5 Are all of the addresses sufficient to physically locate the patient on an outreach visit?			
1 6 Are column totals entered at the bottom of each page?			
1 7 Are column totals correct?			
1 8 Are monthly totals recorded at the end of the month?			
1 9 Are monthly totals correct?			

MONTHLY REPORT

Compare monthly Totals in the Registers with those on the Monthly Report Form	YES	NO	Comments
1 1 Have monthly totals from the Antenatal Register been transferred correctly?			
1 2 Have monthly totals from the Family Planning Register been transferred correctly?			
1 3 Have monthly totals from the Growth Monitoring Register been transferred correctly?			
1 4 Have monthly totals from the Delivery Register been transferred correctly?			
1 5 Are the names of the types of pills written in the <u>same order</u> in the family planning activity and inventory sections as in the Family Planning Register?			
1 6 Does the "number in the stores at the beginning of this month" match "number remaining in the stores at the end of last month"?			

Review all the questions raised about the Monthly Report during the Monthly HMIS Management Meeting. Note responses on the Health Office's highlighted copy of the Monthly Report.

Debriefing at the End of the Visit

After reviewing each of the components of the HMIS meet with the Director of the Center and the MCH staff to review the findings. Note all the corrective actions that need to be taken below. Make sure that the Director makes a comparable list so that he can follow up.

1 Staff members present

2 Corrective Actions to be taken

<u>Action</u>	<u>Responsible</u>
---------------	--------------------

**1995 Service Delivery Point (SDP) Needs Assessment
(including fee collection information)
& Health Need Assessment at the Governorate Level**

Population served within 20 km

Urban

Rural

Sketch the Catchment Area

Number of private pharmacies available in the area

Who is the clinic manager?

What past experience or training has s/he had in management?

What management tasks or activities is s/he responsible for?

Does the manager have other non-managerial responsibilities?

Are staff meetings held regularly in the facility to discuss the problems? Y / N

Supervision

a What is the supervisory structure in the clinic? (*sketch lines of supervision*)

Describe how supervision takes place (*Include supervisory protocol if there is one*)

b What is the supervisory structure with regard to the health units (and other SDPs outside the health center)

Describe how supervision takes place

c Describe any problems with supervision

d Did any person from the Health Office visit the clinic in the last six months? Y/N

If YES What was the purpose?

Overview of Services Offered

Types of services provided in the facility

Are there links between different sections? Y / N
 If YES, specify how?

Clinic-Based

Maternity Care	✓	Family Planning	✓	Pediatric Care	✓
Antenatal Care		Oral Contraceptives		DPT Vaccination	
Delivery		IUD		Polio Immunization	
Postpartum Care		Condoms		Measles Vaccination	
Breastfeeding Education		Injectables		BCG Immunization	
		Norplant		CDD	
Other		Minilap		ARI	
Health Education		Vasectomy		Nutrition	

Outreach

Are outreach services supposed to be part of the services offered?

If Yes

What types outreach services

- General health education Recruitment Follow-Up

Describe the services as they are intended to be carried out?

Describe the services as they are actually carried?

What are the barriers to providing outreach services?

Clinic Schedule

When are the different MCH/FP services scheduled?

Saturday		Sunday		Monday		Tuesday		Wednesday		Thursday	
Service	Hrs	Service	Hrs	Service	Hrs	Service	Hrs	Service	Hrs	Service	Hrs

Attendance

In general, what are the most heavily attended

- a Days
- b Clinics (estimate average attendance)

Sample (most recent week)

Saturday		Sunday		Monday		Tuesday		Wednesday		Thursday	
Service	#pts	Service	#pts	Service	#pts	Service	#pts	Service	#pts	Service	#pts

Possible contributing factors

- a Market Day
- b Other

Finance

Are fees collected from patients?

If yes

a What are the fees?

Service	Charge
Registration	
Lab Tests	
Outpatient	
Inpatient	
Others	

b Are there any patients who are exempted from paying the fees or allowed to pay a reduced fee?

How do you decide whether a patient should be given an exemption or reduction?

What proportion of patients are given the exemption or reduction?

c How is the cash controlled (physically) and accounted for? (receipts ledgers/accounts books)

d For each of the last three months, how much has been collected?

Month

Month

Month

e Allocation of funds received last month

Amount to Health Office

Amount to health facility

f How have the funds been used? Who decides how the funds should be used?

Records (request a copy each)

Patient Records

Are patient records kept?

If Yes

What information do they contain?

Are they individual or family records?

Are they held by the patient or by the clinic?

If by the clinic where are they kept and how are they filed and retrieved?

How is the information used in providing care?

Clinic Records

What clinic records are kept? (MOH OFC etc) What data items do they contain

Who is responsible for

- a Entering the data
- b Tabulating the data

What is done with the information?

- a Where does the information go?
- b How is it transmitted?

- c When is it transmitted?
- d Is any feedback ever received after the information is transmitted?
- e Is the information used in any way by the center itself? If yes how?

Logistics

Storage Facilities

Responsible person

Where are contraceptives and drugs stored?

Under what conditions?

Clean Y/N Organized Y/N

Is there any security?

What type of cold change equipment is available?

What condition is it in?

Are the vaccines properly organized and stored in the refrigerator according to type? Y / N

Is the inside temperature of the refrigerator between 2-8° C?

Y / N

Observed temperature

Is the temperature recorded twice a day on the temperature chart?

Y / N

Is the refrigerator exclusively used for vaccines?

Y / N

Inventory System

How are the inventory records kept for each of the following? Do they appear to be up-to-date?

a Vaccines

b Contraceptives

c Drugs/medications

d Equipment

e Consumable Supplies

d Consumable Supplies

Stock-Outs

Are you out of stock on any drugs vaccines or other commodities and supplies that you need frequently? How long have you been out of stock on these items?

Item	Stock-Out Period	Item	Stock-Out Period	Item	Stock-O Period

Patient Flow

Work Stations/Organization of Tasks

Priority System

In what order are patients seen?

How do they keep track of who should be seen next?

Time in Clinic (estimated)

- a Average Waiting for First Service
- b Average Time in Clinic
- c Client's Perception of Waiting Time

Description of space (including cleanliness) and equipment available (including working condition)

Common Areas

Waiting Area

How is the waiting area(s) arranged? (One general waiting area vs separate waiting areas for each services)

Type of patient seating

Number

Is there any health education provided while waiting?

If yes describe

Patient Registration Area

Personnel working

Type	No	Condition	Utilization
Table			
Staff chair			
Client chair			
Cabinet			
Cash receipt forms			
Client forms			
Register book			

Antenatal Care

Working days/hours

Antenatal Care Providers

Average load Daily

Monthly (previous month)

Waiting Area

Is there a separate waiting area for antenatal care?

If yes,

Clean Y/N Organized Y/N

Clients seating

Audiovisual (VCR and monitor)

Educational materials for videos

Educational posters in the wall

Antenatal Room

Clean Organized

Health Posters

Health Standards Posted

Infection Control

Hand Washing Facilities

Sink Water Soap

Decontamination Supplies

Detergent Chlorox

Antiseptic solution

How equipment are sterilized?

- Soaked for decontamination
- Cleaned with brush and soap
- Sterilized

How is sterility maintained?

Equipment

Type	No	Condition	Utilization
Weighing scale			
Examination table			
Examination lamp			
Sphygmomanometer			
Fatal stethoscope			
Stethoscope			
Privacy drapes			
Screen			
Physician table with chair			
Client chair			

Records

Antenatal card (Availability, usage, storage)

Who is filling the antenatal records?

Is antenatal card completed accurately? Y / N

Prescription forms

Form for ordering lab tests

Registration (*specify data to be recorded*)

Drugs

Drugs Available

How and where are they stored?

Laboratory

Laboratory tests done in the clinic regularly

✓	Test	Comments
	Hemoglobin	
	Hematocrit/PCV	
	Urine for sugar and albumin	
	Pregnancy test	
	Others	

Services

Are there formal protocols for providing services?

Description of services (*observe and record*)

Are there any problems and shortages in providing antenatal services? How to improve the services?

Delivery Services

Working days/hours

Providers

Average load Deliveries Daily

Monthly (previous month)

Other procedures

Space

Service	Clean	Organized	No of Beds	
			Mother	Newborn
Pre-Delivery				
Delivery				
Post-Delivery				

Infection Control

Hand Washing Facilities

- Sink
- Water
- Soap

Decontamination Supplies

- Detergent
- Chlorox

Antiseptic solution

How equipment are sterilized?

- Soaked for decontamination
- Cleaned with brush and soap
- Sterilized

How is sterility maintained?

Equipment

Type	No	Condition	Utilization
Physician table with chair			
Delivery table			
Screen			
privacy drapes			
Examination lamp			
Instrument table			
Sterilizer			
Fetal stethoscope			
Stethoscope			
Sphygmomanometer			
Gloves			
Vacuum extractor			
Thermometer			
Baby weighing scale			
Delivery Pack Artery forceps Cord cut scissors Cord ties Plastic sheeting Gauze swabs Cloth Perineal repair Sponge forceps Needle holder Suture materials Local anaesthesia			
Decontamination basin			
Waste basin w/lid			
Syringes			
Urinary catheters			
Ventilator bag & mask			
Suction catheters			

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Others			
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Records

Registration (*specify data to be recorded*)

Patient Record (Availability, usage storage)

Who is filling out the record?

Is the record completed accurately? Y / N

Prescription forms

Form for ordering lab tests

Drugs

Drugs Available

How and where are they stored?

Laboratory

Laboratory tests done in the regularly in connection with delivery

✓	Test	Comments

Services

Are there formal protocols for providing services?

Description of services (*Observe if possible and record*)

How long does the woman stay in the health facility after delivery?

Services Provided Beside Routine Delivery

Home deliveries

Management of complicated cases

Postpartum care

- Offered examination for the woman (*describe when and how*)
- Health education on breastfeeding (*describe*)
- Health education on newborn care (*describe*)
- Counseling on family planning (*describe*)

Are there any problems and shortages in providing delivery services? How can the services be improved?

Family Planning Services

Working days/hours

Antenatal Care Providers

Average load Daily

Monthly (previous month)

Waiting Area

Is there a separate waiting area for family planning?

If yes,

Clean Y/N Organized Y/N

Clients seating

Audiovisual (VCR and monitor)

Educational materials for videos

Educational posters in the wall

Examination Room

Clean Y/N Organized Y/N

Standards Posted

Contraceptive Mix

Method	No	Price	Amount Dispensed	
			Monthly	
			New	Old
Micogynon				
Neogynon				
Microlut				
IUD CopperT380A				
Neosampon				
Condoms				
Others				

Logistics

Source

Regular period of

Amount supplied

Last date of supply

Infection Control

Hand Washing Facilities

- Sink Water Soap

Decontamination Supplies

- Detergent Chlorox

Antiseptic solution

How equipment are sterilized?

- Soaked for decontamination

Cleaned with brush and soap

Sterilized

How is sterility maintained?

Equipment

Type	No	Condition	Utilization
Physician table and chair			
Client seat			
Examination table			
Examination lamp			
Scale			
Sphygmomanometer			
Stethoscope			
Stool			
Sterilizer			
IUD Insertion & Removal pack Speculum Sponge forceps long artery forceps Tenaculum Scissors Uterine sound Bowl for antiseptic			
Gloves			
Cupboard for supply			
Equipment cupboard			
Instrument table			
Instrument container			
Instrument washing basin			
Waste bin			
Privacy drapes			
Screen			

Other			
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Records

Registration (*specify data to be recorded*)

Patient Record (Availability, usage storage)

Who is filling out the record?

Is the record completed accurately? Y / N

Prescription forms

Form for ordering lab tests

Laboratory

Laboratory tests done in the regularly in connection with family planning

✓	Test	Comments

Services

Are there formal protocols for providing services?

Description of services *(If possible observe)*

Is privacy assured for the client during exam and counseling?

Provision of counseling

Are there demonstration models? *(Which ones)*

Medical examination

Does this facility refer FP clients to other health facilities ?
If YES, specify

Y /N

Patient Flow Chart for a New Contraceptive User

Immunization Services

Working days/hours

Providers

Average load Daily

Monthly (previous month)

Waiting Area

Is there a separate waiting area for immunization services?

If yes,

Clean Y/N

Organized Y/N

Clients seating

Availability of health education materials

Are immunization standards posted on the wall

Infection Control

Hand Washing Facilities

Sink

Water

Soap

Decontamination Supplies

Detergent

Chlorox

Antiseptic solution

How equipment are sterilized?

Soaked for decontamination

Cleaned with brush and soap

Sterilized

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How is sterility maintained?

Equipment

Type	No	Condition	Comments (utilization)
Physician table & chair			
Client seats			
Rectangle basin			
Kidney basin			
Waste bin			
Ampule cutter			
Immunization cards			
Immunization register			
Vaccine carriers			
Ice packs			
Freezer			
Refrigerator			
Gas cylinder			
Dial thermometer			
Disposable syringes			
Others			

Vaccines

Type	No	Condition	Comments (utilization)
BCG			

Poliomyelitis			
Measles			
DPT			
TT			
DT			
Diluent for BCG& measles			

Logistics

Source of supply

Regular period of supply

Amount supplied

Last date of supply

Infection Control

Hand Washing Facilities

- Sink Water Soap

Decontamination Supplies

- Detergent Chlorox

Antiseptic solution

How equipment are sterilized?

- Soaked for decontamination
 Cleaned with brush and soap
 Sterilized

How is sterility maintained?

Are used syringes needles and open vials of vaccine discarded in trash bins and then burnt in the deep hole? Y / N

Services

Are there formal protocols for providing services?

Other Child Health Services

Working days/hours

Providers

Average load Daily

Monthly (previous month)

Waiting Area

Is there a separate waiting area for child health services?

If yes,

Clean Y/N Organized Y/N

Clients seating

Educational posters in the wall

Child Health Consultation/Examining Room

Clean Y/N Organized Y/N

Health education materials

Health standards posted

Services

Service	Y / N	Location	Providers	Equipment
ORT				ORS
Growth monitoring				Weighing scale
Nutrition				Materials
ARI				
Sick treatment				

Are there any problems and shortages in providing services? How can the services be improved?

Laboratory Services

Is there a lab on site? Y / N

If Yes, specify the tests which are done

Is there blood-banking facilities? Y / N

If Yes, Which tests are done for the blood transfusion?

Are there any problems and shortages in providing laboratory services? How to improve the services?

Emergency Services

Other Services

Operating Room

Conference Room

Dressing Room

Clinical Skill Observed

Quality Assurance

Quality Assurance Mechanisms

Is the manager aware of the concept of quality assurance?

Are there any quality assurance mechanisms in place? If yes, describe

Staff Perceptions

How does the staff perceive the quality of the services available at the clinic?

What could be done to improve the quality of the services?

Client Perceptions

Are the clients satisfied with the services at the clinic?

What could be done to make the services better?

Client Interview:

Why did you come to this clinic today?

How far away you are living from the clinic?

Did you get the service you want?

How long did you spent time to get the service?

How much money did you spent in the clinic?

Did the staff treated you well?

Are you happy with the services in this clinic?

How the clinic could be improved?

Community Participation

Is there any mechanism in place to elicit community involvement in the way in which health services are provided?

If Yes

What is the nature of the community involvement?

If a formal advisory board

- a Who is on the board? *(Note also % of females)*

- b How were the members chosen?

- c How frequently does it meet? When was the last meeting?

- d What were the issues discussed?

Is the health facility used for other community activities? If Yes, describe

HEALTH NEED ASSESSMENT
AT THE GOVERNORATE LEVEL

Date

Governorate

Health Office General Director

Donors working in the governorate? Specify areas

What are the common health problems/diseases in this governorate?

What is the policy of fees charging in this governorate?

Is there an MCH/FP department? Specify the organizational chart

- Who is responsible? Names and Qualification

- Facilities available?

Health personnel available

-Is there any training facilities in the governorate?

Health facilities

District	Hospital		Health center			PHCU	
		# beds		MCH /FP	# beds		MCH /FP

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- Is there a defined catchment area for each health facility? Y/N

- Is there a referral system between these health facilities?

- Is there any kind of coordination between these facilities?

- What is the policy for the running the PHCUs as the training of MPHCWs already stopped?

How community is involved in the improvement of health services?

Is there a standard for equipment for each type of health facility? Y / N

If Yes, have a copy

- How the equipment is received from the central level to the health facility?

- Is there an inventory process for the equipment? Y / N

- Is there a responsible persons for the inventory of equipment?
Y / N

- If a health facility in need of an equipment, what is the procedure for filling this need?

- Is there a maintenance department for equipment in the Health Office? Y / N

- How many maintenance technicians do you have in the Office?

How the drug supply assured to health facility?

How contraceptive supply assured to health facility?

Information flow what are the information produced at the governorate level?

How supervision system is achieved? The purposes for supervision

What are the difficulties incountered in the health services?

**OFC Health Center Renovation Costs Report, April 1998
& OFC Health Center Clinical Equipment and Furnishing Report, April 1998**

**Option for Family Care
Health Center Renovation Costs Report
April 1998**

I HADHRAMOUT GOVERNORATE HEALTH CENTERS

1 Seyoun Hosp , MCH & Hostel	\$21,470
2 Al-Shehr MCH	11,033
3 Gheil Bawazır MCH	9,966
4 Al-Shuhar MCH	8,888
5 Al-Hamı MCH	6,946
6 Mukalla Hosp , MCH & Hostel	18,265
7 Deıs Al-Sharqıa MCH	<u>10,219</u>

Total Hadhramout HC's **\$86,787**

II HODEIDAH GOVERNORATE HEALTH CENTERS

8 Al-Thowra Hosp , MCH & Referral	\$30,500
9 Al-Quteı MCH	13,328
10 Bajıl MC	15,544
11 HMI Hodeidah	6,645
12 Al-Dhahı MCH	30,949
13 Beit Al-Faqıh Hosp , MC	18,521
14 Al-Zuhrah MCH	21,249
15 Al-Marawa'a MCH	<u>21,835</u>

Total Hodeidah HC's **\$158,571**

III HAJJAH GOVERNORATE HEALTH CENTERS

16 Hajjah Hosp , MCH	\$15,855
17 Al-Muharaq MCH	26,800
18 Al-Shahel MCH	9,471
19 Al-Tour MCH	35,529
20 Al-Mahabısha Hosp , MCH	10,017
21 HMI Hajjah & Hostel	14,912
22 Mabyan MCH	13,754
23 Shaghadırah	14,756
24 Kuaidınah MCH	<u>17,244</u>

Total Hajjah HC's **\$158,338**

IV LAHAJ GOVERNORATE HEALTH CENTERS

25 Al-Houta, MCH	\$34,560
26 Habil Gabr MCH	13,678
27 Habilein MCH	16,912
28 Al-Daleh MCH	34,290
29 Tour Al-Baha MCH	13,528
30 Al-Waht MCH	11,970
31 HMI Lahaj	<u>4,146</u>

Total Lahaj HC's \$129,084

V Total Renovation Cost \$532,780

**Options for Family Care
Health Center Clinical Equipment and Furnishings Report **
April 1998
John Snow Inc OFC Contract No 279-C-00-95-00516-00**

Lahaj Governorate	Clinical Equipment	Furnishings	Total	Governorate Totals
Al Houta	\$5 733	\$2 708	\$8 441	
Al Waht	\$5 102	\$3 875	\$8 977	
Al Dafeh	\$11 023	\$4 149	\$15 172	
Tour Al Baha	\$6 628	\$3 985	\$10 613	
Hablein	\$5 931	\$3 917	\$9 848	
Hable Gabr	\$2 864	\$1 918	\$4 782	
Total Lahaj Governorate	\$37,281	\$20,552	\$57,833	\$57,833
Hadramout Governorate				
Mukhulla MCH	\$11 597	\$2 881	\$14 478	
Suheir	\$3 272	\$1 062	\$4 334	
Ghail Bawazir	\$7 835	\$1 930	\$9 765	
Al Sheher	\$12 153	\$3 196	\$15 349	
Dias As Sharkia	\$3 823	\$943	\$4 766	
Al Hami	\$3 751	\$1 015	\$4 766	
Seyoun	\$14 513	\$3 145	\$17 658	
Total Hadramout Governorate	\$56,944	\$14,172	\$71,116	\$71,116
Hajja Governorate				
Hajja MCH	\$10 490	\$3 511	\$14 001	
Mabayan	\$4 967	\$1 952	\$6 919	
Shagadra	\$3 928	\$1 471	\$5 399	
Kuaidinah	\$4 101	\$1 853	\$5 954	
Mahabisha	\$8 302	\$3 400	\$11 702	
At Tour	\$4 967	\$2 148	\$7 115	
Al Muharaq	\$5 201	\$2 148	\$7 349	
As Shahel	\$1 118	\$1 168	\$2 286	
Total Hajja Governorate	\$43,074	\$17,651	\$60,725	\$60,725
Hodeidah Governorate				
Az Zuhra	\$4 657	\$1 214	\$5 871	
Al Dahi	\$3 700	\$1 774	\$5 474	
Marawa	\$3 882	\$1 175	\$5 057	
Bayt Al Faqih	\$9 601	\$2 212	\$11 813	
Bajil	\$4 111	\$1 781	\$5 892	
Al Qutar	\$3 782	\$1 261	\$5 043	
Thowra Hospital	\$14 079	\$783	\$14 862	
Total Hodeidah Governorate	\$43,812	\$10,200	\$54,012	\$54,012
Grand Total	\$200,774	\$56,195	\$256,969	\$256,969

** Excludes Midwife Delivery Kits and Health Units

Training Site Selection Criteria

Training Site Selection Criteria

- 1 Have space available for teaching and training
- 2 Have learning materials available
- 3 All MCH and primary health care services are provided at the site
- 4 The center should have an adequate patient load
- 5 Should have basic infrastructure including electricity and water
- 6 Availability of living accommodations for the trainers and trainees
- 7 Willingness and commitment of the community to participate, support and host the training

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Results of the Community Workshop

RESULTS OF THE COMMUNITY WORKSHOPS

A Purpose of the Workshop

Options for Family Care (OFC) conducted two-day health committee workshops in communities where a permanent committee had been established and its membership was comprised of at least two females from the local community. The overall goals and rationale for conducted the workshop are listed below

- **Raise the committee members awareness of local health problems, prevention of these problems, and the importance of the role of the health center and the community** Many of the health committee members were focused on adding curative services to the centers and demonstrated limited understanding of the health center's role in preventive health care
- **Strengthen the local health committee by helping it to better define its role and responsibilities and to define its operating procedures** The committees requested additional guidance in helping them to define their role more clearly. Also, by assisting them in developing operating procedures, the committee could work more efficiently by deciding on a regular schedule of meetings at a fixed location, determining how they would make decisions, and how and when to elect new members
- **Facilitate the development of a workplan for the remaining OFC contract period and beyond, ensuring the workplan includes activities which address priorities identified by the committees** Most of the committees have identified many problems in the center, however, they have had difficulty in prioritizing these problems and organizing activities to resolve priority issues. Also since the OFC contract is ending in September 1998, health committees would have an improved chance in attracting outside support if they could present a well-organized workplan to potential donors
- **Emphasize the importance of teamwork and problem-solving in developing and carrying out their workplan** Through OFC's work with the communities, it has observed that some health centers and committees tend to rely heavily on very few members rather than trying to distribute responsibilities and involve more individuals in the problem-solving process

B Workshop Lead Trainers and Facilitators

The lead trainers for each of the workshops were the OFC Community Participation Coordinators. A major advantage for utilizing the local staff as trainers were they were familiar with the particular health center issues and the strengths and weaknesses of the health committees. The workshop also allowed them to build on their existing training experience since

two of the three Community Participation Coordinators attended the month long Training of Trainers sponsored by OFC in June of 1996 in Sana'a All three also played key roles in conducting refresher training of Female Primary Health Care Workers

The coordinators developed the content of the training with the Community Participation Advisor, prepared and organized all materials (handouts, flipcharts, activity sheets, etc), conducted the training in their respective governorate, and arranged the logistics for the training The other local OFC staff played supportive roles by conducting some of the sessions, providing assistance during the sessions, facilitating small work group activities, and compiling the information prepared by the committees The OFC secretary played a key role by typing the outcome of the sessions directly on a laptop computer during the workshop When available and where appropriate, Health Office and Health Center staff participated as facilitators during the workshop sessions The Director Generals of the Health Offices usually opened and closed the workshops and in their speeches emphasized the importance of the local health committees

C Workshop Participants, Scheduling, and Location

One of the major obstacles in moving the community participation activities forward was the constantly changing membership of many of the committees It has taken some time for health committees to evolve and become a stable and recognized group The health committees are generally comprised of local leaders, teachers, farmers, fishermen, merchants, extension workers, local government employees, and health center staff Workshops were offered to communities which had a stable membership and included a minimum of two female members OFC specified that a maximum number of 20 community members could participate in the two-day workshop

Since the workshop was aimed at health committee members, OFC had to plan the workshops around the members' schedules Many of the health committee members hold leadership positions both in and outside of their communities and their lack of available time caused some scheduling delays for OFC In most cases, it was the center director that acted as a liaison between the committee and OFC and presented the list of participants and confirmed dates of the workshops All workshops included participants who were not officially part of the health committee, the majority of these additional participants were female teachers and female MCH/FP staff

In Hodeidah and Hadhramaut workshops were held in the communities themselves Depending on the availability and appropriateness of space, they took place in health centers and schools Due to geographical issues, workshops in Hajjah took place at the Hajjah HMI

The matrix on the next page summarizes the schedule and number of participants who took part in the workshops

Health Committee	Date of Workshop	Number of Participants
Hodeidah Governorate		
- Zoharah Health Center	14 February 1998	20 Males, 3 Females
- Dhahī Rural Hospital	18 - 19 February 1998	8 Males, 10 Females
- Bajūl Health Center	17 - 18 March 1998	3 Males, 6 Females
- Marawa'a Health Center	17 - 18 March 1998	11 Males, 4 Females
- Al Qatai Health Center	22 - 23 April 1998	10 Males, 8 Females
Hadhramaut Governorate		
- Al Hamī Health Center	8 - 9 March 1998	5 Males, 2 Females
- Dees A Sharqia Health Center	8 - 9 March 1998	8 Males, 2 Females
- Ghail Bawazeer Health Center	10 - 11 March 1998	7 Males, 3 Females
- Al Shuhair Health Unit	10 - 11 March 1998	6 Males
- Shahr Hospital MCH Center	15 - 16 June 1998	8 Males, 4 Females 1 Male from Dees ASharqia 2 Females from Shuhair
Hajjah Governorate		
- Al Tor Health Center	18 - 19 May 1998	7 Males, 2 Females
- Hajjah Health Center	18 - 19 May 1998	5 Males, 7 Females
- Shaghadra Health Center	30 June - 1 July 1998	7 Males, 3 Females
- Ashahel Health Center	30 June - 1 July 1998	3 Males, 6 Females

D Content of the Workshop

Topics covered in the workshop addressed the overall goals listed in Section A, page one, of this report. The sessions were organized in a logical progression of steps. This began by raising participant's awareness of the role of the health center in disease prevention. The following sessions were aimed at assisting the committee in defining its overall purpose and responsibilities, and facilitating a brainstorming session to outline needs and problems, identify priorities, and develop objectives and activities to address priorities. The last session focussed on developing a workplan including target dates and persons responsible for specific activities.

and tasks. Titles of the sessions are listed below (the specific schedule for the two days and content of the sessions appear in Appendix A)

- The Overall Health Situation in Yemen
- Local Diseases and Methods of Prevention
- Health Services Offered by the Center and their Importance to the Community
- Defining Community Participation
- Objectives of the Health Committee
- Teamwork and Cooperation
- Operating Procedures of the Health Committee
- Responsibilities of the Health Committee
- Identifying Needs and Priorities
- Developing Objectives and Activities
- Developing a Workplan

As indicated in the final evaluation prepared by the participants, most of the sessions were well received and deemed important. However, a major drawback to the workshop (identified by the trainers, facilitators, and participants) was the limited amount of time designated for each of the sessions. After the first workshops were conducted in Zoharah and Dhahri Centers, the content was modified to reduce the amount of information provided by the facilitator. More time was devoted to the small work group sessions in order to allow participants more time to come to consensus about their operating procedures, overall purpose, roles and responsibilities and to develop objectives, identify activities, and define tasks.

Outstanding commitments of the Partnership Agreements were addressed during the session on identifying needs and priorities. This was to help ensure that these issues would be addressed in the health committee's workplan of activities for communities who had not completely fulfilled its commitments.

E Results of the Workshops

The outcome of the workshop resulted in a series of documents prepared by the committees themselves which will guide future work and will serve as the basis for OFC follow-up through the remainder of the contract period. These documents have been typed and distributed to the committees. The appendix of this report includes documents prepared by each respective committee and includes

- Overall goals of the Health Committee
- Responsibilities of the Health Committee
- Responsibilities of the Officers of the Health Committee
 - Chairman/Vice Chairman

- Treasurer
- Secretary
- Operating procedures of the Health Committee
 - Regular schedule of meetings
 - Decision-making and representing community interests
 - New members
- A list of needs and problems in priority order
- Objectives for addressing key priorities
- A workplan including activities, responsible parties and target dates for completion

F Future Follow-up

A checklist for conducting field follow-up has been developed in order to monitor the committee's progress in implementing practical aspects of the workshop (Appendix B) Also, since the health committees have come to consensus on date, time and location of their regular meetings, OFC can schedule site visits in order to attend some of the meetings

Lastly, through coordination with the Management Advisor in the implementation of management competitions, the committee's progress in implementing their workplans will be included as one of the criteria in determining the most successful OFC supported center

WORKSHOP SESSIONS, GOALS, AND CONTENT

Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
DAY 1				
9 00 9 30	Session I Opening	<ul style="list-style-type: none"> - Be introduced to each other - Know the purpose and expectations of the workshop - Complete the pretest 	<p>As participants arrive they are given the pretest to complete, facilitator collects the tests at the end of the opening session</p> <p>Facilitator presents the purpose of the workshop and expectations of participants written on a flip chart</p> <p>Purpose (why the workshop is being held)</p> <ul style="list-style-type: none"> - Raise the committee members awareness of local health problems, prevention of these problems, and the importance of role the health center and community - Strengthen the local health committee by helping it to better define its role and responsibilities in the community and to define their operating procedures - Facilitate the development of a workplan for the remaining project period and beyond, making sure the workplan includes activities which address priorities - Emphasize the importance of teamwork, problem-solving in carrying out its workplan 	<ul style="list-style-type: none"> - Flip chart, with purpose and expectations of the workshop - Pretest - Notebooks, folders, pens and pencils
9 30 9 50	Session II Health situation in Yemen	<ul style="list-style-type: none"> - Have an increased awareness of the major health problems affecting Yemen 	<p>Facilitator presents the goal of the session</p> <p>Presentation of the major health problems affecting Yemen</p> <p>Participants are asked to name health problems affecting their community Facilitator writes these on flip chart</p>	<ul style="list-style-type: none"> - Goals of the session on flip chart - Flip chart paper, markers

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Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
9 50 - 10 15	Session III Definition of community participation	- Be able to define community participation, its components, and describe why they are important to the community	Facilitator presents the goals of the session - Present a general definition of community participation - Facilitator asks the group to describe ways in which they have already participated in the activities of the health center - Facilitator presents the "community tree" and asks participants what the tree needs to thrive Each element needed is analogous to resources in the community	- Flip chart with goals of the session - Flipchart paper, markers - Community Tree (Attachment 1)
10 15 10 45	B R E A K			

Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
10 45 - 11 15	Session IV Goals (purpose) of the health committee	- Will all agree on the overall purpose of their health committee	<p>Facilitator presents the goal of the session</p> <p>- Role play is conducted with the director of center, client from the community and a health committee member The client from the community is arguing with the health center director, blaming him for not providing adequate services, having a dirty and in equipped center The health committee member intervenes in the argument and offers to help to solve their differences</p> <p>- Facilitator asks participants to identify the titles of the persons in the role play A short discussion on the overall role of the committee in helping to facilitate solutions and its role as an intermediary between the community as a whole and the health center</p> <p>- Participants are divided into groups and asked to develop overall goals of their committee Facilitators guide the small group discussion as needed</p> <p>- A volunteer from each group presents their goals to the large group The facilitator writes the goals on the flip chart and asks other groups for input Consensus is reached and overall goals are finalized on the flip chart</p>	<p>- Flip chart with goals of the session</p> <p>- Flipchart paper, markers</p>

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Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
11 15 - 11 45	Session V Services in the centers and their importance to the community	<ul style="list-style-type: none"> - Be able to describe the services in the center and why they are important to the community - Know what role the center plays in the prevention of the diseases - Know the role of the community health workers in and outside of the center - Know the purpose of the family file 	<ul style="list-style-type: none"> - Facilitator presents the goals of the session - Facilitator holds up cards and asks participants (non-health workers) to identify the card and its purpose - Through discussion led by the facilitator each service is described, its importance in the community Special attention is given to MCH/FP services and their role in preventive health care - The director of the health center assists in describing the services which were missed by the participants - Importance of family file is also explained 	<ul style="list-style-type: none"> - Flipchart with goals of the session - MCH/FP cards and immunization cards - Handout (a chart with the services of the center listed, a brief description of the service, the staff who provide these services) prevention, - Family File
11 45 - 11 55	B R E A K			
11 55 - 1 00	Session VI Operating procedures for the health committee	<ul style="list-style-type: none"> - Agree upon operating procedures for meetings, decisions, and promoting community involvement - Agree upon dates of health committee meetings for the next one year period 	<p>The facilitator presents the goals of the session</p> <p>The facilitator presents a series of questions that need to be answered, the questions fall into 3 categories</p> <ol style="list-style-type: none"> 1 - Meetings and procedures for meetings and decision-making 2 - Selection of officers and members 3 - Community representation and female involvement <p>Participants are divided into groups, each is asked to answer a series of questions</p> <p>The large group meets and representatives from the small groups present their answers for discussion The facilitator asks for comments from the group and records final answers on flip chart paper based on group consensus</p>	<ul style="list-style-type: none"> - Flip chart with goals of the session - Questions for each group to answer on flip chart paper and on paper (Attachment 2)

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Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
1 00 - 1 20	Session VII Team work and cooperation	- Be able to name the advantages of teamwork versus working alone	<p>Facilitator presents the goal of the session</p> <ul style="list-style-type: none"> - The facilitator asks for 4 volunteers One group of 3 will work together and one individual is asked to work to alone Each is given a small box with words written on small pieces of cardboard When arranged properly, the words make up sentence - Each group is also given a large piece of cardboard and a roll of tape and is asked to tape the words onto the cardboard - The rest of the group is asked to observe the two groups in their effort to arrange the cards into a logical sentence - When one group finishes, the facilitator leads a discussion where participants discuss advantages to working in a group versus working alone 	<ul style="list-style-type: none"> - Flip chart with goals of the session - Flipchart and markers - Words written on cardboard which make a sentence - Small cardboard box - Tape - Heavy paper
DAY 2				
8 30 - 9 00	Session I Responsibilities of the officers of the Health Committee	- Will agree on a written list of responsibilities for each officer of the health committee	<p>The facilitator presents the goal of the session</p> <ul style="list-style-type: none"> - Facilitator asks the officers of the committee Chairman, Secretary, and Treasurer to present his/her responsibilities in front of the large group for discussion (Note On the previous day each officer was given a suggested list of responsibilities and was asked to modify it as necessary for their committees) - The facilitator records the responsibilities of each officer agreed to by the group as a whole on the flip chart during the discussion 	<ul style="list-style-type: none"> - Flip chart with goals of the session - Markers - Flip chart paper - Some suggested responsibilities of health committee (Attachment 3)

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Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
9 00 - 9 40	Session II Responsibilities of the health committee	- Will all agree on a written list of responsibilities which are closely linked to their overall goals developed the previous day	<p>Facilitator presents the goal of the session</p> <p>Each participant has two A4 size cards which s/he has been asked to select from the wall where they were taped at the beginning of the previous day Each describes a responsibility of the health committee The participants were asked to select cards which contain responsibilities which they would like to include in their committee's responsibilities</p> <p>The participants are divided into small groups and asked to discuss the cards they selected and why They are also given blank cards and asked to write additional responsibilities not contained on the cards</p> <p>When the group comes to consensus on the responsibilities, they are asked to tape the cards on a large piece of paper One member of each group presents their responsibilities</p> <p>The facilitator leads a discussion, asking for comments from the group until consensus is reached on the responsibilities of the committee</p>	<p>- Flip chart with goals of the session</p> <p>- A4 size cards with responsibilities listed (Attachment 4)</p> <p>- Blank A4 cards</p> <p>- Markers</p> <p>- Masking tape</p>

Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
9 40 - 10 40	Session III Identifying priorities for health committee activities	<ul style="list-style-type: none"> - Be able to analyze problems - Prioritize their needs and problems according to criteria 	<p>The facilitator presents the goals of the session</p> <p>The facilitator makes a brief presentation about problem, need identification, and priority setting</p> <p>In the large group, participants are asked to brainstorm the health related problems and needs faced by the center and the community. These are listed on the flip chart by the facilitator</p> <p>The participants are divided into small groups and are asked to complete a worksheet. The first column of the worksheet lists the problems/needs identified by the participants during the brainstorming session. In the next three columns the participants are asked to attach a score the problem 1- 5 points using three criteria (importance, feasibility, and impact). In the last column, they must add the total points. The problem/need with the most points becomes priority 1 and so on (Attachment 5)</p> <p>The group reconvenes and a volunteer is asked to read its score for each problem. The facilitator records the score of each group for each problem. The scores for each problem are added. In the last column the problems are numbered in priority order. The problem with the most points becomes priority one and so on (Attachment 6)</p>	<ul style="list-style-type: none"> - Flip chart with goals of the session - Flip chart and markers - Worksheets
10 40 - 11 10	B R E A K			

Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
11 10 - 12 30	Session IV Develop measurable objectives and solutions for addressing the priorities	<ul style="list-style-type: none"> - Will have a plan of action, outlining specific objectives and tasks for addressing priorities - Persons responsible and target dates of completion will be assigned to each priority 	<p>Facilitator presents the goals of the session</p> <p>Facilitator explains to the group the importance of having measurable objectives to address problems, gives several examples of problems and measurable objectives (ones which relate to the health center), s/he also gives examples of possible causes of the problems and possible solutions to address the problems (Note the facilitator uses the flip chart to provide an example of how the participants should fill in the worksheet to be used in the small group work (Attachment 7)</p> <p>Participants are divided into groups Each takes 1 - 2 of the priorities identified from the previous session and fills out the worksheet problem/need, objective, causes of the problem, solutions (activities), and persons responsible for following up the activities</p> <p>Each group should presents their worksheets for discussion The large group is asked to critique the worksheets presented The presenter makes corrections on his/her worksheet as necessary</p>	<p>Flip chart with goals of the session</p> <p>Flip chart paper and markers, List of priorities from the previous session</p> <p>Worksheet</p>
12 30 - 12 40	B R E A K			

Time of the Session	Subject of the session and person responsible	Goals of the session By the end of the session, participants will	Content of the session	Materials needed
12 40 - 1 00	Session VII Developing a timeline of tasks and activities to achieve objectives	- Produce an annual plan with estimated completion dates for activities	Facilitator presents the goal of the session Explain the importance of developing time lines and assigning responsibilities and dates for in achieving goals The facilitator gives an example of a timeline, and the information which should be included The secretary of the committee, with assistance from the group fills in the timeline based on the activities and dates identified in the previous session's worksheets	Flip chart with goals of the session Flip chart and markers Solutions (activities and tasks that the group agreed to work on) from previous session
1 00 - 1 30	Session VIII Post-test and evaluation Closing and distribution of certificates and presents	- Complete the post-test - Complete the evaluation form	Facilitator presents the goals of the session The post-test is handed to the participants for completion (10 minutes) The evaluation is handed to the participants for completion (10 minutes) Participants are given certificates and a briefcase for completing the workshop	Flip chart with goals of the session - Flip charts and markers - Post-test - Evaluation of the training - Participant certificates - Briefcases

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