

# TASC 2/JSI ANNUAL REPORT

## October 2005 to September 2006

### Summary

As of September 30, 2006, JSI is managing eight Task Orders, two of which have been awarded during this reporting period. The two newest Task Orders are from Tanzania and the Europe and Eurasia Bureau of USAID/Washington. Additionally, the Albania Task order was amended to extend the life and scope of work of the project with additional funds. The new Task Orders are:

1. Tanzania – This project was designed to provide strategic, managerial, and technical vision and support to ensure that PMI is implemented efficiently and effectively for maximum impact in Mainland Tanzania and the Zanzibar Islands. Under this project a full time resident advisor will support the USAID Mission in Tanzania in all aspects of planning, administration and management of the U.S. President’s Malaria Initiative (PMI) and collaborate with USAID partners in development of annual PMI workplans and budget and ensure that they are produced on time and submitted to the proper authorities in the MoH and/or USAID. In addition, the resident advisor will provide guidance, feedback, and support to the PMI contractors.
2. Europe and Eurasia – The Quality Family Planning and Reproductive Health project has been designed to increase health promotion and access to quality health care by building the capacity of USAID E&E bilateral to improve the quality of and access to family planning and reproductive health (FP/RH) services and products. This project will identify best practices in policy and programmatic arenas that have improved FP/RH service delivery, package essential elements in tools, expose interested country stakeholders to these best practices and provide technical assistance and mentoring for their implementation.

In Albania the amendment will allow the project to continue family planning training for the community midwives, enhance the capacity of the Ministry of Health to forecast contraceptive needs, and conduct media campaign to enhance the quality and use of contraceptive services in Albania as well as consolidate and institutionalize achievements to-date in these areas. Now that all districts have been covered with the basic package of FP training and Logistics Management Information System (LMIS), a major project activity during the extension period will be to organize and provide technical assistance for a strategic re-assessment of the family planning situation in Albania. Given the high emphasis on FP and low contraceptive prevalence rate the project will assist the MOH in identifying the major barriers to increased contraceptive use and next steps that might be taken by the Government of Albania to improve the access and quality of FP services.

The following table provides the details of the Task Orders JSI is currently implementing.

**Task Orders awarded to JSI, as of September 2006**

<b>Task Order #</b>	<b>Country</b>	<b>Ceiling</b>	<b>Expenditure to Date</b>	<b>Balance</b>	<b>Completion Date</b>	<b>Comments</b>
802	Albania	\$1,325,000	\$805,942	\$519,058	6/30/2007	On going
800	Djibouti	\$9,195,958	\$3,594,371	\$5,601,587	4/26/2007	On going
<b>05</b>	Eastern Europe	\$799,456	0	\$799,456	9/30/2008	
813	Russia	\$9,949,023	\$9,132,701	\$816,322	1/7/2007	On going
<b>03</b>	Tanzania	\$1,326,303	\$124,317	\$1,201,986	9/30/2010	On going
812	Ukraine	\$4,992,549	\$4,872,967	\$119,582	9/29/2006	Ended
801	Ukraine	\$ 999,996	\$ 923,409	\$76,587	9/29/2006	Ended
001	Injection Safety	\$56,824,216	\$15,385,146	\$41,439,071	9/30/2009	On Going
<b>Total</b>		\$85,412,501	\$34,838,853	\$50,573,648		

The activities of the Task Orders are going on as planned. The following section provides summary of accomplishments during this reporting period.

## **SUMMARY TASK ORDER REPORTS**

## **ALBANIA: ALBANIA FAMILY PLANNING PROJECT (AFPP)**

The *Albania Family Planning Project (AFPP)* was designed to support to the Ministry of Health (MOH) by

1. Assisting to achieve and maintain contraceptive security;
2. Completing FP training in the remaining 16 (of 36) districts in the country;
3. Increasing knowledge of modern family planning methods with a Behavior Change Communication (BCC) program.

### **Highlights of Achievement:**

- 1) completed FP training in all remaining districts according to the rollout plan, meaning that there is now nationwide coverage of FP services;
- 2) finalized the BCC strategy and began airing TV spots that promote modern contraception; leveraged UNFPA funds to increase the air time for the TV spots; media survey shows that two-thirds of Albanians have seen the TV spots;
- 3) re-vitalized and expanded the coverage of the LMIS system;
- 4) Conducted a market segmentation analysis using a “total market approach” that highlighted policy issues affecting long-term contraceptive security in Albania.

### **Progress in Achieving Results**

#### ***Access***

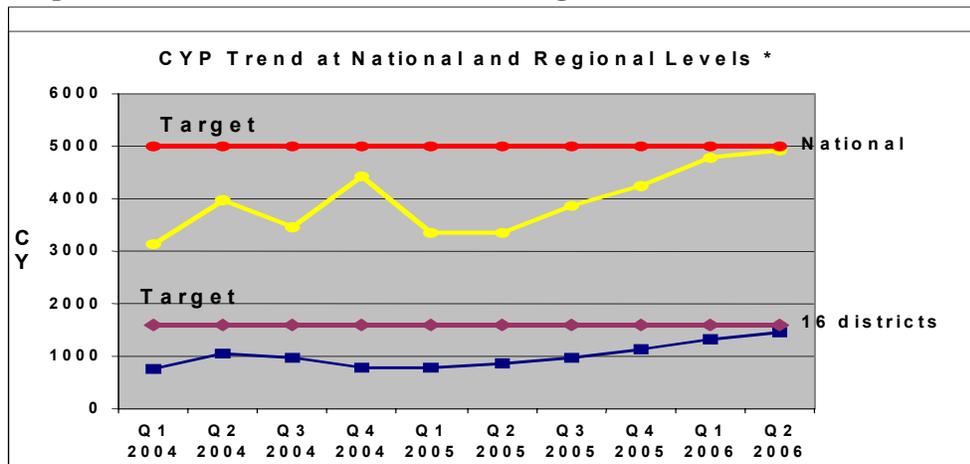
AFPP has covered 91 FP service delivery points (SDP) in the 16 target districts, during the past fiscal year, with a package of FP training and LMIS strengthening. Total coverage now stands at 188. The public sector now has a total of 588 FP-trained providers in the 16 target districts linked to the national contraceptive LMIS system. This include 390 nurse midwives who will deliver FP services in the under-served areas (especially rural areas.), 25 administrative staff from Public Health Directorates whose duties include the day-to-day supervision of family planning activities in their districts and/or the reporting of family planning statistics. The majority of trainees are female (77%).

Approximately 33% of trainees were visited at their worksites after the training to evaluate family planning activities, and to observe their skills and provide remedial on-the-job instruction as required. Local health authorities were fully involved in this follow-up process.

AFPP assisted the MOH to finalize a long-term FP training strategy that was integrated into the AFPP strategic framework & PMP. At the local level, local health directorates have actively supported the program by participating in and organizing the AFPP-supported trainings in their districts. At the national level, the MOH authorities had a leading role in trainer selection and coordination of training activities in the field.

As a result of increased coverage more people are receiving contraceptives showing an increase in the Couple Years of Protection (CYP), as can be seen in the following chart:

**Graph 1: CYP Trend at national and Regional Levels**



\*The table above does not include data for the July-Sept 2006 period because such data are processed and reported only at the end of October 2006, and were not ready for this report.

***Awareness and Knowledge***

Utilization of PHC facilities for FP service is increasing. This is because of the increased number of SDPs providing FP services and increased demand due to the nationwide BCC mass media campaign.

Two TV spots were developed and aired on Albanian TV channels during FY 2005-2006, one of them for urban and another for the rural population. The spots were developed based on qualitative research and were tested with audiences before broadcasting. A recent Media Recall Survey (June 12-July 26) shows that 74% of those interviewed at SDPs recalled seeing at least one FP spot and 42% of those were able to state one message from the TV spot.

***Contraceptive Security***

This reporting period has experienced higher level of contraceptive stock outs at district level and at MOH service delivery points. Except for the Progesterone-only oral pill (POP), stock outs increased during the past year, due entirely to the lack of timely procurement at the national level. Poor communication between the MOH and its primary contraceptive supplier (UNFPA) has resulted in procurement delays. As of September 30, 2006, shipments of low dose oral pills, IUDs, condoms and Depo Provera had arrived, thus ensuring that contraceptive stock outs will decline dramatically in October and November 2006. By November 2006, when the final shipment of low dose arrives, the MOH will have approximately a 2-year supply of contraceptives in stock at the central warehouse, meaning stock outs due to procurement delays will no longer be a concern for next two years.

Stock outs are more frequent at service delivery points (SDPs) than at the district level, which indicates a potential bottleneck preventing contraceptives moving from district level to SDPs. AFPP is investigating this bottleneck and will assist the MOH in correcting it.

Due to AFPP assistance, Logistics Management Information System (LMIS) reporting is now virtually 100%, and the Institute of Public Health is successfully processing LMIS data.

**LMIS shifted from MOH to Institute of Public Health.** The responsibilities for logistics management information system (LMIS), central warehousing and distribution of contraceptives were all shifted to the Institute of Public Health in January/February 2006. This is a major step forward in contraceptive security in Albania, and AFPP worked closely with IPH to ensure contraceptive availability at all levels. This shift enhances the long-term institutionalization and sustainability of LMIS.

**MOH Procurement of Contraceptives.** The MOH procured its first contraceptive in 2005, thus fulfilling its obligation to begin funding its own contraceptives. MOH contraceptive procurement is a major breakthrough in raising the level of contraceptive security in Albania. With AFPP assistance, the contraceptive forecast for Albania was updated in 2006, including financial requirements.

In September 2006, AFPP analyzed the Albania contraceptive market and identified policy issues affecting market segmentation and thus the long term availability of contraceptives.

### ***Challenges and Unplanned Difficulties***

- Albania has experienced cyclical contraceptive stock outs over the past five years that have slowed the rise of CPR in the country. AFPP will assist the MOH to take a number of practical steps to reduce stock outs – (i) refresher training will be provided to LMIS officers from all 36 districts; (ii) facilitate meetings between UNFPA and the MOH to plan procurement and distribution; (iii) assist the IPH to increase the national LMIS reporting; and (iv) follow up with UNFPA on the distribution schedule for contraceptives. Nevertheless, the real challenge is to put in place a system that will ensure long-term contraceptive availability without assistance for AFPP or any other external organization.
- Limited resources have prevented AFPP from assessing the current practice level of Health providers trained in the 20 non-project districts (they were trained under previous projects and their FP skills may have deteriorated.) Supportive supervision and updates/refreshers are essential to maintaining provider skills and the quality of FP services.
- Overburdened MOH policymakers and providers are often unable to focus on FP/RH, which is therefore frequently a neglected component of the government's primary health care service.

### **DJIBOUTI: EXPANDED COVERAGE OF ESSENTIAL HEALTH SERVICES PROJECT (PECSE)**

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This project has been designed to achieve the following Intermediate Results (IR):

- IR 1: Increased Supply of Essential Health Services;
- IR 2: Improved Quality of Services;

### IR 3: Enhanced Local Capacity to Sustain Health Services.

#### **Accomplishments.**

#### IR 1: Increased Supply of Essential Health Services

- A Joint Program Plan for EPI was developed in collaboration with WHO, UNICEF and the Ministry of Health. Its implementation will contribute to the effective coordination of capacity building and service delivery for routine EPI implementation.
- DPT 3 Coverage in rural areas has increased and is estimated to be 16% although poor data quality continues to plague monitoring of results.
- District Health Management Teams developed staff job descriptions and began identifying skill requirements for each position to improve management of health districts, as part of the decentralization policy of the government.
- Rehabilitation work continued including in an urban site. Only six sites remain to be rehabilitated and technical plans for these sites are completed. Water supply for health posts have received considerable attention, and sites either have water available, are awaiting solar pump or other upgrades or are awaiting third-party well-drilling.
- The recent Avian Influenza (H5N1) epidemic led to community training about influenza symptoms and actions to take. The whole country benefited from the favourable environment created by the Health Committees and Community Health Workers.
- The long procurement process for medical materials and other equipment was completed and site equipping is on-going, including upgrade to solar power.
- The essential health package identified by PECSE in collaboration with USAID and the MOH was modified in order to correspond with USAID's performance monitoring system by also adding the encouragement of assisted deliveries. The essential health package includes: Recognition of danger signs for pregnant women and prevention activities against malaria, anaemia and tetanus; Child growth monitoring and breast feeding; IMCI (integrated Management of Childhood Illnesses) focusing on diarrhoea control, ARI, and immunization; Treatment of common diseases, such as malaria; IEC and Health Education; Counselling for HIV/AIDS Prevention; School health (prevention of diseases); Community based services; Assisted deliveries.

#### IR 2: Improved Quality of Services

Activities under this IR have focused on human resource development and improvement of support to rural service providers including increased supportive supervision. Key achievements include:

- Members of the District Management Teams in the five districts were trained in improving quality of services and in technical supervision. District Training Teams were established and are active.
- Third round of training of service providers in five districts continued, primarily on themes of maternal and child health.
- Supervision has been completed to every site; this was not occurring beforehand. An integrated supervision guide was developed.
- Health information system work included development and training in use of new data collection tools. Development, installation and implementation of database are on-going, and are being expanded nation-wide.

### IR 3: Enhanced Local Capacity to Sustain Health Services

Following the study tour on social mobilization for health to Madagascar and Ethiopia, MOH interest in social mobilisation increased.

- The MOH is working with the Project team and other interested donors in order to finalize a National Strategy for Social Mobilisation; this is a huge achievement in a country where there was opposition to mobilization less than two years ago.
- 100% of project-supported health facilities have Community Health Committees with both male and female representation, covering 26 sites. Community members, especially those on Health Committees, were trained in social mobilization techniques.
- 100% of target communities have trained community health workers. The Project trained 2-4 community health workers for each of the 26 Health Committees. Community Health Workers are implementing quarterly plans that they have developed.
- Behavior Change Communication including 7 new and 4 old radio spots, in three different languages, continued. Flipcharts and posters representing all key PECSE themes were pre-tested and are being finalized.

### **RUSSIA: MATERNAL AND CHILD HEALTH INITIATIVE**

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The project's objective is to ensure the adoption of internationally recognized maternal and child health (MCH) standards and practices by the targeted health facilities in Russia. MCHI contributes to USAID/Russia's Strategic Objective 3.2: *Use of Improved Health and Child Welfare Practices Increased*. Indicators directly related include: *Abortion rates reduced*, *Access to More Effective Primary Health Care (PHC) Services Increased*, and *Number of health facilities implementing evidence-based maternal and child health (MCH) care practices*.

## Major Accomplishments:

- Developed a successful replication model that resulted in rapid scale-up from two regions (during WIN 1999-2003) to 16 regions, including four regions in the Russian Far East (RFE). Keys to this success include:
  - a. Using a competitive selection process based on specific and transparent criteria;
  - b. Revising or developing and disseminating “user-friendly” materials such as: the WIN Guide, *How to Implement Effective Health Care for Women and Infants*; training curricula; evidence-based protocols and guidelines, etc;
  - c. Engaging participating regions in developing workplans that reflect the specific needs and priorities of each individual region; and
  - d. Combining the essential components of teamwork, training, follow-up, monitoring and evaluation, and client feedback.
- Reached over ten million clients at 180 health facilities, including clients at over 73,000 deliveries.
- Increased beneficial evidence-based practices from 50% to 76% at targeted facilities, while reducing non-beneficial non-evidence-based practices from 65% to 36% in less than two years.
- Reduced the perinatal mortality rate (between 2003 and 2006) from 12.2% to 9.9% in selected regions and from 9.3% to 7.1% in targeted cities.
- Reduced the abortion rate (between 2003 and 2006; per 1,000 women of reproductive age) from 47 to 45 in the selected regions and from 46 to 41 in targeted cities. This represents a more rapid reduction in MCHI intervention regions than the overall national downward trend.
- Reduced unplanned pregnancies by 13% and increased use of modern contraceptives by 31% in MCHI regions.
- Developed national guidelines for the prevention of mother-to-child transmission (PMTCT) of the human immunodeficiency virus (HIV) in response to the worsening HIV/AIDS situation in Russia and conducted the first study in Russia on the family planning practices of HIV+ women with subsequent development of family planning guidelines for HIV+ women/couples.
- Increased client satisfaction with the services provided at health facilities.
- Changed the way providers relate to clients and to each other. The majority of providers are now enthusiastic and committed to evidence-based practices and the client-centered approach.
- Garnered support from administrators at facility and regional levels, who now demonstrate a commitment to the model through growing policy reform and allocation of resources to support the innovations. Data showing the positive impact of the program and evidence of cost savings were keys to this change. Developed capacity for sustainability through the formation and development of national training-of-trainers, regional and local trainers, technical working groups; a cadre of technical experts; IEC materials and curricula; monitoring and evaluation tools; a network of interregional representatives/coordinators; a website to disseminate materials and updates; and other methods.
- Verified and documented that over USD \$22 million in funding and in-kind resources and allocations had been leveraged from the public and private sectors in just five of the

Project's regions and municipalities. Overall, MCHI leveraged approximately USD \$12 for every one dollar invested by USAID.

- Assisted USAID-funded programs in other countries (e.g. Ukraine, Albania, Georgia, Romania, Central Asian Republics [CAR]) to accelerate their start-up process and learn from the experience in Russia.
- Conducted a three-day dissemination conference on "Improving Quality of Medical Care of Women and Infants: The MCHI Experience." The Conference presented Project results and lessons learned in improving women's and infants' health in 16 regions across Russia. Approximately 300 participants attended from more than 30 Russian regions, Eastern European and Eurasian countries, USAID and other international organizations, and the JSI home office in Boston – May 2006.
- Completed the MCHI Endline Facility-Based Survey – April 2006.
- Presented to USAID/W the key Project findings and accomplishments – June 2006.
- Formed and led the 1<sup>st</sup> national working group on evidence-based protocols development – September 2006.
- Developed a website for dissemination of technical materials throughout Russia and the EE/EA region.

#### Other related Accomplishments

- Registered the Institute for Family Health (IFH), a Russian-based NGO with a strong MCH and reproductive health mandate.
- Hosted a two-day JSI Eastern Europe and Eurasia (EE/EA) Regional Meeting – May 2006.

Overall, the **capacity building** at the regional level has been impressive, and the potential is great for continued achievement and further expansion. The design and implementation process of the MCHI Project is an **excellent model** for similar work in other countries and for the incorporation of evidence-based, internationally-recognized standards of care into the Russian health care system. The Project has reached a substantial part of the 16 MCHI target regions, which together constitute more than one-sixth of Russia's total population. Both **replicability** and **sustainability** are key MCHI successes. Choosing facilities that are interrelated sets of MCH clinics, family planning centers, and HIV/AIDS centers has helped to horizontalize previously vertical institutions and to standardize content and continuity of care.

It is highly likely that the evidence-based interventions introduced by MCHI will be sustained in target facilities beyond the life of the Project and that adoption of those interventions will be rolled out or expanded to most, if not all, of the other health facilities in the intervention regions. The adoption and integration of **internationally-recognized, evidence-based standards** has occurred at an impressive pace across a broad range of political and health institutions, and has actively involved people over a vast geographic area. Interlinking components and a multi-level focus gave the project and its activities strength, breadth, adaptability, and flexibility. By identifying and supporting "catalyst" institutions and individuals, MCHI has helped multi-level leadership implement bold, rapid, and substantive changes.

## **TANZANIA: PRESIDENT’S MALARIA INITIATIVE**

This project has been in operation in Tanzania since May 1, 2006. The main objective of the task order is to provide malaria technical support to USAID – Tanzania and participate in the planning, management and implementation of the President’s Malaria Initiative (PMI). Dr. René Salgado has been assigned to provide this support full time. He is the Technical Advisor to the Mission for President’s Malaria Initiative.

From the start, the activities under the Task Order have been key to the implementation of PMI in Tanzania. Dr. Salgado lead the Tanzania and Zanzibar PMI teams in preparing the Malaria Operational Plan (MOP) for fiscal year 2007. This endeavor involved convening consultative meetings with the National Malaria Control Programme of mainland Tanzania and the Zanzibar Malaria Control Programme in Zanzibar. More than 100 participants from the public and private sectors, bilateral and multilateral agencies (e.g. WHO, UNICEF, etc.), non-governmental and faith-based organizations as well as educational and research institutions attended the consultative meetings. These extensive consultations have been hailed by participants as an excellent opportunity to provide input into PMI-funded malaria activities. Dr. Salgado prepared and facilitated all meetings and was the main writer and editor of the final product, the MOP. Based on the MOP, PMI – Tanzania received \$27 million for FY 2007—the largest share of the PMI pie.

Once the MOP was approved, Dr. Salgado started the preparation of the terms of reference for Requests for Applications (RFAs) for technical services. These RFAs are procurement instruments for PMI activities. A recently completed RFA was for securing indoor residual spraying (IRS) and other malaria actions. On occasion, Dr. Salgado reviews RFA applications and provides input to USAID/Tanzania on the technical soundness of what is proposed.

Dr. Salgado supports USAID/Tanzania for day-to-day management of all PMI activities. In addition, he attends technical meetings, collects and provides data and information to USAID/Tanzania and USAID – Global bureau, helps manage PMI contractors, liaises with NMCP, ZMCP and other malaria stakeholders, provides technical advice on evaluation instruments (DHS, Health Facility Survey, etc.), conducts field visits in the mainland and Zanzibar, organizes support for visiting USAID personnel, provides technical review and input to consultant reports and a myriad of other activities that facilitate the smooth running of PMI in Tanzania.

Dr. Salgado sits at the National Malaria Control Programme in mainland Tanzania. His responsibilities at NMCP include providing technical advice, clarifying USAID rules and regulations for national staff, reviewing and providing input to technical materials, writing speeches and technical reports, convening and managing PMI meetings and responding to ad hoc requests from national authorities.

## **UKRAINE: MATERNAL AND INFANT HEALTH PROJECT**

The Mother and Infant Health Project worked intensively in Ukraine to improve mother and infant health. MIHP cooperated with health authorities and facilities in nine oblasts of the country (Donetsk, Dnipropetrovsk, Lugansk, Volyn, Rivne, Lviv, Kirvograd, Poltava, and Zhythomir), Kiev city and in the

Autonomous Republic of Crimea, and was able to demonstrate important improvements in maternal and infant health. MIHP's impressive results presented during the National Dissemination Conference held in Kiev in September 2006. The main result of the Project is the change in attitudes of health professionals working in MIHP sites regarding perinatal care. They accepted and endorsed a new family-centered approach based on scientific evidence.

As a result of the implementation of effective perinatal care, the level of "over-medicalization" based on out-of-date protocols and obsolete habits decreased both in antenatal clinics and in maternity departments, leading to a better surveillance of pregnant women and to an improvement of mother and newborn health in maternities. For example, MIHP implementation decreased maternal postpartum complications such as postpartum hemorrhage and the improved newborn health, as demonstrated by the elimination of newborn hypothermia. In MIHP sites, the neonatal mortality decreased significantly from 2002 to 2006.

MIHP worked at three levels:

1. Supported MoH to revise, develop and disseminate more than 40 national, evidence-based obstetrical and neonatal protocols. These new standards and protocols are the legal basis for the implementation of effective perinatal care nationwide, and these new protocols are in-line with international standards recommended by WHO.
2. Implemented effective perinatal care in MIHP sites in eleven regions of Ukraine. The Project worked in twenty maternities and forty-two women's clinics, implementing on a daily basis effective perinatal care. The Project has worked with some sites since 2003. In addition to these health facilities, which are directly in charge of perinatal care and in order to create a link between early neonatal care to pediatric care, two pediatric polyclinics implemented an integrated and evidence-based approach to infant health.

The implementation of these evidence-based technologies was monitored carefully through a comprehensive and detailed monitoring and evaluation system. The regular data analysis helped the project and each site to identify problems and weak points and to propose appropriate solutions.

In addition, the Project evaluated the cost impact associated with the implementation of effective perinatal technologies in maternity departments, and was able to demonstrate that in addition to mother and infant health improvement, the implementation of these simple and evidence-based technologies saved money both for families and the health system.

- More than 1600 health professionals were trained; training courses were conducted on 15 topics, and more than 120 Ukrainian health professional became expert trainers, some of them have become international trainers who are now teaching Effective Perinatal Care in NIS countries.
- Due to a fruitful collaboration with WHO/EURO and Eastern European JSI sister projects, MIHP leads the preparation of an updated training package for Effective Perinatal Care. This training package was especially developed for countries with a post-Soviet health system. This material could be used to train medical staff in all NIS and CIS countries, and will certainly contribute to improving the health of mothers and infants in this region of the world.
- New evidence-based training material for antenatal care was developed with the support of the JSI Russian project, and this material is used in the 2 countries with good results.
- A new training package was also developed to improve the quality of pediatric care. This training material, developed for pediatricians and family doctors, is focused on an integrated approach to infant health.

MIHP provided to each of the project sites basic medical equipment according to their specific needs. MIHP procured lifesaving equipment for newborns and mothers, and also insisted on the procurement of a chain of items to implement fully the concept of "warm chain" in maternities. One other driving concept was to help each site to become "friendly and client-oriented" and to encourage family support, privacy and confidentiality.

Schools for Parenthood were created or improved in each antenatal clinic; each of them received simple media systems to improve knowledge of the clients and their family.

After two years of activity, USAID requested the addition of Prevention of Mother to Child Transmission to the project activities in at least three regions. Therefore, the Project decided to totally integrate PMTCT in each activity in order to avoid the consolidation of a “vertical program”. Despite health personnel fears, fears due partially to poor knowledge, the project succeeded in decreasing the level of stigmatization and improved medical care for HIV+ mothers and their newborns in all MIHP maternities.

3. MIHP worked at the education level and supported the revision of University curricula to include evidence-based perinatal care in the pre-service curricula for medical students. This point is crucial because the students will learn effective perinatal technologies from university, and implement them, which will sustain the improvement of perinatal care in Ukraine.

MIHP worked also actively the Kiev Institute of Post graduate education which has included Effective Perinatal care training material in their post graduate curriculum for obstetrician /gynecologists since 2005.

All MIHP activities were supported by comprehensive activities to advocate and sustain the important behavior changes of the community and health professionals. A special effort made to promote the role and the importance of the family in perinatal care by inviting partners and family to support pregnant women attending antenatal consultations and parenthood classes with them, supporting them during labor and delivery, and visiting and helping new mother and baby after birth.

Several IEC materials were developed and disseminated to MIHP sites to support project activities. A didactic video summarizing MIHP work in women’s clinic and maternities was shot on the premises of Lutsk and Zhytomir sites, which made it possible to disseminate the information about effective perinatal technologies to the national level. In addition to this video, USAID prepared and showed the other movie named ”Delivering in Kindness” on the 5<sup>th</sup> TV Channel of the Ukrainian TV network, which attracted the attention of the general public to the project and to effective perinatal care implemented in Ukraine. Radio talk shows complemented Project presence in mass media. The MIHP informational booklet was printed out and started being widely distributed to support the project’s good results.

**GLOBAL: PREVENTING THE MEDICAL TRANSMISSION OF HIV: REDUCING UNSAFE AND UNNECESSARY INJECTIONS IN SELECTED COUNTRIES OF AFRICA AND THE CARIBBEAN.**

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With funds from the President’s Emergency Plan for AIDS Relief (PEPFAR), the United States Agency for International Development (USAID) contracted John Snow Inc. (JSI) to implement *Preventing the Medical Transmission of HIV: Reducing Unsafe and Unnecessary Injections in Selected Countries of Africa and the Caribbean* in Ethiopia, Mozambique, Nigeria, and Uganda. The original 11-month USAID project began officially in early March 2004. A no-cost extension was granted from the original end date of January 2005 to March 31, 2005 while the project negotiated for additional funding with USAID. On March 21, 2005, a contract cost extension was granted that continues the project to September 30, 2009, under the new title: *Immediate Relief to Decrease Unsafe Injections Under the President’s Emergency Plan for AIDS Relief: Uganda, Ethiopia, Mozambique, and Nigeria*. The project is still commonly known by the abbreviated name: Making Medical Injections Safer (MMIS).

This annual performance report for the MMIS Project covers the period October 2005-September 2006. It summarizes the accomplishments of global and country activities in Ethiopia, Mozambique, Nigeria,

and Uganda in the following technical areas : commodity management and procurement, capacity-building and training, behavior change communication, waste management, as well as monitoring and evaluation.

In addition to these countries, JSI continues to work on a five-year Cooperative Agreement with the US Centers for Disease Control and Prevention (CDC) in seven countries in Africa and the Caribbean and is a subcontractor to Initiatives, Inc. for a project in Guyana. Therefore, the project provides direct programming or technical assistance to 12 PEPFAR-supported countries.

The MMIS project assures a constant presence in its program countries through its field offices and host country national staffs. Field staffs' familiarity with their respective countries and ability to influence change within the health system have been a key factor in the project's success to date. MMIS country teams serve as key Ministry of Health (MOH) technical advisors in the areas of injection safety and health care waste management. In all countries, the Ministers of Health or other high-level officials chair National Injection Safety Task Forces, made up of key MOH departments, the Ministry of Environment, key development partners, and other stakeholders in injection safety and health care waste management. In most countries, MMIS staff also play the role of secretariat of the National Injection Safety Task Forces.

At the international level, MMIS continues to have strong working relationships with the WHO Africa Regional Office (WHO/AFRO), WHO headquarters in Geneva, and the Safe Injection Global Network (SIGN). JSI/MMIS has been an active participant in the Geneva-based Immunization Safety Steering Committee and has contributed to WHO's global efforts to develop guidelines for health care waste management. The Immunization Safety Steering Committee has been dissolved at the end of 2005 and its activities streamlined in other departments of WHO/Geneva. MMIS continues to work with the relevant departments of this organization on injection safety issues. Additionally, MMIS is an active participant in the quarterly PEPFAR Partners meetings chaired by USAID.

# **DETAILED TASKORDER REPORTS**

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GHS -I-00-03-00026-00



MINISTRY OF HEALTH

# QUARTERLY PROGRESS REPORT

October 1 – December 31, 2005



## Albania Family Planning Project 2004 – 2006

January 2006



The Albania Family Planning Project is implemented by John Snow, Inc. in collaboration with  
The Manoff Group

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## ACRONYMS

<b>AFPP</b>	<b>Albania Family Planning Project</b>
<b>BCC</b>	<b>Behavior Communication Change</b>
<b>CS</b>	<b>Contraceptive Security</b>
<b>CYP</b>	<b>Couple of Year Protection</b>
<b>FP</b>	<b>Family Planning</b>
<b>FY</b>	<b>Fiscal Year</b>
<b>HC</b>	<b>Health Center</b>
<b>IEC</b>	<b>Information Education Communication</b>
<b>IPH</b>	<b>Institute of Public Health</b>
<b>IUD</b>	<b>Intrauterine Device</b>
<b>JSI</b>	<b>John Snow, Inc.</b>
<b>LMIS</b>	<b>Logistic Management Information System</b>
<b>Manoff</b>	<b>JSI subcontractor for BCC</b>
<b>MCH</b>	<b>Mother and Child Health</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MWRA</b>	<b>Men and Women of Reproductive Age</b>
<b>PHC</b>	<b>Primary Health Care</b>
<b>PHD</b>	<b>Public Health Directory</b>
<b>PMP</b>	<b>Performance Management Plan</b>
<b>RH</b>	<b>Reproductive Health</b>
<b>RHU</b>	<b>Reproductive Health Unit</b>
<b>SDP</b>	<b>Service Delivery Points</b>
<b>SPARHCS</b>	<b>Strategy Pathway to Reproductive Health Commodity Security</b>
<b>TIP</b>	<b>Trial of Improved Practices</b>
<b>UNFPA</b>	<b>United Nation Fund Population Aid</b>
<b>URC</b>	<b>University Research Corporation</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>WCR</b>	<b>Women Consultancy Room</b>

**I. Executive Summary**

This quarter -- October 1 to December 31, 2005 -- continued the intensive **implementation phase** for all three components of the Albania Family Planning Project: Contraceptive Security, Family Planning Training and Behavior Change Communication.

The MOH decided to shift the LMIS to the Institute of Public Health, and in January, IPH will begin to collect LMIS data. AFPP will train IPH staff in LMIS operations.

Family planning training carried out the follow-up of the trainings done in five of the sixteen target districts. The additional districts trained in this quarter are five, bringing the total number of districts trained to 11.

The BCC media campaign work began by launching the TV spots to promote family planning in Albania.

Thirty-eight (38) new FP service delivery points were added to the MOH system this quarter, and all the new sites reported LMIS data for the first time.

During this quarter, AFPP solidified its good working relationships with ProShedetit, the Ministry of Health and the Institute of Public Health, all of which are participating as active partners in AFPP-sponsored activities.

## PERFORMANCE MANAGEMENT PLAN (PMP)

SO 3.2: Improved Selected Health Care Services in Target Areas										
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (Jul.-Sept. 2005)	Current Quarter (Oct. – Dec. 2005)	Expected & Actual Achievements for the 2 <sup>nd</sup> year (Sept 2005–Sept 2006)		Target FY 2006
								Expected	Actual	
% of service delivery points providing family planning services	# of SDPs with commodities, trained provider(s), IEC materials/ total # of SDPs  SDP's = 440 MOH facilities (Maternities, WCRs, HCs); 300 currently providing FP and 140 additional sites will provide FP services Unit: %	LMIS Reports; project reports  Quarterly	16 Project Districts	LMIS Officer	0 % (2004 LMIS)	53.9 % (96/178)	74.18 % (135/182 <sup>2</sup> )			90 %
			National		68 % (2004 LMIS)	82% (366/446)	89.8% (405/451)			99 %
Couple years of protection (CYP) *	Total number of contraceptives distributed by type (method) in a given period with weights applied to different methods.  1 CYP = 15 Packets Oral Pills 1 CYP = 4 Depo Injections 3.5 CYP = 1 IUD 1 CYP = 120 Condoms Unit: #	LMIS Reports  Quarterly	16 Project Districts	LMIS Officer	774 per quarter (2004 LMIS)	985	1104.7			1600
			National		3,750 per quarter (2004 LMIS)	3,880.7	4187.1			5000

\*When calculated annually means average quarterly CYP

<sup>1</sup> The figures of the last quarter have also been updated from the latest LMIS reports.

<sup>2</sup> The denominator of this indicator was adjusted upward from 178 to 182 because there are 4 more SDPs more than originally planned (1 SDP in Devoll, 1 SDP in Kolonje, 1 SDP in Delvine and 1 SDP in Skrapar)

IR 1: Health resources efficiently managed											
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (Jul.-Sept. 2005)	Current Quarter (Oct. – Dec. 2005)	Expected & Actual Achievements for the 2 <sup>nd</sup> year (Sept 2005–Sept 2006)		Target FY 2006	
								Expected	Actual		
<b>Sub IR1.2: Health information systems improved</b>											
% of service delivery points stocked out of condoms, POP, injectables and low dose contraceptives in 16 target districts	# of SDPs reporting zero stock of specific commodities/ # of SDPs reporting  Unit: %	Routine LMIS Reports  Quarterly	Project 16 districts	LMIS Officer							
			Condoms		28 %	19.6%	7.3%			10 %	
			POP		64 %	64.1%	74.3%			10 %	
			Low dose		22 %	10.9%	3.7%			10 %	
			Injectables		14 %	10.9%	10.1%			10 %	
<b>IR 2: Quality of PHC services improved</b>											
<b>IR2.2: Skills of PHC providers enhanced</b>											
% of SDPs in 16 target districts with staff trained using national FP curriculum	# of SDPs in target districts with at least one staff person trained using national FP curriculum/ total # SDPs in intervention districts  SDP = MOH facilities (maternities, WCRs, health centers) Unit: %	Training Records; Quarterly	<b>By type of SDP:</b>	Training Officer							
					Maternity	0 %	37.5 % (6/16)	68.8 (11/16)			90 %
					WCR	0 %	90.9 % (10/11)	100 (16/16)			90 %
					Health Center	0 %	53 % (80/151)	72% (108/150)			90 %
					<b>By cadre:</b>						
					Doctors	0 %	58 % (103 / 178)	70.06 % (124/177)			90 %
Nurses/ midwives	0 %	57% (203/357)	78% (284/364)			90 %					

IR 3: Use of PHC services increased										
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (Jul.-Sept. 2005)	Current Quarter (Oct. – Dec. 2005)	Expected & Actual Achievements for the 2 <sup>nd</sup> year (Sept 2005–Sept 2006)		Target FY 2006
								Expected	Actual	
<b>IR 3.1 Access to PHC services increased</b>										
Total # of family planning visits in 16 target districts	Total clients visits to SDPs for first FP visits, re-visits, and counseling  Unit: #	LMIS Reports;  Quarterly	First visits	LMIS Officer	750 per quarter	1256	1590			1500
			Re-visits		1339 per quarter	1862	1977		2680	
			Counseling only		686 per quarter (2004 LMIS)	1220	1854		1370	
<b>IR3.2 Awareness of PHC services increased</b>										
% MWRA attending SDPs, who have been exposed to at least one campaign material and can state at least one message	# of MWRA attending SDPs, who state that they have been exposed to at least one campaign material and can state at least one message/ # of MWRA interviewed. Unit: % Campaign materials = TV spots or programs, events, pamphlets/ brochures). MWRA attending SDPs that provide MCH services are MWRA attending target facilities for maternal or routine child health care	Exit interview at SDPs; during campaign; end of project	National by:  exposure <sup>3</sup> ;  type of message state;	BCC Officer	0% 0%	0% 0%	0% 0%	0% 0%		50% 18%

<sup>3</sup> Having been exposed to at least one campaign material

IR3.3: Community participation in health promotion activities increased										
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (Jul.-Sept. 2005)	Current Quarter (Oct. – Dec. 2005)	Expected & Actual Achievements for the 2 <sup>nd</sup> year (Sept 2005–Sept 2006)		Target FY 2006
								Expected	Actual	
% of villages which have FP service provided by at least one community midwife in 16 districts	# of villages which have FP service provided by at least one community midwife in 16 districts / total # of village in the 16 districts  Unit: %	Training Records;  Quarterly	16 Project Districts	Training Officer	0	9.64 % (128/1328)	13.78% (183/1328)			18 %

## II. SUMMARY OF MAJOR ACTIVITIES DURING THE REPORTING PERIOD

### A. Project Management

Planned Action	Status at End of Quarter	Comments
Maintain effective communication with USAID and JSI Headquarters	Ongoing	<p><b>USAID:</b> AFPP maintains good communication with USAID by delivering materials on schedule, minimizing the administrative burden placed on the Mission, regularly updating USAID and inviting Mission representatives to participate in project activities.</p> <p><b>JSI HQ:</b> AFPP has regular and frequent communication with JSI headquarters.</p>
Submit deliverables on schedule	Done	<ul style="list-style-type: none"> <li>• Annual Report</li> <li>• Contraceptive Security Strategy (First Draft)</li> <li>• Weekly reports</li> <li>• BCC Baseline Report</li> <li>• BCC strategy Document</li> </ul>

### B. Programmatic Activities

Component 1: Contraceptive Security	Status at End of Quarter	Comments
Conduct a (SPARHCS) Study and renew the Contraceptive Security Strategy 2003	Done	The first draft of Contraceptive Security Strategy 2005 was submitted and the final draft will be submitted quarter to be ready for CS commission meeting.
Provide ongoing technical support to the LMIS	Ongoing	AFPP assisted districts with LMIS software problems, supported & trained the LMIS operator. AFPP assisted the MoH to decentralize the LMIS by training 11 districts in "Computerized LMIS at District Level" with financial support of UNFPA.
Provide LMIS training in 16 districts	Ongoing	Completed LMIS training in Delvine, Devoll, Kolonje, Mirdite, Skrapar. This brings the total of districts trained to 11/16 completed.
Support MoH implementation of the National Contraceptive Security Strategy 2003	Ongoing	The MoH with the advice of AFPP moved the management of LMIS to Institute of Public Health, sharing thus the technical load of work the MoH has to do. The CSC will hold its first meeting under new leadership early in 2006.

<b>Component 2: Family Planning Training</b>	<b>Status at End of Quarter</b>	<b>Comments</b>
Conduct Follow-up visits	Ongoing	Follow up was accomplished to first five districts trained in FP: Diber, Fier, Lezhe, Lushnje and Vlore. The purpose of follow-up is to provide additional data regarding the outcome of Project interventions, assess the effectiveness of training, and to provide on-the-job support and teaching when needed.
Conduct FP training for providers	Ongoing	<b>Delvine, Devoll, Kolonje, Mirdite, Skrapar</b> districts completed the FP trainings; a total of 108 MOH staff at 38 facilities trained; also trained 14 (out of 108) community midwives in these districts. A total of 11 districts have been trained to date.
<b>Component 3: Behavior Change Communication</b>	<b>Status at End of Quarter</b>	<b>Comments</b>
Collaborate with Proshendetit	Done	Proshendetit played an active role for drafting the TV spots scripts. They made their comments and gave their impressions through the pre-testing phase. Proshendetit collaborators in field supported the pre-testing activities at their sites. Proshendetit and AFPP coordinated their activities to deliver FP brochures in 4 districts where AFPP implements.
Air the spot	Done	By December 31, and January 1 and 2, the BCC urban TV spot was broadcasted from the three most watched TV channels (per the baseline survey data)
Implement other media activities	On going	The BCC component has started to work on the "call in" shows about FP. Also another short spot containing FP messages from the MoH is going to be made soon.
Monitor and Evaluate BCC interventions	Done	In order to establish a baseline for the indicator, the AFPP conducted a national survey in 21 districts of the country, through the month of November.

### III. PROGRESS MADE THIS QUARTER

#### A. Contraceptive Security and LMIS

In the process of moving toward the national goal of **Contraceptive Independence**, which is defined as “*Complete self-reliance in maintaining contraceptive security, with no need for external donors to fund contraceptives or related logistics technical assistance,*” the MoH procured its first contraceptive – DepoProvera – the cost of which equals approximately 10% of the total cost of public sector contraceptive commodities in Albania. 3/4<sup>th</sup> of Depo users get the injectable from the public sector.

**LMIS shifted from MOH to Institute of Public Health.** Near the end of AFPP Year 1, the MoH shifted LMIS operations from the Reproductive Health Unit to the Institute of Public Health. LMIS is more likely to be sustainable at IPH because the Institute has more IT capability and also currently manages the vaccine supply system for Albania. This shift enhances the long-term institutionalization and sustainability of LMIS. Actually this quarter the data analysis is made fully by IPH under the assistance of AFPP and MoH.

The MOH Reproductive Health Unit retains responsibility and authority for MoH contraceptives but LMIS operations now fall under IPH. LMIS data will continue to be analyzed and used by the RHU to maintain contraceptive availability at all government health facilities, and all policy decisions re LMIS will continue to be made by the RHU.

During this quarter, LMIS was expanded in the 5 districts: Delvine, Devoll, Kolonje, Mirdite and Skrapar. Table 1 shows that in the five target districts for this quarter, thirty-one (31) new SDPs began providing FP services and reporting LMIS data.

**Table 1: New FP Service Delivery Points in Districts this Quarter**

Target Districts for this Quarter	# of Service Delivery Points (SDPs) part of LMIS during 2004	# of SDPs part of LMIS system at the end of the reporting quarter
Delvine	1	5
Devoll	1	6
Kolonje	1	8
Mirdite	1	8
Skrapar	1	10
<b>Total</b>	<b>5</b>	<b>37</b>

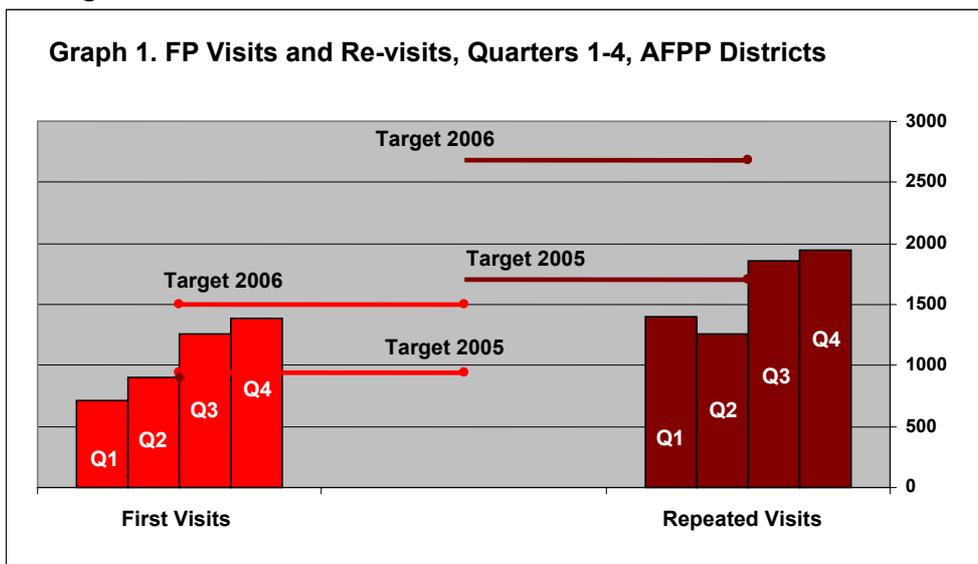
*Source: LMIS*

As mention above, with the shift of LMIS to IPH, the Information System (LMIS), technically is managed from IPH. The reporting rate achieved for this quarter is 78% for the project area and 85% national.

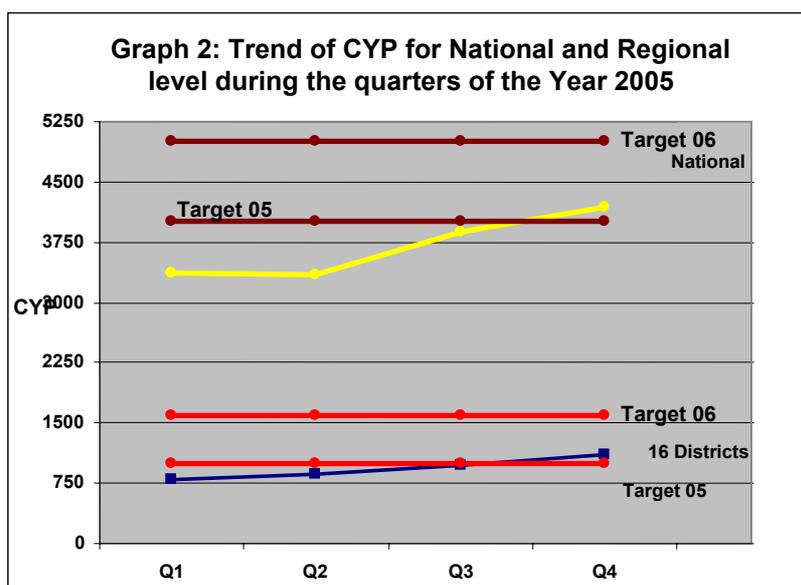
% of FP service delivery points reporting LMIS data this quarter	In sixteen (16) project districts	78%
	In all FP SDPs in Albania	85%

Based on the above reporting rate the indicators produced from LMIS shows the following results.

**Use of FP Services.** First visits and re-visits in the AFPP focus districts is increasing steadily, and the trend is going achieving targets established at the beginning of the project. As we can see from Graph No.1 below, the first visits and repeated visits are moving toward pre-determined targets.



**Couple Years of Protection.** CYP is showing a steady increase, both in the project area and nationally. The national increase is more significant as the project area has still some more districts where the FP has to be expanded in the remaining year of the project. CYP is calculated using LMIS data, so the increased LMIS reporting rates contributed to the upward CYP trend.



**Contraceptive Stockouts.** The data below show that stockouts has been a chronic problem for the MoH. But the latest data provides reason for optimism as stock out rates are falling.

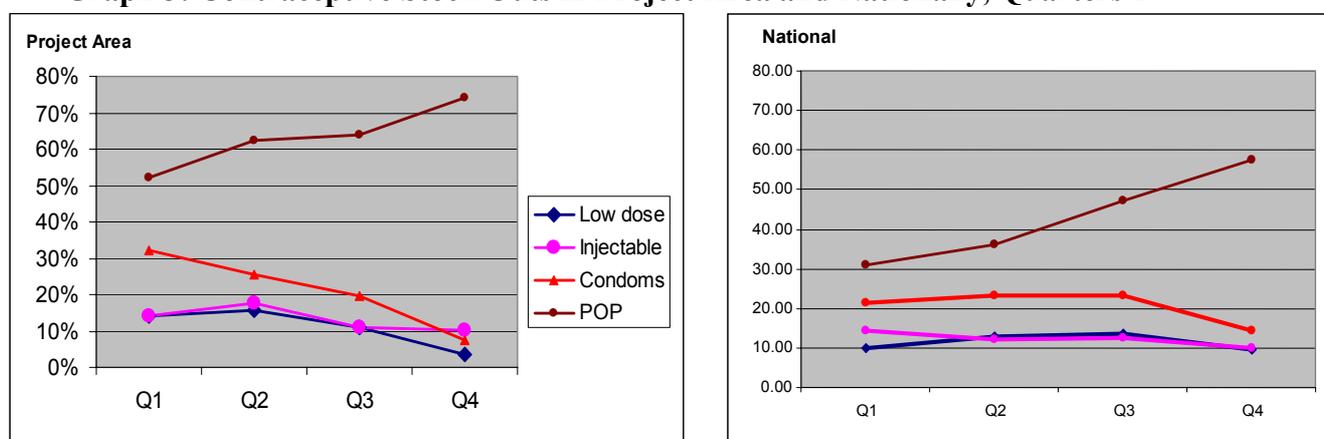
Table 2: Stockouts in 16 AFPP Districts						Target 2006
	Q4 2004	Q1 2005	Q2 2005	Q3 2005	Q4 2005	
<b>Low dose</b>	22%	14%	19%	10%	4.2%	10%
<b>Injectable</b>	14%	14%	20%	10%	10.4%	10%
<b>Condoms</b>	28%	31%	26%	19.6%	5.2%	10%
<b>POP</b>	64%	53%	59%	64.1%	74.1%	10%

Source: LMIS

The data show that contraceptive stock outs were reduced significantly in this quarter. In the project area this reduction has continued since the second half of the year 2005. The stock out situation for the progesterone only pill (POP) did not improve during the quarter, but a POP shipment (30,000 cycles of Microval) arrived at the UNFPA warehouse in Tirana the first week of January 2006. This quantity of POP Microval should be sufficient for about four-year at projected consumption levels. All SDPs will be supplied will Microval during February 2006.

Bad news: the expected stock out for DepoProvera at SDPs is due to a stock out at the central warehouse in Tirana. UNFPA has ordered DepoProvera (13,000 vials) using MOH funds.

**Graph 3: Contraceptive Stock Outs in Project Area and Nationally, Quarters 1-4**



The stockout issue, including policy decisions on the types of contraceptives to be distributed in the SDPs, is an important part of the agenda for the upcoming meeting of the Contraceptive Security Commission.

### Next Steps for Contraceptive Security Component

- Finalize Contraceptive Security Report 2005
- Determine with MoH what will be AFPP's specific role in advancing the CS agenda and supporting the Contraceptive Security Commission
- Ensure that the CS Commission meets to confirm national support for updating and implementing the National CS Strategy of 2003.
- Conduct LMIS refresher training throughout the country (funded by UNFPA.)

## B. FAMILY PLANNING TRAINING

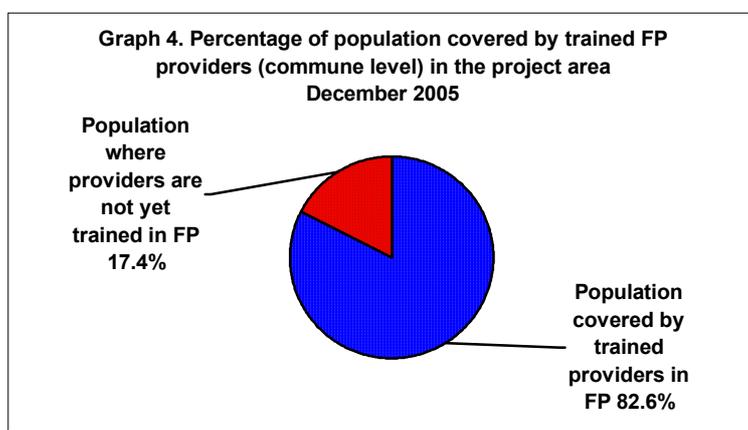
There were two main activities of this component during this quarter:

- ✚ FP Training
- ✚ Follow Up

### ❖ FP Training

Family Planning training continues to proceed on schedule according to the roll-out plan (Appendix A). The districts in which the training was carried out this quarter are: Delvine, Devoll, Kolonje, Mirdite and Skrapar, which encompasses 4.19% of the total population of Albania. The majority of the providers trained were from health centers, as most of the population in these districts live in rural areas.

Graph 1 show that 82.6 % of the population in the AFPP project area (16 districts) is now covered by FP providers with the training completed during this quarter.



To date, the total number of SDPs covered by training in FP and with the integrated LMIS system has reached 134. Thirty-three (33) were new sites added\this quarter where the FP services had not previously been provided. Table 2 shows the categories of SDPs with staff trained and equipped with FP commodities this quarter.

**Table 3: Service Delivery Points Covered During October-December 2005**

Districts	Number of SDP by Type			Total
	HC	WCR	Maternity	
Devoll	3	1	1	5
Delvine	4	1	1	6
Kolonje	7	1	1	9
Mirdite	5	1	1	7
Skrapar	8	2	1	11
<b>Total</b>	<b>27</b>	<b>6</b>	<b>5</b>	<b>38</b>

The total number of staff trained during this reporting quarter is 108, including doctors, nurses/Midwives and other staff. To increase the sustainability of the FP program at the district level, AFPP trained four staff from Public Health Directorates whose duties include the day-to-day supervision of family planning activities in their districts or the reporting of family planning statistics. Their total number in all five districts is 4.

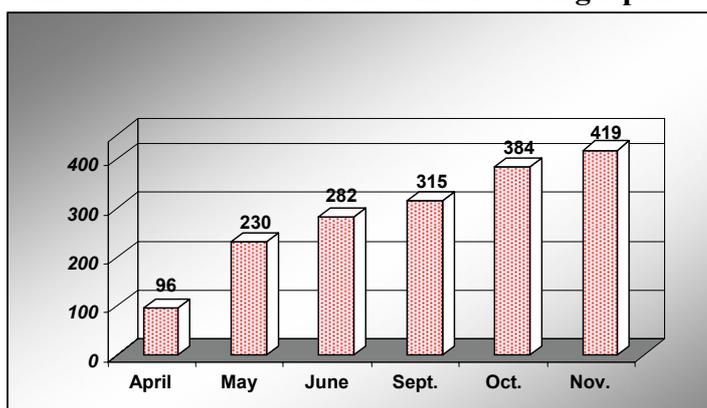
**Table 4: Total Number of Providers and Other Staff Trained, October-December 2005**

Districts	Providers		Others	Total
	Doctors (FP+Ob/Gy)	Nurse Midwife	Supervisors	
Delvine	4	11	1	16
Devoll	4	16	1	21
Kolonje	6	17	0	23
Mirdite	4	17	2	23
Skrapar	3	22	0	25
<b>TOTAL</b>	<b>21</b>	<b>83</b>	<b>4</b>	<b>108</b>

Of the 83 Nurse Midwives, 14 were community midwives, which increases community outreach of family planning information and service, and also strengthens the link between community midwives and local health centers providing FP services. AFPP is including a limited number of community midwives in FP training as a first step to extending FP services to the community level.

The cumulative increase by month in number of providers trained, since April when the training began, is shown in the bar graph below.

**Graph 5: Number of Providers Trained in FP during April - October 2005**



The achievement of this process clearly is reflected in the PMP table, showing that training targets have been met or exceeded to date.

Following table shows the number of providers trained according to gender. The majority of providers trained (82 %) are female.

**Table 5: Providers and PHD Staff Trained Disaggregated By Gender  
October-December 2005**

	Female	%	Male	%	Total
Family Doctors	7	38.89%	11	61.11%	18
Nurses	32	88.89%	4	11.11%	36
Midwives	47	100.00%	0	0.00%	47
Ob-Gyn.	0	0.00%	3	100.00%	3
Other (District staff)	3	75.00%	1	25.00%	4
<b>Total</b>	<b>89</b>	<b>82.41%</b>	<b>19</b>	<b>17.59%</b>	<b>108</b>

In order to evaluate change in knowledge after training, a simple pre - and post - test was used. The following table (no. 5) summarizes test scores (a perfect score = 20.)

<b>Table 6: Average Scores of Pre/Post Test by District and Profession (Maximum Score-20)</b>				
Profession	District	Pre-test score average	Post-test score average	Change in %
Family Doctors				
	Delvine	12.0	14.3	<b>+16</b>
	Devoll	13.3	19.0	<b>+30</b>
	Kolonje	13.3	18.3	<b>+27</b>
	Mirdite	12.0	19.0	<b>+37</b>
	Skrapar	13.0	17.0	<b>+24</b>
Midwives				
	Delvine	12.3	14.8	<b>+17</b>
	Devoll	11.9	18.3	<b>+35</b>
	Kolonje	11.9	16.7	<b>+29</b>
	Mirdite	8.1	18.5	<b>+56</b>
	Skrapar	11.0	14.0	<b>+21</b>
Nurses				
	Delvine	11.3	14.3	<b>+21</b>
	Devoll	13.6	18.6	<b>+27</b>
	Kolonje	12.5	14.6	<b>+14</b>
	Mirdite	7.0	18.0	<b>+61</b>
	Skrapar	10.5	15.9	<b>+34</b>
Ob-Gyn's				
	Delvine	15.0	16.0	<b>+6</b>
	Kolonje	12.0	17.0	<b>+29</b>
	Skrapar	13.0	18.0	<b>+28</b>

Specific PMP indicators for this training component are shown below.

Indicators	Quarter 2 July-September 2005	Quarter 3 October-December 2005
<b>IR 2.2</b>		
% of SDPs in 16 target districts with staff trained using national FP curriculum	53.9% (96/178)	74.18% (135/182)
<b>By Type</b>		
% of Maternities in 16 target districts with staff trained using national FP curriculum	37.5% (6/16)	68.8% (11/16)
% of WCR in 16 target districts with staff trained using national FP curriculum	90.9% (10/11)	100% (16/16)
% of Health Centers in 16 target districts with staff trained using national FP curriculum	53.0 % (80/151)	72% (108/150)
<b>By Cadre</b>		
% of Doctors in 16 districts trained with FP national curricula (GP+Ob-Gyn.)	57.9% (103/178)	68.1% (124/182)
% of Nurse/Midwives in 16 districts trained with FP national curricula	57% (203/356)	78% (284/364)
<b>IR 3.3</b>		
% of villages in 16 districts with one FP-trained community midwife	9.64 (128/1328)	13.78% (183/1328)

### ❖ Follow – Up

The purpose of the Integrated Monitoring & Evaluation Plan is to provide additional data regarding the outcome of Project interventions that currently have more quantitative (process) oriented indicators, rather than qualitative (outcome) indicators. Equally important is providing follow-up visits to facilities with trained Family Planning (FP) providers to provide on-the-job support and teaching when needed. In addition, Albania Family Planning Project (AFPP) has internal indicators (not usually reported to USAID/A quarterly) that help monitor the quality and effectiveness of interventions and the data collected may be used for revising approaches and activities, providing feedback to the Project team and partners, and for the final report.

## Methodology

### **Sampling**

The follow-up process had a two-stage sampling design.

First stage: Selection of the overall number of SDPs for each eligible district.

Project resources (human, financial, time) were stretched to meet the follow-up goals, and it was not possible to reach all trainees and health facilities. Due to these constraints, as a

minimum, a convenience sample of *33% of the health facilities* and trained health providers were included in the assessment. A sample of health centers was drawn from each intervention district.

The training database was the source of information for sampling. This information includes the number of service providers trained on FP by the project, number and names of service delivery points (SDPs) with at least one service provider trained on FP (table 1).

#### Second stage of sampling: Selection of Service Delivery Points

Service delivery points were selected randomly through a “blind draw” process. This process was repeated for each district. Table 2 gives the sample of SDPs within each district. All service providers who were trained in family planning at each selected SDP were interviewed.

**Table 7. Number of Providers & Service Delivery Points Trained and Sampled by District**

	Diber		Fier		Lezhe		Lushnje		Vlore		Totals	
	# trained	#	# trained	#	# trained	#	# trained	#	# trained	#	# trained	#
<b>Providers</b>	47	12	90	17	39	10	50	9	176	15	<b>176</b>	<b>63</b>
<b>SDPs</b>	16	5	23	8	12	5	19	6	16	5	<b>86</b>	<b>29</b>

#### Key findings

There were 63 health providers interviewed, which included all providers who were trained in family planning at 29 selected SDPs.

IEC materials (FP logo and poster) were displayed in all SDPs. FP pamphlets were not available in most sites since they were not available for distribution until the beginning of November.

-  Not all SDPs can provide clients with the method of their choice because of stock-outs of some methods. Some of SDPs were supplied during the follow-up visit and for the others the Inspector of Mother & Child took notes to supply them as soon as possible. Stock outs of POP was expected because of the stock-outs in the central store. In the majority of facilities, commodities were stocked according to expiration date and in a proper way to avoid damage.
-  FP records were available in 21 out of 29 SDPs, and more than 90% of providers who deal with FP service measure and record BP for clients who chose pills, record type of method used and the method was appropriate to client’s medical history 12 out of 21 do not record when the client should return to the clinic. Of the 29 SDPs visited, 21 of them had FP records to be audited and 8 SDPs didn’t have FP records at all.
-  Of the 62 FP records audited, 56 clients continued to use the method they had chosen by them. The low drop-out rate may indicate an improvement in the quality of counseling. 100% of providers interviewed stated that if a client is already using a contraceptive method, they routinely ask whether she is satisfied with the method, has any question, problems or concerns.

- ✚ The pre/post test used during training sessions was administered to health providers during follow-up. The results were significant as they showed that there was no decrease in knowledge of family planning gained during the training (compared to post-training scores) but in fact the majority of scores were higher. This was a very positive finding during the follow-up evaluation.
- ✚ Providers were asked to demonstrate correct use of condom in order to see if they are capable to counsel clients correctly. The main mistake noted during demonstration was that 17 out 52 providers did not pinch the air from the tip of the condom before putting it on the male model. The interviewer explained and corrected mistakes and then the provider was able to do correct demonstrate correctly and with confidence.
- ✚ The majority of providers responded correctly to interview questions on selected topics related to counseling clients on family planning methods. A significant percentage (55.6 %) did not score well in stating the correct information to be discussed with clients who may be at risk for STI/HIV. As part of the interview, all the providers stated that they always counsel clients on whether or not their family planning method offers protection from STI/HIV. But, observation of client visit revealed that 42.1% of clients were told whether their method provided protection from STI/HIV and 63% of client stated in exit interview that the provider informed them (today or on a previous visit) whether their method provides protection from STI/HIV. Furthermore, 42.1% of providers explain to clients that only condom provides protection from STI/HIV. Providing accurate information on reducing STI/HIV risk is an area that will be highlighted in discussion with trainers and more emphasis will be placed on this in future training sessions. The interviewers provided immediate feedback to the providers and clarified what should have been correct responses and the importance of providing complete and accurate information during counseling sessions.

### **General satisfaction**

All providers stated that they feel confident to provide family planning services and 92.1 % (58 out 63) stated that they feel comfortable in discussing family planning and issues related to sexuality with clients.

### **DISCUSSION OF FINDINGS AND NEXT STEPS:**

As part of the follow-up assessments of facilities and providers, Interviewers did on-the-job-training and took appropriate actions in order to try and resolve problems faced in the field. Inspectors of Mother& Child of the respective districts were present at follow-up activities in order to increase their capacity to monitor family planning activities, provide support to providers, be more aware of the challenges faced by providers and facilities providing family planning services and help resolve problems (e.g. stockouts).

### **NEXT STEPS**

- Results/findings of the follow-up visits will be presented to and discussed with the master trainers. This will provide a forum for identifying the strengths of the training and areas that need strengthening.
- Client data (exit interviews and observations of counseling) are an important part of assessing the effectiveness of training and a good/effective family planning program.

Since during the first round of follow-up visits there was not an opportunity to collect client data, interviewers will return to as many sites as is feasible and make every effort to observe counseling sessions and conduct exit interviews. Findings of client data will be presented to and discussed with master trainers and the Program Manager for identifying areas that need strengthening. In future follow-up visits to subsequent districts, more time will be allotted for follow-up to increase the likelihood of obtaining client data.

- Findings regarding LMIS will be shared with the Program Manager and LMIS Officer in order to plan next steps for strengthening of problem areas (expired commodities, late or inaccurate LMIS reporting, lack of FP records and stock-out SDPs).
- Findings regarding IEC will be shared with IEC Officer in order to plan distribution of FP brochures.

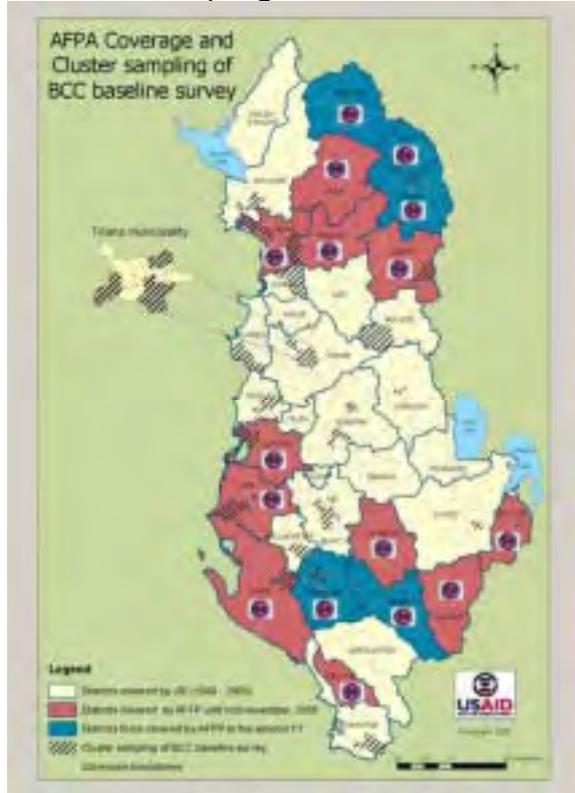
## BEHAVIOR CHANGE COMMUNICATION

### ❖ Baseline Survey

Simultaneously with the preparation of the media campaign, the Baseline Survey activity was prepared and completed.

The indicator for BCC success presented in the Albania Family Planning Performance Monitoring Plan is: *Percentage of married women of reproductive age (MWRA) attending service delivery points (SDPs), who have been exposed to at least one campaign material and can state at least one message.*

In order to establish a baseline, in November 2005, AFPP conducted a national survey of 602 MWRA contacted through SDPs in 21 districts. The following Map shows the coverage of the Cluster sampling of the BCC baseline Survey.



The BCC Officer and Project Manager conducted a two-day interviewer training for the baseline. (Agenda attached)

AFPP selected four women to conduct the interviews. The interviewers ranged in age from 27 to 44. All had previous training and experience with survey protocols and questionnaires. All had previously served as interviewers in 2002 for the national Reproductive Health Survey.

The questionnaire was prepared in close collaboration with the BCC Senior Advisor and was pre-tested in rural and urban areas in Tirana district. The questionnaire consisted of 20 questions stated as open-ended but with fixed-choice response categories in which the interviewers recorded the respondent's answer (the choices were not read to the respondents). The interviewers were organized into two teams. Each team was accompanied and supervised by a team leader.

In addition, AFPP staff performed several monitoring field visits. Each week the interviewers returned to the AFPP office and debriefed with the BCC Officer and Project Director.

**Survey Results--Sample Characteristics:** Surprisingly, while the great majority of rural women said that they did not want to be pregnant at the present time (almost 82%), a slimmer majority of urban women said that they did not want a pregnancy at the current time (about 60%). This may be largely explained by the different types of SDPs surveyed in rural and urban areas. In rural areas women were generally at the health center for a child health visit, while in the urban facilities—especially at maternities, women came for women’s or maternal health care and may have been pregnant or trying to become pregnant.

**Survey Results—Ministry of Health (MOH) FP Logo Recognition:** The USAID-funded SEATS project, working with the Albanian MOH, developed a FP logo in the late 1990s. Well over 40% of responses in rural areas recognized the logo as associated with FP even when it was not shown on a facility wall; in urban areas over half the replies indicated that the logo meant family planning in some way. When shown a picture of the logo on a facility wall, recall improved dramatically: over 62% of rural responses spontaneously associated the logo with family planning, while about 67% of urban responses identified the logo as having to do with family planning. However, few responses indicated the entire meaning of the logo (family planning supplies, counseling, and trained provider available at the facility), even when shown on a facility wall. SEATS conducted a post-media campaign survey in which it advertised the logo. Although the sample was very different, 69% of their sample identified the logo as meaning a source for FP services. This indicates that there is still good recall, which could improve with more advertising.

**Survey Results—Exposure and Message Awareness of PROShëndetit/AFPP Print Materials:** The first PROShëndetit print material, an all-methods booklet, began to be distributed a little over a month before the AFPP BCC baseline survey data collection. AFPP also distributes the material. Slightly fewer than 5% of respondents had seen it. The booklet is informational rather than message-driven and therefore is not included in the measurement of AFPP’s BCC indicator. Through the kindness of the United Nations Population Fund (UNFPA) and NESMARK, a non-USAID-supported social marketing project, AFPP obtained the Albanian translated poster of a globally-distributed all-methods poster, initially funded through USAID. NESMARK had been distributing the poster in the private sector for some time and AFPP began distributing it in the public sector only one month before survey data collection began. Nevertheless, 2.6% of respondents said they had seen the poster. These figures can be used as baselines to follow the performance of AFPP’s print material distribution mechanism.

**Survey Results--Exposure and Message Awareness of AFPP Materials:** AFPP was developing two television (TV) spots at the time of the survey. The spots were launched during the New Year holiday, which occurred after the baseline survey was completed. Since no AFPP materials, other than the PROShëndetit brochure developed with AFPP collaboration, had been distributed before the baseline survey, the BCC indicator of exposure and message awareness was 0.

**Survey Results—TV Watching Habits:** The survey showed that among MWRA, TOP Channel is by far the most popular channel with over 62% viewer share in rural areas and over 72% share of the urban audience. This was followed by public television in the rural

areas and VIZ+ in urban areas. KLAN TV came in third in both rural and urban areas. Soap operas captured about 72% of MWRA urban and rural viewers. News was the second most watched type of program by the MWRA sample (37.4%). Few respondents said that they watched advertising. The survey could not indicate the viewing habits of husbands with wives of reproductive age, the other part of the primary audience.

**Conclusion:** The survey suggests several programmatic actions:

1. The MOH FP logo should be advertised emphasizing that it represents a facility with trained providers giving counseling, information, and FP supplies—the MOH should periodically advertise the logo after the end of AFPP to maintain recognition and emphasize service availability.
2. AFPP spots should air during the most popular times and programs (soap operas and news); men are usually also home at this time.
3. AFPP should advertise during the soap operas and news broadcasts on TOP Channel, public television, and if affordable, VIZ+ and KLAN TV.
4. AFPP should negotiate with Schering about contributing funds to airing AFPP spots because the spots should contribute to the company's consumer base.
5. AFPP should add other BCC interventions as planned because few MWRA watch advertising.

#### ❖ Finalize and Air the TV spots

The BCC component works from a research-based strategy, developed in the first half of 2005. One of the most important activities to implement is the creation and broadcast of two TV spots containing BCC messages and promoting the national logo.

The Project's primary audience is married women of reproductive age (MWRA) and their husbands.

In the previous quarters, the BCC team derived behaviors that Albanian couples might find feasible and that would move them forward toward effective use of modern contraception from the qualitative research. These, were field tested through the TIP-s (Trials of Improved Practices) phase of formative research. The feasible behaviors were "translated" into messages to address to the Project's audience to promote the use of modern family planning methods and maximize clients' choice. Activities this quarter have followed the approved media plan derived from strategy., BCC staff of AFPP start preparing the implementation of the campaign. The two television spots were drafted to promote the through verbal and visual means.

The primary audience (MWRA and their husbands) does not differentiate between social class or residence., however these and other social variables might affect how audience segments perceive and identify with the spots. Therefore we developed two spots. One of the spots is located in an urban dwelling and another in a rural village. Both spots contain messages addressed to everyone, but show different life styles and habits. Spots presented several family planning, contraception, and gender status messages, but emphasized the improvement of intimate marital life and the lack of harm to the woman's body from modern contraceptives.

Based on the profiles of the characters of the spot, we carefully chose the "stars" of the spots: two actors and two actresses to act. The actors are all well-known and popular artists in the country and the production company was also very experienced. We shot the urban spot on

November 23 and the rural spot on December 3. After ten days of post-production work at the film agency, the spot was ready to be pre-tested.

**Figure 1: Pictures taken during the shooting process of Urban (left) and Rural (right) Spots**



❖ Pre-testing the spot

After some consultations with the Social Marketing and BCC Senior Advisor at Manoff, we decided to pretest the spots with a step beyond rough cuts but not yet finalized. We advertised in major newspapers for a bid, to choose the company/agency to film and produce the TV spots. The winning film agency offered the lowest price, but very skilled professionals to shoot and produce the spot. The film and photography directors are well-known personalities in their field.

The spots were pre-tested in four districts: Lezhë, Berat, Fier and Tiranë. Four interviewers (two men and two women) were trained in two days in the AFPP office. They had previous experience with the AFPP – BCC activities, as well as conducting focus groups.

The pre-testing consisted of focus groups discussions and filling in individual questionnaires. People interviewed were of our primary target audience, but some focus groups were organized with a secondary audience, (health professionals). The first tour started on December 13-th and ended on 23-rd. We were very much supported in the field by AFPP and PROShëndetit collaborators, which facilitated the teams' work, especially with gathering people for the focus groups.

Data were collected and analyzed during the data collection period. Based on the findings of the pre-testing, the “rough” cuts were modified. The results from the urban spot pre-testing (first round) showed a very high level of liking, appropriateness, feeling that it is meant for them, and comprehension; therefore only a few small refinements were made to the spot. Then the urban spot, with the consent of USAID, was ready to be aired. No second pre-testing round was needed for the urban spot. Pretests of the rural spot revealed some important issues. The rural spot was modified, and will undergo a second round of pre-testing in January 2006.

❖ Airing the Spot

*Contacting TV Channels:* AFPP did contacted and discussed our advertising activities with marketing people from the predefined TV channels selected to broadcast the AFPP TV spots. Baseline Survey data show that our audience's the most watched and preferred TV-s channels are Top Channel, Vizion +, TVSH and Klan TV. We only contacted the two most popular stations in rural and urban areas. The difference in preferences in the number two spot between rural and urban areas necessitated airing on three stations. AFPP collected offers from them and started to compile a broadcast plan. The Ministry of Health provided a letter to require special rates, etc for the AFPP TV spots, considering their social benefit.

*Launching the Urban spot:* The urban spot start airing in the last day of December 2005. Traditionally the New Year Holidays in Albania are very popular and are celebrated by all. TV stations prepare and broadcast special entertainment programs (talk shows, music clips and humor) or famous movies. We decided to launch simultaneously in the three selected TV stations (Top Channel, TVSH and Klan TV), for three days in a row, during the usually most popular type of programs of each television station. (Table 8).

**Table 8: Broadcasting time table of the Urban Spot during the New Year Holidays**

	<b>KLAN</b>	<b>TOP</b>	<b>TVSH</b>
<b>30-Dec</b>			
<b>20.45 - 21.15</b>	Before - Zone e Lire		
<b>31-Dec</b>			
<b>17.20 - 18.10</b>		Before News	
<b>19.10 - 19.35</b>	Before News		
<b>20.35 - 20.55</b>			After the President Speech
<b>1st Jan</b>			
<b>13.30 - 14.30</b>			After the Vienna Concert
<b>14.00 - 15.00</b>		Rit. Portokalli (Entertainment)	
<b>2nd Jan</b>			
<b>13.00 - 14.00</b>		Rit. TopShow (Entertainment)	
<b>19.10 - 19.35</b>			Before News
<b>21.30 - 23.00</b>	Film or entertainment		

## Next Steps:

- 📅 Conduct the Media Recall Survey
- 📅 Conduct the second round of pre-testing of the rural TV spot.
- 📅 Sign the contracts with selected TV-s to broadcast the TV spots for an 8-week period. Finalize the media plans (airing schedules)
- 📅 Prepare and produce a short spot with MoH people speaking and with testimonials of well-known users.
- 📅 Start contacts and prepare the call in shows.

#### **IV. SUMMARY OF KEY MEETINGS/ACTIVITIES**

**October 17th**

**Meeting at MoH**

- **Transfer of LMIS to IPH Meeting:** with v/Minister Zamira Sionimeri, Staff of Reproductive Health Unit (Nedime and Miranda), IPH v/Director Alban Ylli.

**October 20th**

**Meeting at IPH**

- **Meeting at IPH** with v/director of IPH Alban Ylli, Head of Statistics and Non-Infectious Diseases Department, Gazmend Bejtja, and the RH person at IPH, Miranda Hajdini. Discussed roles and responsibilities of IPH in managing the LMIS for contraceptives.

**October 27, 2005**

**Meeting with Zamira Sinoimeri – Vice Minister of MoH**

**Issues Discussed:**

- MOH Payment for contraceptives
- Problems of Contraceptive Security in Albania
- Setting meeting date for the Contraceptive Security Commission

**November 2, 2005**

**Meeting with Matty Tim – World Learning**

- Coordinating activities in the areas in which we work together.

**November 23, 2005**

**Meeting with the ACPD representative – Elona Gjebrea**

- Coordinating FP/RH training activities
- Sharing information re contraceptive security in the target populations.

**Meeting with Nedime, Nesmark and UNFPA at MoH**

- Contraceptive distribution for NESMARK
- Discussing the AFPP TV Spot

**December 01-02, 2005**

**Computerization of LMIS Training at District Level – Organized by UNFPA**

UNFPA agreed to assist the MoH by conducting LMIS software refresher training in 22 districts. Because JSI has the expertise and also provided technical assistance for previous LMIS trainings, UNFPA asked AFPP staff to conduct this training. These 22 districts are now able to process FP reports data quickly, before sending it to the MOH headquarters. In this refresher training were explained all the problems and difficulties the users of LMIS in districts have found in using the software. They all can forward the data electronically to the central MoH. By reducing the data input burden at the center, the MoH is able to produce LMIS reports more quickly and thus better manage contraceptives in the country.

**APPENDIX A**

**AFPP Plan of Activities, Sept-Dec 2005**

**Training Activities for Next Quarter, Jan-Mar 2006**

### AFPP Plan of Activities, September-December 2005

Districts	October (Weeks)																													
Training activities	40							41							42							43								
	3	4	5	6	7	8	9	10	11	12	13	14	16	17	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
Diber (follow-up)	FP Training																													
Mirdite	FP Training																													
Kolonje								FP Training																						
Skrapar																						FP Training								
November (Weeks)																														
Training activities	44						45						46						47											
	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27		
Delvine	FP Training																													
Devoll							FP Training																							
December (Weeks)																														
Training activities	48						49						50						51											
Follow-up	28	29	30	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25		
Lezhe													Follow-Up																	
Fier													Follow-Up																	
Lushnje																			Follow-Up											
Vlore																			Follow-Up											

 FP Training

 Weekend

 Follow-Up

 Holidays

### Training Activities for Next Quarter, January-March 2006

FEBRUARY	Weeks																														
	5			6						7						8						9									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28			
Devoll																															
Kolonje																															
Delvine																															
Skrapar																															
Mirdite																															
Puke																															
MARCH	Weeks																														
	9			10						11						12						13									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Permet																															
Tepelene																															

 FP Training

 Weekend

 Follow-Up

 Holidays

**APPENDIX B**  
**Contraceptive Stock Out and LMIS Reporting Summary**

## Percentage of SDP's in AFPP Districts Reporting LMIS Data, January 2006

District	Total of SDP's	Reported SDP's	% of reported SDP's
Delvinë	5	4	80
Devoll	6	6	100
Dibër	16	4	25
Fier	19	19	100
Has	1	1	100
Kolonje	8	8	100
Kukës	1	1	100
Lezhë	11	11	100
Lushnje	17	17	100
Mirditë	8	7	87.5
Përmet	1	1	100
Pukë	1	1	100
Skrapar	10	10	100
Tepelenë	1	1	100
Tropojë	1	1	100
Vlorë	17	17	100
<b>TOTAL</b>	<b>123</b>	<b>109</b>	<b>88.6</b>

**Note:** Diber's low reporting rate is due to internal organization problems within the district health office. Besides, Diber is a very remote area and some SDPs which unable to report due to an unusually harsh (cold) winter. Mirdita suffers the same problems as Diber.

## Contraceptive Stock-Outs, October – December 2006

District	# of SDP's Reported	Low Dose		Injection		Condom		POP	
		# SDPs Stocked Out	%	# SDPs Stocked Out	%	# SDPs Stocked Out	%	# SDPs Stocked Out	%
Delvinë	4	0	0	1	25	0	0	1	25
Devoll	6	0	0	0	0	0	0	5	83.3
Dibër	4	1	25	1	25	0	0	4	100
Fier	19	0	0	0	0	0	0	5	26.3
Has	1	0	0	0	0	0	0	1	100
Kolonje	8	0	0	1	12.5	0	0	8	100
Kukës	1	0	0	0	0	0	0	0	0
Lezhë	11	0	0	4	36.4	2	18.2	11	100
Lushnje	17	0	0	1	5.9	1	5.9	14	82.4
Mirditë	7	0	0	0	0	0	0	6	85.7
Përmet	1	0	0	0	0	0	0	0	0
Pukë	1	0	0	0	0	0	0	1	100
Skrapar	10	0	0	0	0	3	30	9	90
Tepelenë	1	0	0	0	0	0	0	0	0
Tropojë	1	0	0	0	0	0	0	0	0
Vlorë	17	3	17.6	3	17.6	2	11.8	16	94.1
<b>Total</b>	<b>109</b>	<b>4</b>	<b>3.7</b>	<b>11</b>	<b>10.1</b>	<b>8</b>	<b>7.3</b>	<b>81</b>	<b>74.3</b>

## APPENDIX C

### BCC Workshop Agenda

<b>Mirdite district</b>				
Urban area			Ob-Gyn	N/M
	WCR	2	0	2
	Maternity	2	0	2
Rural area			FD	
HC	Fan	3	2	1
HC	Kthell	2	0	2
HC	Kurbnesh	2	0	2
HC	Reps	3	1	2
HC	Rubik	3	1	2
Village level				
Ambulanca	Arrez	1	0	1

<b>Kolonje district</b>				
Urban area			Ob-Gyn	N/M
	WCR	1	0	1
	Maternity	2	1	1
Rural area			FD	N/M
HC	Barmash	2	1	1
HC	Clirimi	2	0	2
HC	Leskovik	3	1	2
HC	Mollas	3	1	2
HC	Novosel	1	0	1
HC	Radanj	1	0	1
HC	Tac	2	1	1

Ambulanca	Klos	1	0	1
Ambulanca	Shtuf	1	0	1
Ambulanca	Zall-xhuxh	1	0	1
<b>Total</b>		<b>21</b>	<b>4</b>	<b>17</b>

<b>Village level</b>				
Ambulanca	Borove	1	0	1
Ambulanca	Gjonc	1	0	1
Ambulanca	Kagjinas	1	0	1
Ambulanca	Qinam	2	0	2
<b>District Total trained</b>		<b>22</b>	<b>4</b>	<b>18</b>

<b>Skrapar district</b>				
Urban area			Ob-Gyn	N/M
	WCR Corovode	3	1	2
	WCR Polican	1	0	1
	Maternity	1	0	1
Rural area			FD	N/M
HC	Bogove	1	0	1
HC	Cepan	1	1	0
HC	Gjebes	1	0	1
HC	Leshnje	1	1	0
HC	Potom	1	0	1
HC	Vendreshe	2	0	2
HC	Zhepe	1	0	1
<b>Village level</b>				
Ambulanca	Bargullas	1	0	1
Ambulanca	Buzuq	1	0	1
Ambulanca	Ibrollar	1	0	1
Ambulanca	Jaupas	1	0	1
Ambulanca	Kapinove	1	0	1
Ambulanca	Koprencke	1	0	1
Ambulanca	Muzhenck	1	0	1
Ambulanca	Orizaj	1	0	1
Ambulanca	Turbehove	1	0	1
Ambulanca	Zaloshnje	1	0	1
<b>District Total trained</b>		<b>23</b>	<b>3</b>	<b>20</b>

<b>Delvina district</b>				
Urban area			Ob-Gyn	N/M
	WCR	1	0	1
	Maternity	3	1	2
Rural area			FD	N/M
HC	Finiq	2	1	1
HC	Mesopotam	3	1	2
HC	Vergo	2	0	2
<b>Village level</b>				
Ambulanca	Blerimas	1	0	1
Ambulanca	Brajlat	1	0	1
Ambulanca	Clirimas	1	0	1
<b>District Total trained</b>		<b>14</b>	<b>3</b>	<b>11</b>

<b>Devoll district</b>				
Urban area			Ob-Gyn	N/M
	WCR	1	0	1
	Maternity	1	0	1
Rural area			FD	N/M
HC	Bitincke	2	1	1
HC	Hocisht	1	1	0
HC	Miras	2	1	1
HC	Proger	2	1	1
<b>Village level</b>				
Ambulanca	Baban	1	0	1
Ambulanca	Bicke	1	0	1

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Ambulanca	Cangonj	1	0	1
Ambulanca	Fitore	1	0	1
Ambulanca	Hocisht Grace	1	0	1
Ambulanca	Kapeshtice	1	0	1
Ambulanca	Poloske	1	0	1
Ambulanca	Verlem	1	0	1
District Total trained		17	4	13

GHS -I-00-03-00026-00



MINISTRY OF HEALTH

# QUARTERLY PROGRESS REPORT

January 1 – March 31, 2006



## Albania Family Planning Project 2004 – 2006

May 2006



The Albania Family Planning Project is implemented by John Snow, Inc. in collaboration with The Manoff Group

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## ACRONYMS

<b>AFPP</b>	<b>Albania Family Planning Project</b>
<b>BCC</b>	<b>Behavior Communication Change</b>
<b>CS</b>	<b>Contraceptive Security</b>
<b>CYP</b>	<b>Couple of Year Protection</b>
<b>FP</b>	<b>Family Planning</b>
<b>FY</b>	<b>Fiscal Year</b>
<b>HC</b>	<b>Health Center</b>
<b>IEC</b>	<b>Information Education Communication</b>
<b>IPH</b>	<b>Institute of Public Health</b>
<b>IUD</b>	<b>Intrauterine Device</b>
<b>JSI</b>	<b>John Snow, Inc.</b>
<b>LMIS</b>	<b>Logistic Management Information System</b>
<b>Manoff</b>	<b>JSI subcontractor for BCC</b>
<b>MCH</b>	<b>Mother and Child Health</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MWRA</b>	<b>Men and Women of Reproductive Age</b>
<b>PHC</b>	<b>Primary Health Care</b>
<b>PHD</b>	<b>Public Health Directory</b>
<b>PMP</b>	<b>Performance Management Plan</b>
<b>RH</b>	<b>Reproductive Health</b>
<b>RHU</b>	<b>Reproductive Health Unit</b>
<b>SDP</b>	<b>Service Delivery Points</b>
<b>UNFPA</b>	<b>United Nation Fund Population Aid</b>
<b>URC</b>	<b>University Research Corporation</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>WCR</b>	<b>Women Consultancy Room</b>

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## I. Executive Summary

This quarter -- January 1 to March 31, 2006 -- continued the intensive **implementation phase** for all three components of the Albania Family Planning Project: Contraceptive Security, Family Planning Training and Behavior Change Communication.

The logistics management (LMIS), central warehousing and distribution of contraceptives were all shifted to the Institute of Public Health in January/February 2006. This is a major step forward in contraceptive security in Albania.

Family planning training carried out the first round of formal training follow-up during this quarter, visiting service delivery points and FP providers in six districts. Five additional districts were covered with FP training during the quarter, bringing the total number of districts covered to 13.

Airing of television spots promoting family planning began in January, and the initial response from stakeholders has been very positive. The AFPP media plan calls for the spots to be aired from January through March, then a break, with a second round of airings beginning in June/July.

Twenty-two (22) new FP service delivery points were added to the MOH system this quarter, and all the new sites reported LMIS data for the first time.

During this quarter, AFPP solidified its good working relationships with ProShendetit, the Ministry of Health and the Institute of Public Health, all of which are participating as active partners in AFPP-sponsored activities.

## PERFORMANCE MANAGEMENT PLAN (PMP)

SO 3.2: Improved Selected Health Care Services in Target Areas						
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (Jul.-Sept. 2005) <sup>4</sup>
% of service delivery points providing family planning services	# of SDPs with commodities, trained provider(s), IEC materials/ total # of SDPs  SDP's = 440 MOH facilities (Maternities, WCRs, HCs); 300 currently providing FP and 140 additional sites will provide FP services Unit: %	LMIS Reports; project reports  Quarterly	16 Project Districts	LMIS Officer	0 % (2004 LMIS)	74.18 % (135/182)
			National		68 % (2004 LMIS)	89.8% (405/451)
Couple years of protection (CYP) *	Total number of contraceptives distributed by type (method) in a given period with weights applied to different methods.  1 CYP = 15 Packets Oral Pills 1 CYP = 4 Depo Injections 3.5 CYP = 1 IUD 1 CYP = 120 Condoms Unit: #	LMIS Reports  Quarterly	16 Project Districts	LMIS Officer	774 per quarter (2004 LMIS)	1104.7
			National		3,750 per quarter (2004 LMIS)	4187.1

\*When calculated annually means average quarterly CYP

IR 1: Health resources efficiently managed						
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (Jul.-Sept. 2005)
<b>Sub IR1.2: Health information systems improved</b>						
% of service delivery points stocked out of condoms, POP, injectables and low dose contraceptives in 16 target districts	# of SDPs reporting zero stock of specific commodities/ # of SDPs reporting  Unit: %	Routine LMIS Reports  Quarterly	Project 16 districts	LMIS Officer		
			Condoms		28 %	7.3%
			POP		64 %	74.3%
			Low dose		22 %	3.7%
			Injectables		14 %	10.1%

<sup>4</sup> The figures of the last quarter have also been updated from the latest LMIS reports.

<sup>5</sup> The denominator of this indicator was adjusted upwards from 182 to 185 because there are 3 more SDPs more than originally planned (2 SDPs in Permet and 1 SDP in Tepelene)

**IR 2: Quality of PHC services improved**

**IR2.2: Skills of PHC providers enhanced**

% of SDPs in 16 target districts with staff trained using national FP curriculum	# of SDPs in target districts with at least one staff person trained using national FP curriculum/ total # SDPs in intervention districts  SDP = MOH facilities (maternities, WCRs, health centers) Unit: %	Training Records; Quarterly	<b>By type of SDP:</b>	Training Officer	0 %	68.8 (11/16)
			Maternity			
			WCR			
			Health Center			
			<b>By cadre:</b>			
			Doctors			
Nurses/ midwives						

<b>IR 3: Use of PHC services increased</b>						
<b>Indicator</b>	<b>Indicator Definition and Unit of Measure</b>	<b>Data Source/ Frequency</b>	<b>Disaggregation</b>	<b>Person Responsible</b>	<b>Baseline (Year)</b>	<b>Last Quarter (Jul.-Sept. 2005)</b>
<b>IR 3.1 Access to PHC services increased</b>						
Total # of family planning visits in 16 target districts	Total clients visits to SDPs for first FP visits, re-visits, and counseling  Unit: #	LMIS Reports;  Quarterly	First visits  Re-visits  Counseling only	LMIS Officer	750 per quarter  1339 per quarter  686 per quarter  (2004 LMIS)	1590  1977  1854
<b>IR3.2 Awareness of PHC services increased</b>						
% MWRA attending SDPs, who have been exposed to at least one campaign material and can state at least one message	# of MWRA attending SDPs, who state that they have been exposed to at least one campaign material and can state at least one message/ # of MWRA interviewed. Unit: % Campaign materials = TV spots or programs, events, pamphlets/ brochures). MWRA attending SDPs that provide MCH services are MWRA attending target facilities for maternal or routine child health care	Exit interview at SDPs; during campaign; end of project	National by:  exposure <sup>6</sup> ;  type of message state;	BCC Officer	0% 0 %	0% 0 %

<b>IR3.3: Community participation in health promotion activities increased</b>						
<b>Indicator</b>	<b>Indicator Definition and Unit of Measure</b>	<b>Data Source/ Frequency</b>	<b>Disaggregation</b>	<b>Person Responsible</b>	<b>Baseline (Year)</b>	<b>Last Quarter (Jul.-Sept. 2005)</b>
% of villages which have FP service provided by at least one community midwife in 16 districts	# of villages which have FP service provided by at least one community midwife in 16 districts / total # of village in the 16 districts  Unit: %	Training Records;  Quarterly	16 Project Districts	Training Officer	0	13.78% (183/1328)

<sup>6</sup> Having been exposed to at least one campaign material

## II. SUMMARY OF MAJOR ACTIVITIES DURING THE REPORTING PERIOD

### A. Project Management

Planned Action	Status at End of Quarter	Comments
Maintain effective communication with USAID and JSI Headquarters	Ongoing	<b>USAID:</b> AFPP maintains good communication with USAID by delivering materials on schedule, minimizing the administrative burden placed on the Mission, regularly updating USAID and inviting Mission representatives to participate in project activities. <b>JSI HQ:</b> AFPP has regular and frequent communication with JSI headquarters.
Submit deliverables on schedule	Done	<ul style="list-style-type: none"> <li>• Contraceptive Security Strategy Report 2006</li> <li>• Weekly reports</li> <li>• BCC First Media Recall Survey</li> <li>• BCC Second Media Recall Survey</li> </ul>

### B. Programmatic Activities

Component 1: Contraceptive Security	Status at End of Quarter	Comments
Submit the Contraceptive Security Strategy Report 2005	Done	The Contraceptive Security Strategy Report 2006 submitted and in the coming quarter a round table to discuss the report will be called.
Provide ongoing technical support to the LMIS	Ongoing	AFPP assisted the IPH and MoH in the process of shifting successfully the LMIS to IPH and taking over the contraceptive storage and distribution.
Provide LMIS training in 16 districts	Ongoing	Completed LMIS training in Permet and Tepelene. This brings the total of districts trained to 13 (out of total 16)
Component 2: Family Planning Training	Status at End of Quarter	Comments
Conduct Follow-up visits	Ongoing	Follow up was accomplished to five districts: Devoll, Kolonje, Delvine, Skrapar, Mirdite and Puke. The purpose of follow-up is to provide additional data regarding the outcome of AFPP interventions, assess the effectiveness of training, and provide on-the-job support and teaching when needed.
Conduct FP training for providers	Ongoing	<b>Permet and Tepelene</b> districts completed the FP trainings; a total of 67 MOH staff at 22 facilities trained; also trained 10 (out of 46) community midwives in these districts.

<b>Component 3: Behavior Change Communication</b>	<b>Status at End of Quarter</b>	<b>Comments</b>
Collaborate with Proshendetit	Done	Proshendetit played an active role for drafting the BCC TV scripts. They made their comments and gave their impressions during the pre-testing phase. Proshendetit and AFPP coordinated their activities to deliver FP brochures in districts where AFPP carried out the FP training.
Air the spot	Done	The FP TV spots aired from January 16 to March 19 on Top Channel, Klan TV and Vizion+, following a Media Plan based on data from a baseline survey.
Implement other media activities	On going	Work begun on the "call in" shows about FP. There will be two shows, 75 minutes each, registered and broadcast by TVSH. Also another short spot containing FP messages from the MoH is going to be made soon.
Media recall survey	Done	Two weeks after starting to air the spots, a media recall survey was conducted, to measure the impact on beneficiaries and to have feedback for adjustment in the next airing period.

**C. Consultant Visits During the Quarter**

<b>Technical Area Being Supported</b>	<b>Name</b>	<b>Area of Specialty</b>	<b>Dates in Albania</b>	<b>Purpose Of Visit</b>
<b>Project Supervision and Contraceptive Security Consultant</b>	<b>Patrick Dougherty</b>	<b>Senior Advisor</b>	<b>25 Feb - 03 March, 2006</b>	<p>Review progress to date with the Project Director.</p> <p>Agree on a detailed close out plan for the project. AFPP ends September 2006.</p> <p>Meet with ProShendetit to strengthen coordination with AFPP, and arrange for a smooth AFPP close out process that includes vacating offices leased from ProShendetit.</p> <p>Review project expenditures to date and agree on a final budget for the remainder of the project.</p>
<b>Training</b>	<b>Mary Lee Mantz</b>	<b>Training Technical Advisor</b>	<b>25 Feb - 03 March 2006</b>	<p>Review progress to date against training activities in the workplan.</p> <p>Assist Training Officer in planning implementation of training activities for the remainder of the Project.</p> <p>Review data in the training data base, with a focus on data monitoring key training indicators.</p> <p>Assist Training Officer to identify lessons learned and implications for current and future training/follow-up.</p> <p>Provide technical assistance to other Project components, as appropriate.</p>

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### III. PROGRESS MADE THIS QUARTER

#### B. Contraceptive Security and LMIS

**Contraceptive Security Report 2006** finalized and presented to the MoH. During the next quarter a meeting with MoH, AFPP and IPH will be held to discuss the issues raised in the Report.

**Contraceptive Security.** National commissions have proliferated in recent years, and in an effort to streamline, the MOH abolished the National Contraceptive Security Commission and merged its functions into the broader National Reproductive Health Commission. This new arrangement may in the long run help to get contraceptive security a more prominent place on the national reproductive health agenda in Albania. The National RH Commission is better placed to deal with important CS issues such as changing the method mix for modern methods and market segmentation. AFPP's approach will be assist the National RH Commission to establish a strong Contraceptive Security Subcommittee that meets regularly to monitor contraceptive stock levels and enhance overall contraceptive availability.

**LMIS shifted from MOH to Institute of Public Health.** The logistics management information system (LMIS) and the central-level warehousing and distribution of contraceptives were shifted to the Institute of Public Health during this quarter. AFPP has long advocated for this shift, which is a major step forward in contraceptive security in Albania. AFPP will work closely with IPH to ensure contraceptive availability is maintained at the current high levels in the MOH system. IPH has a long and successful history of managing vaccines in Albania, and now aims to do the same for contraceptives. LMIS is more likely to be sustainable at IPH because the Institute has more IT capability and also currently manages the successful vaccine supply system for Albania. This shift enhances the long-term institutionalization and sustainability of LMIS. This quarter, for the first time, the analysis of the quarterly LMIS data was done fully by IPH with only some assistance from AFPP and MoH Reproductive Health Unit.

**A Contraceptive Forecast** using PipeLine Software was prepared for the years 2006 and 2007 showing contraceptive quantities required for the public sector, and costs. Based on this new forecast, the Vice Minister confirmed that the government will pay the amounts shown in the table below.

#### Timetable for Government Contraceptive Procurement

Year	% Procured by Government*	Status	Amount
2005	10%	Achieved	\$14,043
2006	20%	In Process	<b>\$ 8,991</b>
2007	40%	In Process	<b>\$ 13,966</b>
2008	60%	Committed	Dollar amount of govt. contribution determined each year by the total cost of contraceptives ordered
2009	80%	Committed	
2010	100%	Committed	

With assistance provided by AFPP, the MoH prepared and submitted to UNFPA the following request for contraceptives for the year 2006 and 2007.

**Total Contraceptive Requirements, 2006-2008\***

<b>Methods</b>	<b>Quantity</b>	<b>Cost/Unit</b>	<b>Estimated Cost</b>
Rigevidon (cycles)	162,391	\$ 0.23	\$ 37,350
Depo-Provera (Viabes)	34,562	\$ 0.85	\$ 29,378
IUD (Pieces)	5,010	\$ 0.30	\$ 1,503
Condoms (Pieces)	581,085	\$ 0.02	\$ 11,622
<b>Total Cost</b>			<b>\$ 79,853**</b>

\* This forecast is based on actual consumption of contraceptives in 2005, and assumes an increase of 8% per annum for each method (Orals, Injections, IUD and Condoms).

\*\* Transportation and other miscellaneous costs will raise the total to approximately \$87,500.

During this quarter, LMIS was expanded in two districts: Permet and Tepelene. Twenty new Service Delivery Points (SDPs) began providing FP services and reporting LMIS data during this quarter.

**Table 1: New FP Service Delivery Points this Quarter**

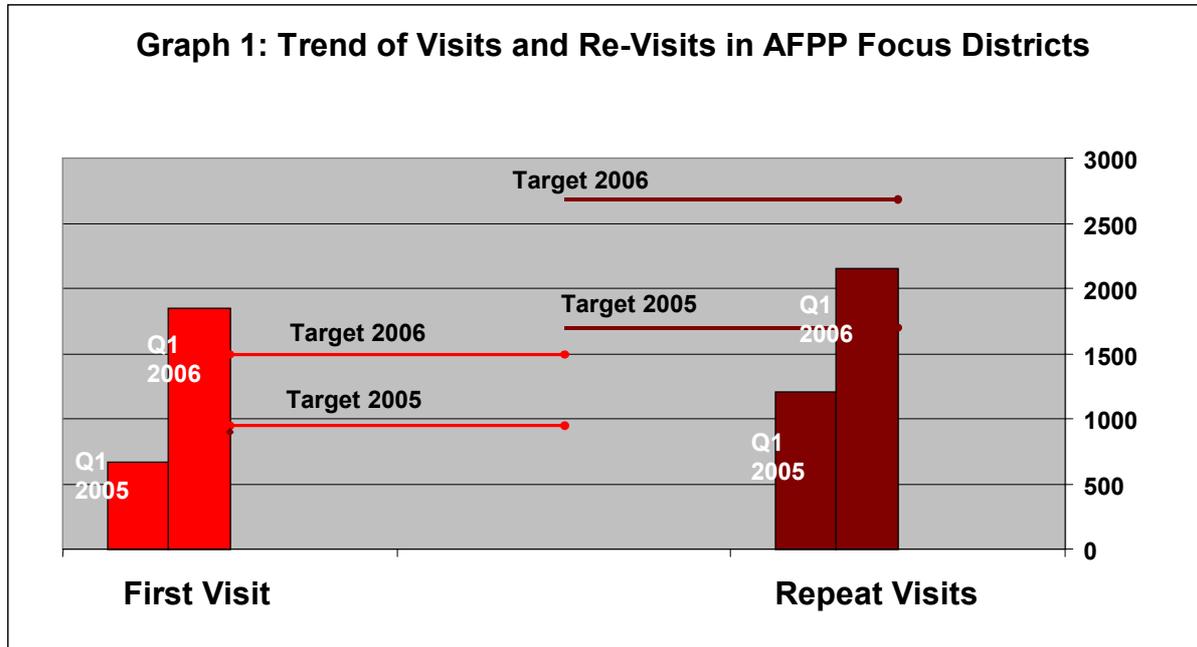
<b>Target Districts for this Quarter</b>	<b>Baseline: No. of FP Service Delivery Points (SDPs)</b>	<b>No. of FP SDPs at end of this quarter</b>
<b>Permet</b>	1	11
<b>Tepelene</b>	1	11
<b>Total</b>	<b>2</b>	<b>22</b>

*Source: LMIS*

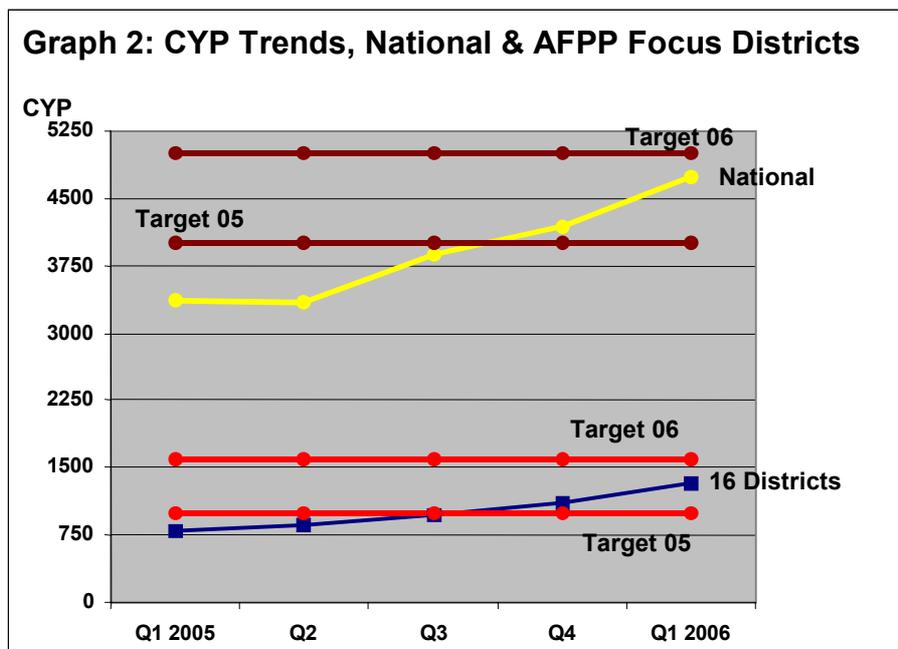
The processing of LMIS shifted to IPH during the quarter. IPH managed to achieve an outstanding reporting rate: 97.7 % for the project area and 90.8 % in national level.

% of FP service delivery points reporting LMIS data this quarter	In sixteen (16) project districts	97.7 %
	In all FP SDPs in Albania	90.8 %

**Use of FP Services.** First visits and re-visits in the AFPP focus districts is increasing steadily due to expansion of FP service delivery points and the national BCC campaign. First visits have already exceeded the 2006 target (end-of-project), and repeat visits are increasing rapidly to achieving the 2006 target.



**Couple Years of Protection.** CYP is showing a steady increase, both in the project area and nationally. CYP is calculated using LMIS data, so the increased LMIS reporting rates contributed to the upward CYP trend.



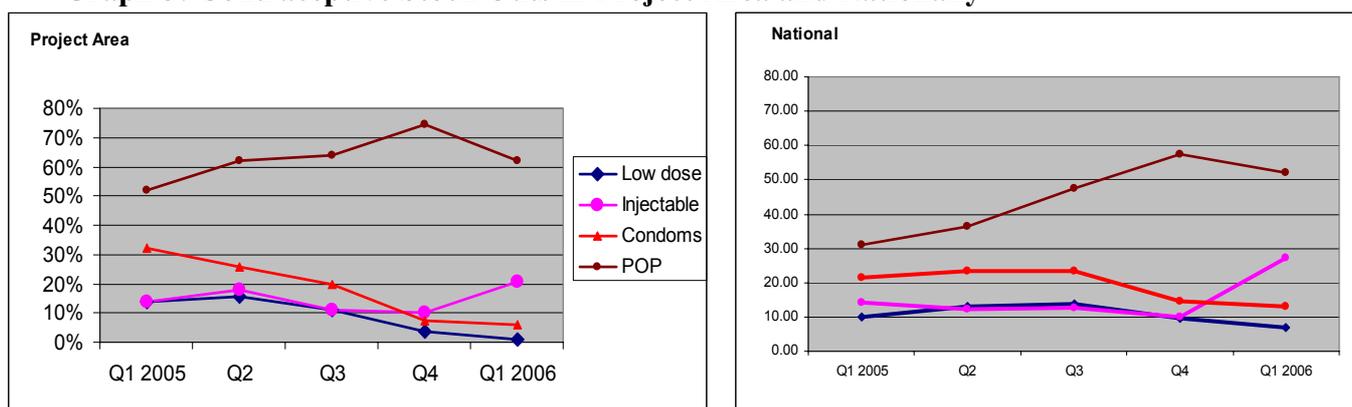
**Contraceptive Stock Outs.** The data below show that contraceptive stock outs are a chronic problem, but the situation is improving. The data below show that low dose pills and condoms are now widely available.

Table 2: Stock Outs in 16 AFPP Districts						Target 2006
	Q1 2005	Q2 2005	Q3 2005	Q4 2005	Q1 2006	
Low dose	14%	19%	10%	5.1 %	0.8 %	10%
Injectable	14%	20%	10%	10.2 %	20.9 %	10%
Condoms	31%	26%	19.6%	7.6 %	6.2 %	10%
POP	53%	59%	64.1%	75.4 %	62.0 %	10%

Source: LMIS

A UNFPA shipment of POP (30,000 cycles of Microval) arrived in Tirana in January 2006, and distribution began in February. We expect to see the POP stock out rate (62%) fall dramatically in the next quarter. However, injectable stock outs will continue to rise until a new shipment arrives, tentatively in May 2006.

**Graph 3: Contraceptive Stock Outs in Project Area and Nationally**



The stock out for DepoProvera at SDPs is due to a stock out at the central warehouse in Tirana. UNFPA has ordered DepoProvera (13,000 vials) using MOH funds. They are expected to be in Albania in early May 2006.

Rigevidon may stock out in the coming quarter because a large quantity will expire in June 2006. IPH has a quantity of Rigevidon at the central warehouse that will be distributed in May 2006, but that quantity is only half the amount normally supplied to districts. The MoH is ordering through UNFPA a quantity of Rigevidon, but it is not expected to arrive before July 2006.

#### Next Steps for Contraceptive Security Component

- Discuss Contraceptive Security Report 2006 with MoH, IPH, USAID and UNFPA
- Conduct LMIS refresher training to strengthen and support IPH
- Market Segmentation Study by a DELIVER consultant
- Assist MoH in the selection of the KOK pill which will substitute for Rigevidon
- Collect all Rigevidon expiring at the end of the May
- Ensure IPH distributes Microval (POP) down to the commune level.

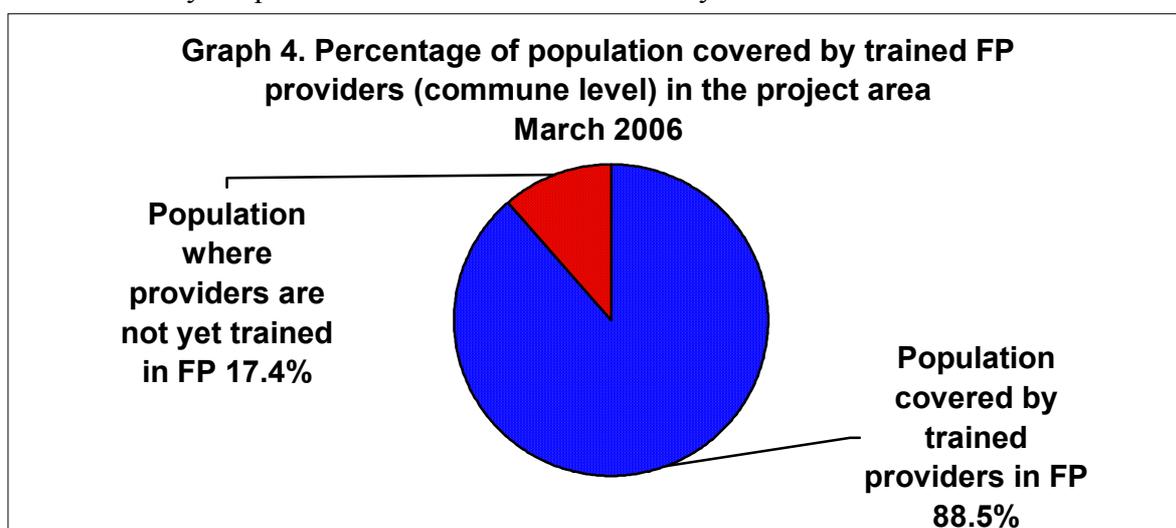
### C. FAMILY PLANNING TRAINING

There were two main activities in this component during the quarter:

- ✚ Family Planning Training
- ✚ Training Follow Up

Family planning training continues to proceed on schedule according to the roll-out plan (Appendix A). During this quarter, training was carried out in two small districts, Tepelene and Permet, that contain approximately 2% of the total population of Albania. The majority of the providers trained were from health centers, as most of the population in these districts live in rural areas.

At the end of this quarter, 88.5 % of the total population in the project area (16 districts) is now covered by FP providers who have been trained by AFPP.



To date, the total number of SDPs covered by FP/LMIS training has reached 156. Twenty (20) are new sites added this quarter where FP services had not previously been provided.

**Table 3: Service Delivery Points Covered During January-March 2006**

Districts	Number of SDP by Type			Total
	HC	WCR	Maternity	
Permet	9	1	1	11
Tepelene	9	1	1	11
<b>Total</b>	<b>18</b>	<b>2</b>	<b>2</b>	<b>22</b>

The total number of staff trained during this reporting quarter is 67, including doctors, nurses/midwives and other staff. To increase the sustainability of the FP program at the district level, AFPP trained four staff from Public Health Directorates whose duties include the day-to-day supervision of family planning activities in their districts or the reporting of family planning statistics.

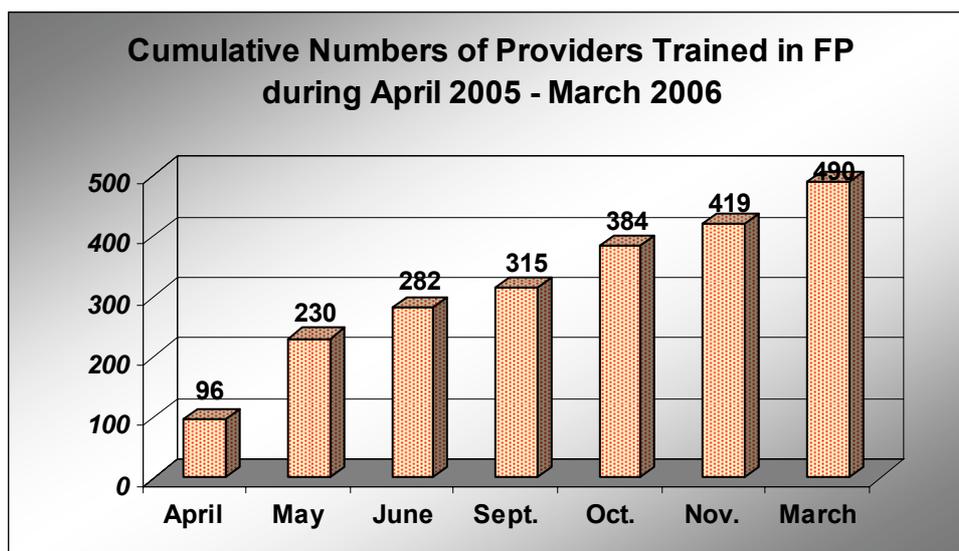
**Table 4: Total Number of Providers and Other Staff Trained, January-March 2006**

DISTRICTS	Providers		Others	Total
	Doctors (FP+Ob/Gy)	Nurse Midwife	Supervisors	
Permet	9	26	1	36
Tepelene	10	20	1	31
<b>TOTAL</b>	<b>19</b>	<b>46</b>	<b>2</b>	<b>67</b>

Of the 46 nurse midwives, 16 were community midwives, which increases community outreach of family planning information and services, and also strengthens the link between community midwives and local health centers providing FP services. AFPP is including a limited number of community midwives in FP training as a first step to extending FP services to the community level.

The cumulative increase by month in number of providers trained, since April when the training began, is shown below.

**Graph 5**



Following table shows that the majority of providers trained (79 %) are female.

**Table 5: Providers & PHD Staff Trained, By Gender, January - March 2006**

	Female	%	Male	%	Total
Family Doctors	7	41.18%	10	58.82%	17
Nurses	9	81.82%	2	18.18%	11
Midwives	34	97.14%	1	2.86%	35
Ob-Gyn.	1	50.00%	1	50.00%	2
Other (PHD staff)	2	100.00%	0	0.00%	2
<b>Total</b>	<b>53</b>	<b>79.10%</b>	<b>14</b>	<b>20.90%</b>	<b>67</b>

In order to evaluate change in knowledge after training, a pre - and post - test was used. The following table summarizes test scores.

<b>Table 6: Average Scores of Pre/Post Test by District and Profession (Maximum Score = 20)</b>				
<b>Profession</b>	<b>District</b>	<b>Pre-test score average</b>	<b>Post-test score average</b>	<b>Change in %</b>
Family Doctors				
	Permet	14	18.9	<b>+26</b>
	Tepelene	12.9	17.3	<b>+26</b>
Midwives				
	Permet	13.6	19	<b>+28</b>
	Tepelene	10.7	14.5	<b>+26</b>
Nurses				
	Permet	13.8	18	<b>+23</b>
	Tepelene	12	17.7	<b>+32</b>
Ob-Gyn's				
	Permet		20	
	Tepelene	13	13	<b>0</b>

Specific PMP indicators for this training component are shown below.

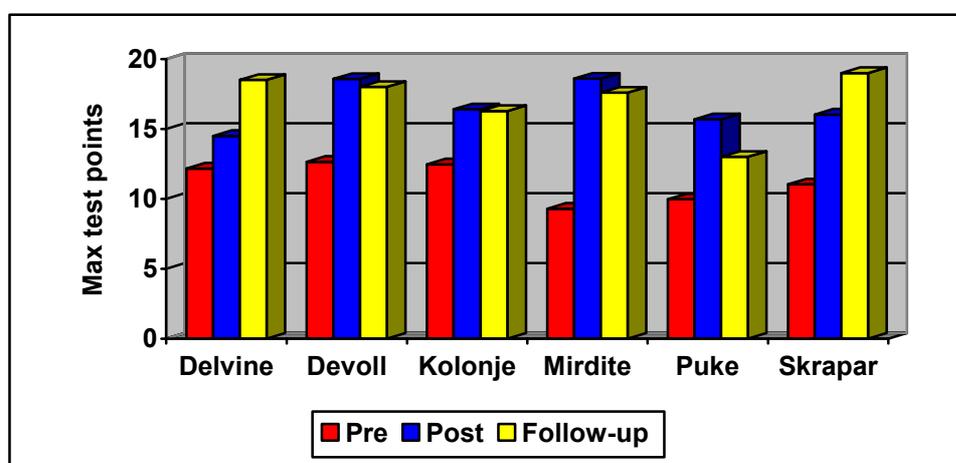
<b>Indicators</b>	<b>Quarter 3 October-December 2005</b>	<b>Quarter 1 January-March 2006</b>
<b>IR 2.2</b>		
% of SDPs in 16 target districts with staff trained using national FP curriculum	74.18% (135/182)	84.86% (157/185)
<b>By Type</b>		
% of Maternities in 16 target districts with staff trained using national FP curriculum	68.8% (11/16)	81.3% (13/16)
% of WCR in 16 target districts with staff trained using national FP curriculum	100% (16/16)	100% (18/18)
% of Health Centers in 16 target districts with staff trained using national FP curriculum	72% (108/150)	83.4% (126/151)
<b>By Cadre</b>		
% of Doctors in 16 districts trained with FP national curricula (GP+Ob-Gyn.)	68.1% (124/182)	77.3% (143/185)

% of Nurse/Midwives in 16 districts trained with FP national curricula	78% (284/364)	89.2% (330/370)
<b>IR 3.3</b>		
% of villages in 16 districts with one FP-trained community midwife	13.78% (183/1328)	16.34% (217/1328)

### Training Follow – Up

Formal training follow-up of a sample of trainees was conducted in six districts this quarter. Results showed that knowledge of family planning gained during the training had been well maintained (Puke being the exception.) In two districts, Delvine and Skrapar, knowledge actually increased since the post test.

**Graph 6. Comparison of Pre/Post/Follow-up Test Scores**



The purpose of the Integrated Monitoring & Evaluation Plan is to provide additional data regarding the outcome of Project interventions that currently have more quantitative (process) oriented indicators, rather than qualitative (outcome) indicators. Equally important is providing follow-up visits to facilities with trained Family Planning (FP) providers to provide on-the-job support and teaching when needed. In addition, Albania Family Planning Project (AFPP) has internal indicators (not usually reported to USAID/A quarterly) that help monitor the quality and effectiveness of interventions and the data collected may be used for revising approaches and activities, providing feedback to the Project team and partners, and for the final report.

### Training Follow Up Methodology

**Sampling: First Stage** -- Selection of the number of SDPs for each eligible district.

Project resources (human, financial, time) were stretched to meet the follow-up goals, and it was not possible to reach all trainees and health facilities. Due to these constraints, as a minimum, a convenience sample of *33% of the health facilities* and trained health providers were included in the assessment. A sample of health centers was drawn from each intervention district to date. The training database was the source of information for sampling. This information includes the number of service providers trained in FP by the project, number and names of service delivery points (SDPs) with at least one trained service provider.

**Sampling: Second Stage -- Selection of Service Delivery Points.**

Service delivery points were selected randomly through a “blind draw” process. This process was repeated for each district. Table 2 gives the sample of SDPs within each district. At each of the selected SDPs, all service providers who were trained in family planning were interviewed.

**Table 7. Number of Providers & Service Delivery Points Trained and Sampled by District**

	Delvine		Devoll		Kolonje		Mirdite		Puke		Skrapar		Totals	
	# trained													
Providers	16		21		23		23		33		25		141	
	# trained	# sampled												
SDPs	5	2	6	2	9	3	8	2	10	1	11	4	49	<b>14</b>

**Key Findings**

A total of 26 health providers were interviewed at 14 SDPs. Follow-up data indicates that the quality of FP service delivery has been greatly improved and expanded, and that the majority of providers’ skills and knowledge are very good. Client exit interviews and observation of counseling sessions confirm most results obtained from provider interviews. The main area of concern is a significant percentage of providers are not informing clients about whether their FP method provides protection from STI/HIV or not. This also was confirmed in client exit interviews. This important issue will be addressed in future trainings and retroactively with trainees who have already completed training.

-  Not all SDPs can provide clients with the method of their choice because of stock outs of some methods. Some of SDPs were supplied during the follow-up visit and for the others the Inspector of Mother & Child took notes to supply them as soon as possible. Stock outs of POP were expected because of the stock outs in the Tirana central store. In 19 % of SDPs there was evidence of expired commodities. In the majority of facilities, commodities were stocked according to expiration date and in a proper way to avoid damage.
-  FP records were available in 31 out of 42 SDPs visited, and 83.9% of the FP providers measured and recorded blood pressure for clients who chose pills, recorded method used and ensured that the method was appropriate to the client’s medical history. Approximatley half (16 out of 31) did not record when the client should return to the clinic. One SDP distributed no contraceptives, and 10 SDPs didn't have FP records at all.
-  92.2 % of the clients interviewed reported that they continued to use the method that they had chosen for themselves. This low drop-out rate (8%) may indicate an improvement in the quality of counseling. 100% of providers interviewed stated that if a client is already using a contraceptive method, they routinely ask whether she is satisfied with the method, has any question, problems or concerns.

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- ✚ The pre/post test used during training sessions was administered to health providers during follow-up. The results were significant as they showed that there was almost no decrease in knowledge of family planning since the training.
  - ✚ Providers were asked to demonstrate correct use of a condom to see if they are able to counsel clients correctly. 47.40% failed to demonstrate correct condom use (52.6% were successful.) The primary mistake noted during the demonstration was that providers did not pinch the air from the tip of the condom before putting it on the male model. The interviewer explained and corrected mistakes.
  - ✚ The majority of providers responded correctly to interview questions on selected topics related to counseling clients on family planning methods. But a significant percentage (54 %) did not score well in stating the correct information to be discussed with clients who may be at risk for STI/HIV. As part of the interview, all the providers stated that they always counsel clients on whether or not their family planning method offers protection from STI/HIV. Observation of client visits revealed that 78 % of clients were told whether their method provided protection from STI/HIV. However, only 56% of providers explained to clients that only condoms provide protection from STI/HIV. Providing accurate information on reducing STI/HIV risk is an area that will be highlighted in discussion with trainers and more emphasis will be placed on this in future training sessions. The interviewers provided immediate feedback to the providers and clarified what should have been the correct responses and the importance of providing complete and accurate information during counseling sessions.
  - ✚ Providers stated that Cue Cards are helpful, but only 16% were actually observed using Cue Cards during a client visit. This rate increased to 70% for FP counseling session.

### **General satisfaction**

All providers stated that they feel confident to provide family planning services and 92.1 % (58 out of 63) stated that they feel comfortable in discussing family planning and issues related to sexuality with clients.

As part of the follow-up assessments of facilities and providers, interviewers did on-the-job-training and took appropriate actions in order to try and resolve problems faced in the field. Inspectors of Mother & Child of the respective districts were present at follow-up activities in order to increase their capacity to monitor family planning activities, provide support to providers, be more aware of the challenges faced by providers and facilities providing family planning services and help resolve problems (e.g., stockouts).

### **NEXT STEPS FOR FP TRAINING**

- Results/findings of the follow-up visits will be presented to and discussed with the master trainers. This will provide a forum for identifying the strengths of the training and areas that need strengthening.
- Client data (exit interviews and observations of counseling) are an important part of assessing the effectiveness of training and the quality of the family planning program. Since during the first round of follow-up visits there was not an opportunity to collect client data, interviewers will return to as many sites as is feasible and make every

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effort to observe counseling sessions and conduct exit interviews with clients. Findings of client data will be presented to and discussed with master trainers and the Program Manager for identifying areas that need strengthening. In future follow-up visits to other districts, more time will be allotted for follow-up to increase the likelihood of obtaining client data.

- Findings regarding LMIS will be shared with the Program Manager and LMIS Officer in order to plan next steps for strengthening of problem areas (expired commodities, late or inaccurate LMIS reporting, lack of FP records and contraceptive stockouts at SDPs).
- Findings regarding IEC will be shared with IEC Officer in order to plan distribution of FP brochures.
- Follow-up for the remaining five districts will be conducted between late May and early July. This accelerates the follow-up schedule to allow more time for final data analysis. Follow-up will also be expanded to include a small sample of community midwives.

#### ○ **BEHAVIOR CHANGE COMMUNICATION**

BCC focused on TV spots during this quarter. Two TV spots were developed – one aimed at rural audiences and one at urban. Both spots underwent an exhausting pre-testing process before they were ready for airing. The spots began airing January 16, 2006 and continued during most of the quarter.

#### **The Media Plan**

AFPP decided to air spots on the most watched TV channels: Top Channel, Vision+, Klan TV and TVSH. Soap operas, news and talk shows were the programs found to be most watched in Albania, so the spots were scheduled to run during such programs. All of this was organized into a formal media plan and costs were negotiated with the various TV channels. A letter of support from the MoH Vice Minister enabled AFPP to get very favorable rates, including a 50% discount from Top Channel and Vision+, and 70% discount from Klan TV. TVSH was not responsive and due to their bureaucratic procedures, no agreement was signed with them.

#### **Airing and Monitoring the Spots**

Even though the TV channels guaranteed accuracy with respect to the airing schedule, AFPP staff strictly monitored the airings. No irregularities were detected; on the contrary, Klan TV and Vision+ played some spots for free.

#### **Media Recall Survey 1**

Media recall surveys are routinely conducted after new TV spots are launched to determine the audience coverage. The new urban spot began airing just before Christmas/New Year holidays, and AFPP conducted a survey 72 hours after the spot began showing on TV. Phone calls were made to 191 people from Tirana, Fier and Shkodra, who were called at home and interviewed with regards to the urban spot. Approximately 8% of the respondents said they had seen the spot. This result is satisfactory result if we consider:

1. The urban spot was shown only nine times in total; once a day, on each of three channels, for three days.

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2. The spot ran on three of the most watched channels, but there were many more channels to choose, including many TV channels that were offering special programs for the holidays.
  3. The people called were picked at random from the telephone book, without knowing in what area (urban, suburban or rural) they lived.
  4. The time of day of the call varied; in the beginning, we called in the morning or early afternoon. Then we switched to evening calls and tended to reach more married couples.

The results were of a great help for the next step, the design of the 8-week media plan. We learned more about people's TV habits and some more hints how to make our media plan more cost effective.

### **Media Recall Survey 2**

Fourteen days after the spots begin to air, we conducted the second Media Recall Survey in 9 districts to study the viewership and the impact of the TV spots. There were field visits in 6 districts, where interviewers visited health facilities. In three additional districts, telephone interviews were conducted. A total of 281 respondents were reached during Survey 2 (103 people via telephone, 178 interviewed in health centers or in other venues in villages or towns.)

The most important findings from Survey 2 include:

- 68.4% of the female respondents (71.6% of urban and 55% of rural) had seen at least one of the spots
- 48.9 % of the male respondents (52.4% of urban and 45.7% of rural) had seen at least one of the spots
- 30.5% of the female respondents (33.6% urban and 26.3% rural) were able to state at least one spot message
- 22.7% of the male respondents (26.1% urban and 19% rural) were able to state at least one spot message

Other findings and recommendations related to the efficiency of the Media Plan include:

- The percentage of female viewers who had seen the spots is higher within the age group of our beneficiaries (15–49 yrs), so airing during soap operas proved to be effective.
- The majority of respondents had seen the spots during soap operas, before and after the news, so we should continue to air during these time slots.
- In order to reach more rural people, we should broadcast on national TV, Klan TV and TVSH, preferably during the main news programs.
- In order to reach more males, we should consider broadcasting during sport programs and news.

See the final report of Survey 2 for all the findings and recommendations.

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### Contraceptives on TV (Top Show)

The AFP project initiated a special show dedicated to Contraceptives and Family Planning. For the maximum audience, AFPP approached Top Show, which is currently one of the most popular talk shows in the country. Representatives from MoH and other FP actors were invited to participate and tell their FP experiences. The program sensitized FP providers and beneficiaries about modern contraceptive methods. The project's BCC specialist took part in the program and repeatedly promulgated the main BCC messages and FP logo.



AFPP plans to collaborate with TVSH's traditional health program with Dr. Flamur Topi, a well-known host of health programs in Albania for many years. AFPP staff met with Dr. Topi and planning for the show is underway. .

### Next Steps for BCC

- ✚ Finalize the Media Plan (airing schedules) for the next block of 12 weeks of broadcasts.
- ✚ Prepare and broadcast the Call In Show
- ✚ Write a FP/contraceptive article in one of the main newspapers
- ✚ Produce and distribute FP pins to FP providers
- ✚ Prepare and implement the pilot face-to-face communication, in collaboration with URC.

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#### **IV. SUMMARY OF KEY MEETINGS/ACTIVITIES**

##### **Meeting with MoH Vice Minister – Zamira Sinoimeri**

The new Vice Minister confirmed that the *National Contraceptive Security Strategy* adopted in 2003 remains the framework for CS in the country. In 2005, government procured its first contraceptives for the public sector (approximately US\$13,000), and the MOH will double that amount in 2006. UNFPA will remain the contraceptive procurement agent for the MOH.

##### **Meeting with NESMARK representative – Adrian Paravani**

The social marketing program is now an NGO separate from the MOH (it was formerly a department within the MOH.) This change has created some pricing problems that caused NESMARK to temporarily suspend the sale of oral pills and DepoProvera (condoms are continuing to be sold.) NESMARK is on the verge of substantially raising its prices to comply with KfW's insistence on sustainability. There is a real need for a national market segmentation strategy that will help to guide NESMARK during its transition. Now that the MOH is beginning to pay for public sector contraceptives, the govt. has a financial incentive to segment the contraceptive market and encourage NESMARK to provide contraceptives to those who are able to pay.

##### **Meeting with Nedime Ceka – RH Unit MoH**

This meeting touched on a broad range of topics, including a review of LMIS data for the previous quarter, forecasting, procurement, etc. The main focus was on the expected DepoProvera and Rigevidon stock outs, and the urgency in making an order for these commodities.

##### **Meeting with Agim Shehi – Director of PHC at MoH**

This meeting focused on the shift of LMIS to IPH, and the need to monitor IPH performance during this transition period to offer assistance while they understand the complexity of the LMIS. The Director promised to look for some way to improve LMIS, especially by making it a priority for the districts.

##### **LMIS WORKSHOP – ISHP            20 January**

**Objective:**     Discussing roles and responsibilities of IPH in managing the LMIS with all its aspects.

1. Gazmend Bejtja – Non-infectious disease department
2. Miranda Hajdini – Specialist on non-infectious disease department
3. Arti Cicolli – IT Specialist
4. Agim Kasa; Manuela Murthi - AFPP

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**LMIS WORKSHOP – AFPP Office**

1. Gazmend Bejtja – Non-infectious disease department
2. Miranda Hajdini – Specialist on non-infectious disease department
3. Miranda Hysa – MoH/RH Unit
4. Agim Kasa; Manuela Murthi - AFPP

**Meeting with UNFPA - AFPP Office      21 March**

The points discussed:

- contraceptive procurement
- contraceptive forecasting for the coming year
- types of contraceptives appropriate for Albania
- technical and management capacity of IPH

1. Lida Nuri; Mirela Shyti – UNFPA

2. Manuela Murthi; Agim Kasaj – AFPP

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**APPENDIX A**  
**AFPP Plan of Activities, January – March 2006**  
**Training Activities for Next Quarter, April – June 2006**



## AFPP Training Plan of Activities for Next Quarter, April - June 2006

APRIL	Weeks																														
	5							6							7																
	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
KUKES																		1 <sup>st</sup>													
KUKES																															
MAY	Weeks																														
	9							10							11																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
HAS																															
TROPOJE																															
TROPOJE																															
JUNE	Weeks																														
	14					15							16																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PERMET						6																									
TEPELENE																															
KUKES																															
HAS																															
TROPOJE																															

FP Training

Weekend

Follow-Up

Holidays

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**APPENDIX B**  
**AFPP Media Plan, January – March 2006**

**16 - 22 JANUARY 2006**

BCC	Monday - 16/01/06			Tuesday - 17/01/06			Wednesday - 18/01/06			Thursday - 19/01/06			Friday - 20/01/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel															
Vizion+	U	20.10	"Njerka"							U	20.10	"Njerka"			
Klan															
TVSH															

**22 - 29 JANUARY 2006**

BCC	Monday - 23/01/06			Tuesday - 24/01/06			Wednesday - 25/01/06			Thursday - 26/01/06			Friday - 27/01/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel													U	18.45	"Fati 1 Gruaje"
Vizion+				U	20.10	"Njerka"							U	20.10	"Njerka"
Klan													R	16.50	Before News
TVSH															

**30 JANUARY - 5 FEBRUARY 2006**

BCC	Monday - 30/01/06			Tuesday - 31/01/06			Wednesday - 01/02/06			Thursday - 02/02/06			Friday - 03/02/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel				U	18.45	"Fati 1 Gruaje"							U	18.45	"Fati 1 Gruaje"
Vizion+	U	20.10	"Njerka"				U	20.10	"Njerka"						
Klan	U	17.35	After News										U	17.35	After News
	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News
TVSH															

**6 - 12 FEBRUARY 2006**

BCC	Monday - 06/02/06			Tuesday - 07/02/06			Wednesday - 08/02/06			Thursday - 09/02/06			Friday - 10/02/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel	U	18.45	"Fati 1 Gruaje"							U	18.45	"Fati 1 Gruaje"			
Vizion+				U	20.10	"Njerka"							U	20.10	"Njerka"
Klan				U	17.35	After News									
	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News
TVSH															

**13 - 19 FEBRUARY 2006**

BCC	Monday - 13/02/06			Tuesday - 14/02/06			Wednesday - 15/02/06			Thursday - 16/02/06			Friday - 17/02/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel				U	18.45	"Fati 1 Gruaje"	U	17.35	Top Show				U	18.45	"Fati 1 Gruaje"
Vizion+	U	20.10	"Njerka"							U	20.10	"Njerka"			
Klan							U	17.35	After News						
	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News
TVSH															

**20 - 26 FEBRUARY 2006**

BCC	Monday - 20/02/06			Tuesday - 21/02/06			Wednesday - 22/02/06			Thursday - 23/02/06			Friday - 24/02/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel				U	18.45	"Fati 1 Gruaje"	U	17.35	Top Show				U	18.45	"Fati 1 Gr
Vizion+				U	20.10	"Njerka"							U	20.10	"Njerka"
Klan	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	17.35 After News Before News	R	16.50	Before N
TVSH															

**27 FEBRUARY - 5 MARCH 2006**

BCC	Monday - 27/02/06			Tuesday - 28/02/06			Wednesday - 01/03/06			Thursday - 02/03/06			Friday - 03/03/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel	U	18.45	"Fati 1 Gruaje"										U	18.45	"Fati 1 Gr
Vizion+	U	20.10	"Njerka"				U	20.10	"Njerka"						
Klan	U	17.35	After News										U	17.35	After Ne
	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before N
TVSH															

**6 - 12 MARCH 2006**

BCC	Monday - 06/03/06			Tuesday - 07/03/06			Wednesday - 08/03/06			Thursday - 09/03/06			Friday - 10/03/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel													U	18.45	"Fati 1 Gr
Vizion+				U	20.10	"Njerka"							U	20.10	"Njerka"
Klan				U	17.35	After News									
	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before N
TVSH															

**13 - 19 MARCH 2006**

BCC	Monday - 13/03/06			Tuesday - 14/03/06			Wednesday - 15/03/06			Thursday - 16/03/06			Friday - 17/03/06		
	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program	U/R	Ora	Program
Top Channel				U	18.45	"Fati 1 Gruaje"							U	18.45	"Fati 1 Gr
Vizion+															
Klan							U	17.35	After News						
	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before News	R	16.50	Before N
TVSH															

 **Urban Spot**       **Rural Spot**

**APPENDIX C**  
**Contraceptive Stock Out and LMIS Reporting Summary**

**Percentage of SDP's in AFPP Districts Reporting LMIS Data, April 2006**

<b>District</b>	<b>Total of SDP's</b>	<b>Reported SDP's</b>	<b>% of reported SDP's</b>
Delvinë	5	5	100.0
Devoll	6	6	100.0
Dibër	16	16	100.0
Fier	19	19	100.0
Has	1	1	100.0
Kolonje	8	8	100.0
Kukës	1	1	100.0
Lezhë	11	10	90.9
Lushnje	17	17	100.0
Mirditë	8	8	100.0
Përmet	1	1	100.0
Pukë	10	9	90.0
Skrapar	10	10	100.0
Tepelenë	1	1	100.0
Tropojë	1	1	100.0
Vlorë	17	17	100.0
<b>TOTAL</b>	<b>132</b>	<b>130</b>	<b>98.5</b>

**Contraceptive Stock-Outs in AFPP Districts, January – March 2006**

District	# of SDP's Reported	Low Dose		Injection		Condom		POP	
		# SDPs Stocked Out	%	# SDPs Stocked Out	%	# SDPs Stocked Out	%	# SDPs Stocked Out	%
Delvinë	5	0	0.0	0	0.0	0	0.0	4	80.0
Devoll	6	0	0.0	2	33.3	0	0.0	5	83.3
Dibër	16	0	0.0	4	25.0	0	0.0	11	68.8
Fier	19	0	0.0	1	5.3	1	5.3	6	31.6
Has	1	0	0.0	1	100.0	0	0.0	0	0.0
Kolonje	8	0	0.0	1	12.5	0	0.0	8	100.0
Kukës	1	0	0.0	1	100.0	0	0.0	0	0.0
Lezhë	10	0	0.0	5	50.0	0	0.0	8	80.0
Lushnje	17	1	5.9	2	11.8	4	23.5	14	82.4
Mirditë	8	0	0.0	0	0.0	1	12.5	8	100.0
Përmet	1	0	0.0	1	100.0	0	0.0	0	0.0
Pukë	9	0	0.0	6	66.7	0	0.0	0	0.0
Skrapar	10	0	0.0	0	0.0	0	0.0	1	10.0
Tepelenë	1	0	0.0	0	0.0	0	0.0	0	0.0
Tropojë	1	0	0.0	0	0.0	0	0.0	0	0.0
Vlorë	17	0	0.0	4	23.5	2	11.8	15	88.2
<b>Total</b>	<b>130</b>	<b>1</b>	<b>0.8</b>	<b>28</b>	<b>21.5</b>	<b>8</b>	<b>6.2</b>	<b>80</b>	<b>61.5</b>

Note: The overall stock out situation has improved. We notice very low stock outs of Low Dose. Also, condom and POP stockouts are decreasing (a very big decrease in POP stock out is expected next quarter because all the districts were supplied with POP during end of February and beginning of March 2006).

**APPENDIX D**  
**Detailed Summary of Providers Trained by AFPP**  
**January - March 2006**

Permet district				
Urban area			Ob-Gyn	N/M
	WCR	3	0	3
	Maternity	3	1	2
Rural area – Commune Level			FD	N/M
HC	Ballaban	2	1	1
HC	Carshove	3	1	2
HC	Frasheri	2	1	1
HC	Fshat Kelcyre	3	1	2
HC	Kasine	2	1	1
HC	Kelcyre	3	0	3
HC	Komuna Q.P.	1	1	0
HC	Petran	1	1	0
HC	Suke	2	1	1
Village level				
Ambulanca	Gjinkar	1	0	1
Ambulanca	Gorice	1	0	1
Ambulanca	Kaluth	1	0	1
Ambulanca	Komarake	1	0	1
Ambulanca	Lene	1	0	1
Ambulanca	Leshice	1	0	1
Ambulanca	Mokrice	1	0	1
Ambulanca	Ogren	1	0	1
<b>District Total trained</b>		<b>33</b>	<b>9</b>	<b>24</b>

Tepelene district				
Urban area			Ob-Gyn	N/M
	WCR	1	0	1
	Maternity	2	1	1
Rural area - Commune Level			FD	N/M
HC	Buz	1	1	0
HC	Luftinje	2	1	1
HC	Komuna QenderT	2	1	1
HC	Krahes	2	1	1
HC	Memaliaj	3	0	3
HC	Memaliaj qender	2	1	1
HC	Progonat	1	0	1
HC	Qesarat	3	1	2
HC	Lopes	2	1	1
Village level				
Ambulanca	Dames	1	0	1
Ambulanca	Dhemblan	1	0	1
Ambulanca	Gusmar	1	0	1
Ambulanca	Lulezim	1	0	1
Ambulanca	Martaloz	1	1	0
Ambulanca	Nivice	1	0	1
Ambulanca	Veliqot	1	0	1
Ambulanca	Xhafaj	1	0	1
<b>District Total trained</b>		<b>29</b>	<b>9</b>	<b>20</b>



GHS -I-00-03-00026-00



MINISTRY OF HEALTH

# QUARTERLY PROGRESS REPORT

April 1 – June 30, 2006



## Albania Family Planning Project 2004 – 2006

July 2006



The Albania Family Planning Project is implemented by John Snow, Inc. in collaboration with The Manoff Group

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## ACRONYMS

<b>AFPP</b>	<b>Albania Family Planning Project</b>
<b>ACSP</b>	<b>Albanian Child Survival Project</b>
<b>ARC</b>	<b>American Red Cross</b>
<b>BCC</b>	<b>Behavior Communication Change</b>
<b>BP</b>	<b>Blood Pressure</b>
<b>CS</b>	<b>Contraceptive Security</b>
<b>COC</b>	<b>Combined Oral Contraceptive</b>
<b>CYP</b>	<b>Couple of Year Protection</b>
<b>FP</b>	<b>Family Planning</b>
<b>FY</b>	<b>Fiscal Year</b>
<b>GP</b>	<b>General Practitioner</b>
<b>HC</b>	<b>Health Center</b>
<b>HIS</b>	<b>Health Information System</b>
<b>HMIS</b>	<b>Health Management Information System</b>
<b>IEC</b>	<b>Information Education Communication</b>
<b>IPH</b>	<b>Institute of Public Health</b>
<b>IUD</b>	<b>Intrauterine Device</b>
<b>JSI</b>	<b>John Snow, Inc.</b>
<b>LMIS</b>	<b>Logistic Management Information System</b>
<b>Manoff</b>	<b>JSI subcontractor for BCC</b>
<b>MCH</b>	<b>Mother and Child Health</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MT</b>	<b>Master Trainers</b>
<b>MWRA</b>	<b>Men and Women of Reproductive Age</b>
<b>NM</b>	<b>Nurse Midwife</b>
<b>PHC</b>	<b>Primary Health Care</b>
<b>PHD</b>	<b>Public Health Directory</b>
<b>PM</b>	<b>Project Manager</b>
<b>PMP</b>	<b>Performance Management Plan</b>
<b>POP</b>	<b>Progesterone Only Pill</b>
<b>RH</b>	<b>Reproductive Health</b>
<b>RHU</b>	<b>Reproductive Health Unit</b>
<b>RT</b>	<b>Regular Trainers</b>
<b>SDP</b>	<b>Service Delivery Points</b>
<b>STI/HIV</b>	<b>Sexual Transmitted Infection/ /Human Immunodeficiency Virus</b>
<b>TIP</b>	<b>Trial of Improved Practices</b>
<b>UNFPA</b>	<b>United Nation Fund Population Aid</b>
<b>URC</b>	<b>University Research Corporation</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>VNM</b>	<b>Village Nurse Midwife</b>
<b>WCR</b>	<b>Women Consultancy Room</b>

## EXECUTIVE SUMMARY

AFPP continued the intensive **implementation phase** this quarter -- April 1 to June 30, 2006 -- for all three components of the Albania Family Planning Project: Contraceptive Security, Family Planning Training and Behavior Change Communication.

In Logistics Management (LMIS) work, the Institute of Public Health (IPH) began to take over the management for the central warehousing and distribution of contraceptives. AFPP played an important role in this transition and helped make the warehousing and distribution work successful. This shifting of responsibility continues to go smoothly between AFPP and the IPH. In Albania LMIS work has many challenges and therefore this is seen as a step forward in contraceptive security in Albania.

Twenty-eight new Family Planning service delivery points were added to the MOH system this quarter, and all of the new sites reported LMIS data for the first time. With these additional sites the total number of LMIS reporting units reached 188. This is the final number in this stage of FP extension, showing that AFPP has reached its target.

Follow-up Family Planning (FP) activities were carried out in the two districts of the sixteen target districts. Additionally, three more districts were trained in this quarter, bringing the total number of trained districts up to 16.

In our BCC work, television spots aired for a second round this past quarter. Some of these additional spots have been aired at a reduced cost with a support letter from the MoH vice Minister. The spots were aired between May 1 and June 18, 2006.

During this quarter, AFPP solidified its good working relationships with ProShedetit, the Ministry of Health and the Institute of Public Health, all of which are participating as active partners with AFPP. Also, all of these partners are working on varying Family Planning activities which reflects a strong relationship among the Family Planning partners working in Albania.

## PERFORMANCE MANAGEMENT PLAN (PMP)

<b>SO 3.2: Improved Selected Health Care Services in Target Areas</b>						
<b>Indicator</b>	<b>Indicator Definition and Unit of Measure</b>	<b>Data Source/ Frequency</b>	<b>Disaggregation</b>	<b>Person Responsible</b>	<b>Baseline (Year)</b>	<b>Last Quarter (Jan.-March, 2006)<sup>7</sup></b>

<sup>7</sup> The figures of the last quarter have also been updated from the latest LMIS reports.

% of service delivery points providing family planning services	# of SDPs with commodities, trained provider(s), IEC materials/ total # of SDPs  SDP's = 440 MOH facilities (Maternities, WCRs, HCs); 300 currently providing FP and 140 additional sites will provide FP services Unit: %	LMIS Reports; project reports  Quarterly	16 Project Districts	LMIS Officer	0 % (2004 LMIS)	84.86% (157/185)
			National		68 % (2004 LMIS)	93.61% (425/454)
Couple years of protection (CYP) *	Total number of contraceptives distributed by type (method) in a given period with weights applied to different methods.  1 CYP = 15 Packets Oral Pills 1 CYP = 4 Depo Injections 3.5 CYP = 1 IUD 1 CYP = 120 Condoms Unit: #	LMIS Reports  Quarterly	16 Project Districts	LMIS Officer	774 per quarter (2004 LMIS)	1328.5
			National		3,750 per quarter (2004 LMIS)	4732

\*When calculated annually means average quarterly CYP

<b>IR 1: Health resources efficiently managed</b>								
<b>Indicator</b>	<b>Indicator Definition and Unit of Measure</b>	<b>Data Source/ Frequency</b>	<b>Disaggregation</b>	<b>Person Responsible</b>	<b>Baseline (Year)</b>	<b>Last Quarter (Jan.-March. 2006)<sup>9</sup></b>		
<b>Sub IR1.2: Health information systems improved</b>								
% of service delivery points stocked out of condoms, POP, injectables and low dose contraceptives in 16 target districts	# of SDPs reporting zero stock of specific commodities/ # of SDPs reporting  Unit: %	Routine LMIS Reports  Quarterly	Project 16 districts	LMIS Officer				
			Condoms				28 %	6.2 %
			POP				64 %	62.0 %
			Low dose				22 %	0.8 %
			Injectables		14 %	20.9 %		
<b>IR 2: Quality of PHC services improved</b>								
<b>IR2.2: Skills of PHC providers enhanced</b>								
% of SDPs in 16 target districts with staff trained using national FP curriculum	# of SDPs in target districts with at least one staff person trained using national FP curriculum/ total # SDPs in intervention districts	Training Records; Quarterly	<b>By type of SDP:</b> Maternity	Training Officer	0 %	81.3% (13/16)		

<sup>8</sup> The denominator of this indicator was adjusted upwards from 185 to 188 because there are 3 more SDPs more than originally planned (1 SDP in Kukes, 1 SDP in Has and 1 SDP in Tropoje)

<sup>9</sup> The figures of the last quarter have also been updated from the latest LMIS reports.

	SDP = MOH facilities (maternities, WCRs, health centers) Unit: %		WCR		0 %	100% (18/18)
			Health Center		0 %	83.4% (126/151)
			<b>By cadre:</b>			
			Doctors		0 %	68.9% (124/180)
			Nurses/ midwives		0 %	89.2% (330/370)

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<sup>10</sup> Denominator is corrected from 180 to 173 because 16 out 21 WCR had not Ob-Gyn provider working there

<sup>11</sup> There are trained 14 N/M more than initial target because of local health services need for trained providers to offer FP services

**IR3.3: Community participation in health promotion activities increased**

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (Jan.-March. 2006) <sup>1</sup>
% of villages which have FP service provided by at least one community midwife in 16 districts	# of villages which have FP service provided by at least one community midwife in 16 districts / total # of village in the 16 districts  Unit: %	Training Records;  Quarterly	16 Project Districts	Training Officer	0	16.34% (217/1328)

## II. SUMMARY OF MAJOR ACTIVITIES THIS QUARTER

### A. Project Management

Planned Action	Status at End of Quarter	Comments
Maintain effective communication with USAID and JSI Headquarters	Ongoing	<p><b>USAID:</b> AFPP maintains good communication with USAID by delivering materials on schedule, minimizing the administrative burden placed on the Mission, regularly updating USAID and inviting Mission representatives to participate in project activities.</p> <p><b>JSI HQ:</b> AFPP has regular and frequent communication with JSI headquarters.</p>
Submit deliverables on schedule	Done	<ul style="list-style-type: none"> <li>• Weekly reports</li> <li>• Ongoing reports</li> <li>• Press Package</li> <li>• BCC Second Media Recall Survey</li> </ul>

### B. Programmatic Activities

Component 1: Contraceptive Security	Status at End of Quarter	Comments
Support MOH implementation of the National Contraceptive Security Strategy 2006	Ongoing	After having submitted the Contraceptive Security Strategy Report 2006, a FP roundtable was held where the contraceptive security was the pivotal theme. MoH and IPH focused their discussion on the importance of Contraceptive Security priorities set on the April 2006.
Provide ongoing technical support to the LMIS	Ongoing	AFPP assisted the IPH and MoH in the process of managing and successfully overcoming any barrier in the process of the LMIS in IPH as well as contraceptive storage and distribution.
Provide LMIS training in 16 districts	Ongoing	The completion of LMIS training (integrated with the overall FP training) in three districts Kukes, Has and Tropoje marked the moment that Albania have access in integrated FP and all providers are part of LMIS.
Component 2: Family Planning Training	Status at End of Quarter	Comments
Conduct Follow-up visits	Ongoing	Follow-up was accomplished in two districts trained in FP: Permet and Tepelene. The follow-up provides additional data regarding the outcome of Project interventions, assessment of the effectiveness of training, and provides on-the-job support and teaching when needed.

Conduct FP training for providers	Ongoing	<b>Kukes, Has and Tropoje</b> districts completed the FP trainings; a total of 90 MOH staff at 31 facilities were trained; also 15 (out of 60) community midwives in these districts were trained. A total of 16 districts have been trained to date.
<b>Component 3: Behavior Change Communication</b>	<b>Status at End of Quarter</b>	<b>Comments</b>
Collaborate with Proshendetit	On going	Proshendetit played an active role in drafting the TV spots scripts. They made their comments and gave their impressions through the pre-testing phase. Proshendetit and AFPP coordinated their activities to deliver FP brochures in districts where AFPP carried out trainings.
Airing the spots	Done	The FP TV spots aired from <u>1May – 18 June 2006</u> on Top Channel, Klan TV and TVSH (national TV) following a Media Plan, drafted on basis of the baseline survey.
Implement other media activities	On going	The BCC component has started to work on the " <b>call in</b> " shows about FP. There will be 2 shows of 75 minutes each registered and broadcasted by TVSH. <b>Community outreach workshop.</b> The purpose was to ensure that IPH, MOH, and all USAID-funded projects working in family planning and outreach collaborate fully to produce training and tools for behavior change outreach that all involved organizations will share. The project aims to communicate face-to-face FP messages to married women/couples.
Media recall survey	On going	A media recall survey was started on <u>12 June 2006</u> (it is ongoing), to measure the impact on beneficiaries and to have feedback for eventual adjustment in the next airing period.

**C. Consultant Visits During the Quarter**

Technical Area Being Supported	Name	Area of Specialty	Dates in Albania	Purpose Of Visit
<p><b>BCC Consultant</b></p>	<p><b>Laurie Krieger</b></p>	<p><b>Behavior Change Communication</b></p>	<p><b>June 4 - June 11, 2006</b></p>	<p>Worked with AFPP staff, to develop a detailed community outreach plan, including timeline, any additional materials needed, and any additional outreach worker and supervisor training needed.</p> <p>Worked with AFPP staff and virtually with Ms. Mary Lee Mantz to outline and begin development of additional training for outreach workers.</p> <p>Together with AFPP staff and Proshendetit decided on any new materials needed.</p>

### III. PROGRESS MADE THIS QUARTER

#### C. Contraceptive Security and LMIS

**Contraceptive Security:** Contraceptive Security has been a very important activity for AFPP. In the MoH roundtable on FP (Annex 1), organized by AFPP on June 7 – 8, the issue of contraceptive security was the pivotal theme, especially in the first plenary session. The MoH and IPH focused their discussion on the importance of Contraceptive Security priorities set in April 2006. Besides mentioning what was achieved to date – the most important being the MoH paying for 2006 and 2007 (paying for what? Commodities?) and shifting the process of LMIS to IPH – the discussion reinforced the rest of the priorities, especially the establishment of a Contraceptive Security Working Group (Technical Working Group) under RH Commission. Market segmentation was mentioned as an important study to carry out in order to better manage government resources. While discussing market segmentation, an interesting part of the discussion focused on the relation between Cost and CYP for the contraceptives distributed in the Public Sector. The MoH believes that more should be done in support of the long term contraceptives, such as the case of IUD which provide a very high CYP for a very low cost.

Last quarter, under MoH request, UNFPA began the necessary steps for procurement of the public system contraceptives which are projected to be sufficient for the next two years. Depo-Provera - one of the contraceptives from this procurement - is planned to arrive by July 2006. UNFPA is working to make make possible the arrival of the rest of this procurement as soon as possible.

**LMIS in the Institute of Public Health.** AFPP is working closely with IPH to ensure contraceptive availability, forecasting and distribution in the MOH - LMIS system. The MOH Reproductive Health Unit retains responsibility and authority for MoH contraceptives but LMIS operations now fall under IPH. LMIS data continues to be supervised by the RHU to maintain contraceptive availability at all government health facilities, and all policies regarding LMIS will continue to be made by the RHU. At the last MoH roundtable many of the presentations focused on the new role of IPH in taking over the LMIS. IPH representatives shared their ideas for achieving this new role. The IPH was chosen because of their availability of human resources, technical expertise and other administrative support. Coping with the reporting demands in relation to time, accuracy and quality was a very important issue when assessing the technical expertise of IPH. Reporting problems have played a major role in the on-going problem of stock-outs. Representatives of the MoH noted that a very important role in this process has to be played by the district director. To get more involved in monitoring of this process, MoH will soon issue a guideline for the role of director of PHD. Through this they will have to be more responsible for the reports generated from the local to the central level.

**Contraceptive quantity forecast:** Last quarter by MoH request, UNFPA procured contraceptives for the public system which are projected to be sufficient for the next two years. Depo-Provera - one of the contraceptives from this procurement - is planned to arrive by July 2006. The rest of this procurement is expected to arrive in Albania by October 2006. Based on this, the contraceptive situation in upcoming months is as follows:

**COC (Rigevidon):** Contraceptive quantities distributed in the last quarter (April-June) were not able to sufficiently supply districts with the required rigevidon. This happened because

the stock in the central warehouse was not properly stocked to meet the districts requirements District warehouses are now stocked out as they have distributed all of their supplies to the SDPs, and this supply is projected to meet public demand only until the end of July.

**Condom:** All districts were sufficiently supplied for the reported quarter. However, the current quantity remaining in the central warehouse will be insufficient for the upcoming quarter. This current supply will cover only half of the districts' needs for contraceptives. It seems there will be a stock-out if the procured quantity does not arrive by beginning of August 2006. From UNFPA's information, the procurement could possibly arrive in August 2006.

**Injections:** All the SDPs were in short supply of injections (Depo-Provera) for the last two quarters. 16,000 vials did arrive to the IPH warehouse on the 15th of June. All districts received the quantities they had requested. This latest procurement and the expected delivery in July will ensure adequate stock for the next two years.

**Microvale (POP):** The last procurement of this arrived in January 2006 and there should be a sufficient supply for the next three years or more.

During this quarter, LMIS expanded into the last five districts: Tepelene, Permet, Kukes, Has and Tropoje. Table 1 shows that in the five targeted districts for this quarter, 34 new SDPs began providing FP services and reporting LMIS data.

**Table 1: New FP Service Delivery Points in Districts this Quarter**

Targeted Districts for this Quarter	# of Service Delivery Points (SDPs) part of LMIS during 2004	# of SDPs part of LMIS system at the end of the reporting quarter
Tepelene	1	11
Permet	1	10
Kukes	1	15
Has	1	4
Tropoje	1	8
Puke	10	1
<b>Total</b>	<b>15</b>	<b>49</b>

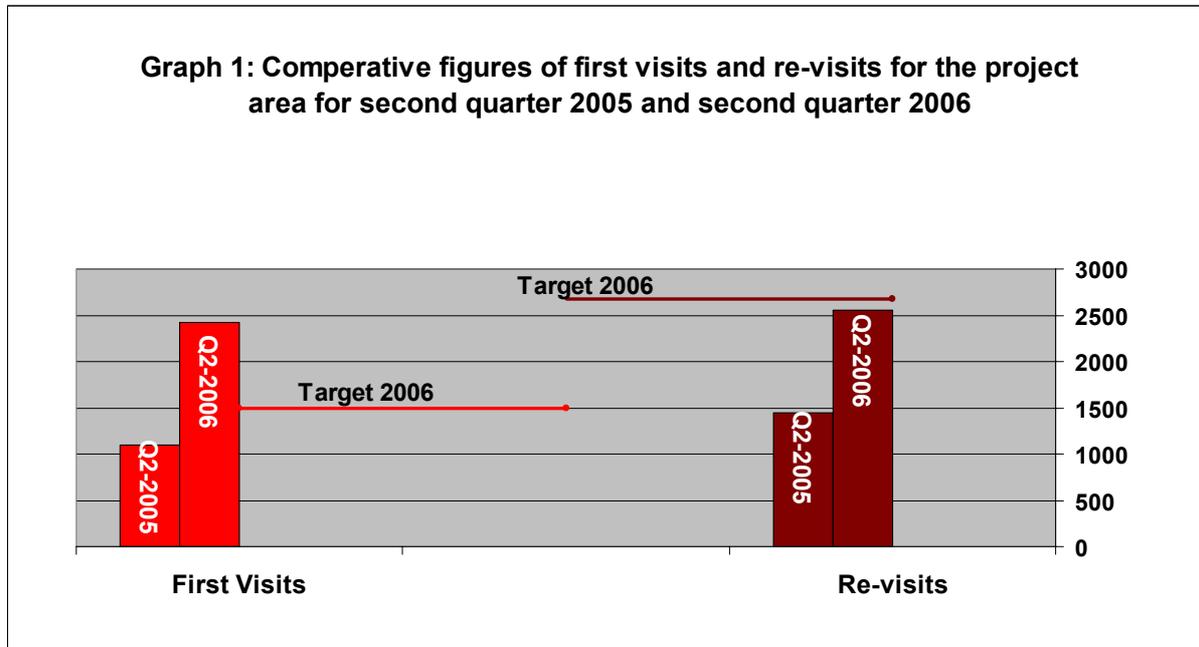
*Source: LMIS*

As mentioned above, with the shift of the LMIS responsibility to IPH, the Information System is managed from IPH. The reporting rate achieved for this quarter is 96.7 % for the project area and 92.3 % at the national level.

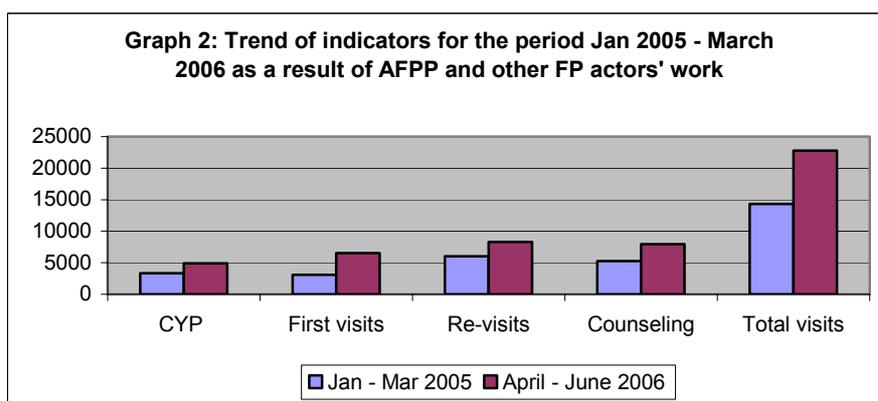
% of FP service delivery points reporting LMIS data this quarter	In sixteen (16) project districts	96.7 %
	In all FP SDPs in Albania	92.3 %

Based on the above reporting rate the indicators produced from LMIS show the following results.

**Use of FP Services:** Comparing the figures from the last two years of the same quarter we see that first visits and re-visits in the AFPP focus districts is increasing significantly and achieving targets established at the beginning of the project.

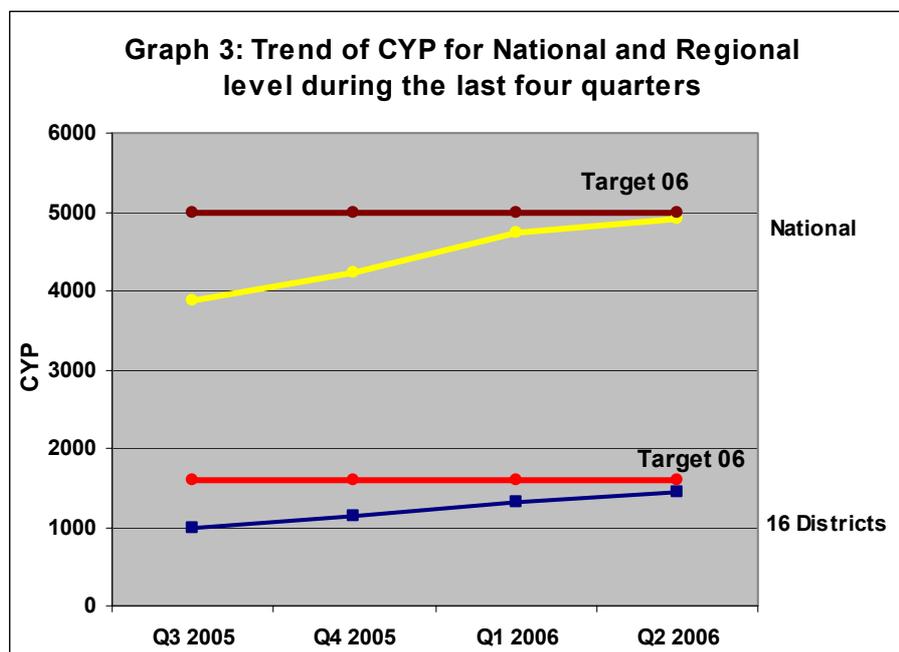


The first visits have increased beyond the target set. The new visits for the non-project area has increased by 75% for the same period, as compared to the increase on first visits in project area has been 150%. The main reason for this is the expansion of FP services in new SDPs in non-covered areas. Also, another contributing factor is other FP intervention affecting the demand, such as a heavily mass media intervention.



**Couple Years of Protection:** CYP is showing a steady increase, both in the project area and nationally. The project area CYP increase of 68% is more significant than the national CYP increase of 36% as the project area has doubled the number of new SDPs offering FP services (from 92 to 180 SDPs). As a result of AFPP intervention and support activities, the CYP has significantly increased in all districts, even though the reporting increased this quarter

(9.55%) compared with the previous quarter (3.8%). CYP is calculated using LMIS data, so the increased LMIS reporting rates contributed to the upward CYP trend.



**Contraceptive Stockouts.** The data below shows that stock-outs remain a chronic problem for the MoH.

Table 2: Stockouts in 16 AFPP Districts						Target 2006
	Q2 2005	Q3 2005	Q4 2005	Q1 2006	Q2 2006	
<b>Low dose</b>	15.6%	10.9%	5.1%	0.8%	34.5%	10%
<b>Injectable</b>	17.8%	10.9%	10.2%	21.5%	50.6%	10%
<b>Condoms</b>	25.6%	19.6%	7.6%	6.2%	9.2%	10%
<b>POP</b>	62.2%	64.1%	75.4%	61.5%	37.9%	10%

Source: LMIS

It seems that stock-out is the main problem in offering FP services in the public sector. In previous quarters we have seen a decrease in stock-outs for Low Dose and Injectables. But the situation worsened this quarter. This quarter Albania saw a stock-out on the national level for these methods. Actually all Depo-Provera is already distributed throughout the country in all Public Health Directories from IPH with the support of UNFPA and AFPP. The result which show still a high stock out comes as the district staff have not been able to distribute the contraceptives received until the last point of the chain (SDPs – the end point of reporting unit).

The most critical cases for the upcoming quarter are the stock-levels for condoms and pills (LoFemenal). As mentioned above, the actual remaining stock in the central warehouse will be insufficient, the supply will cover only half of the districts' needs for condoms, while there is no stock of COC in the warehouse for the upcoming quarter. It seems Albania will face stock-outs if the procured contraceptives do not arrive by the beginning of August 2006. UNFPA is working to make sure the shipment will come as soon as possible.

In order to not face the same problems in the upcoming years, the MoH has to complete with more anticipation the financial procedures needed to keep consistent supplies. Also, IPH in

their role of supporting LMIS, needs to be more familiar and take more responsibility in the daily work of LMIS. With the latest developments, it is obvious that more coordination and communication is needed among the actors involved.

#### **Next Steps for the Contraceptive Security Component:**

- Carry out the Market Segmentation Study with help from a DELIVER consultant.
- Assist the MoH in implementing and focusing the contraceptive security strategy.
- Assist IPH in the daily work of LMIS.
- Analyze and discuss with IPH staff lessons learned from the last two quarters data.

#### **B. Family Planning Training**

There were two main activities in component during this quarter:

- FP Training
- Follow Up

**Family Planning Training:** Family Planning training continues to proceed on schedule according to the roll-out plan (Appendix A). The districts in which the training was carried out this quarter are: Kukes, Has and Tropoje, which hold 11.36% of the total population of Albania. The majority of the providers trained were from health centers, as most of the population in these districts live in rural areas.

Kukes, Has and Tropoje were the last three districts in the project area that remained to be trained. 99.9 % of the population in the AFPP project area (16 districts) are now covered by FP providers.

Improvement of training tools was focused on during this quarter. One change was on the cover page of Counseling cards for Family Planning clients. The USAID logo was replaced at the left lower corner of the cover page and the MoH logo was added at the right lower corner of cover page and national FP logo was emphasized.

On the back side of the cover page, the contents of the Cue cards, who prepared Cue cards and goal of AFPP was added.

#### **Figure 1: Cover and Back page of Cue Cards as revised during the reporting quarter**

**Kartat Udhëzuese për Këshillimin e Klientëve**  
Planifikimi Familjar i Integruar

**USAID**  
NGA POPËLËN AMERIKAN

**MINISTRIA E SHËNDETËSISË**

**Planifikimi i Kartave Udhëzuese:**

	Faqe
Spërthësi Injektiv e Metodatë Këmbësore të Planifikimit Familjar (IPITNGK) .....	2
Kontracetivët Oralë të Kurorësuar me Dosis të Lartë (KODL) .....	6
Kontracetivët Oralë të Ujshëmë (KOU) .....	9
Metodatë Veshës me Progjesteron – Injektionë (DIPG) .....	10
Metodatë Veshës me Progjesteron – Pëlhurë (PVP) .....	14
Plasë për Mëshirën Lartur me Kontracetivët Oralë .....	17
Si Mund të Thuhet një Grupë që nuk është Shprehur .....	18
Shërbime (SjS) .....	19
Metodatë Udhëzuese Veshës me Sij (UVS) .....	21
Metodatë Barientë – Prezervativë Mashtullorë .....	23
Metodatë e Dëshmë Barientë (MDS) .....	25
Metodatë e Mëshirësme – Shërbime Mashtullorë dhe Familjarë .....	27

\*Ky publikim është i mundësuar me mbështetjen logjike të Agjencisë Ndërkombëtare të Shëndetit të Botës për Zhvillim Njerëzor (UNFPA). Përkrahja e shprehur në 188.000\$ nuk përfshijë kompenzimin për shërbime të Agjencisë së Shëndetit të Botës për Zhvillim Njerëzor në të "Qendrat e Shëndetit të Botës"."

To date, the total number of SDPs covered with FP training and LMIS integrated systems has reached 188. Twenty eight (28) were new sites added this quarter where the FP services had not previously been provided. Table 3 shows the type of SDPs with staff trained and supplied with FP commodities this quarter. One remaining SDP from the Puka district was trained during this quarter.

**Table 3: Service Delivery Points Covered During April - June 2006**

Districts	Number of SDP by Type			Total
	HC	WCR	Maternity	
<b>Kukes</b>	<b>14</b>	<b>1</b>	<b>1</b>	<b>16</b>
<b>Has</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>5</b>
<b>Tropoje</b>	<b>7</b>	<b>1</b>	<b>1</b>	<b>9</b>
<b>Puke</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>
<b>Total</b>	<b>25</b>	<b>3</b>	<b>3</b>	<b>31</b>

The Total number of staff trained during this reporting quarter is 98, including doctors, nurses/Midwives and other staff. To increase the sustainability of the FP program at the district level, AFPP trained two staff from Public Health Directorates whose duties include

the day-to-day supervision of family planning activities in their districts or the reporting of family planning statistics. Their total number in all three districts is 8.

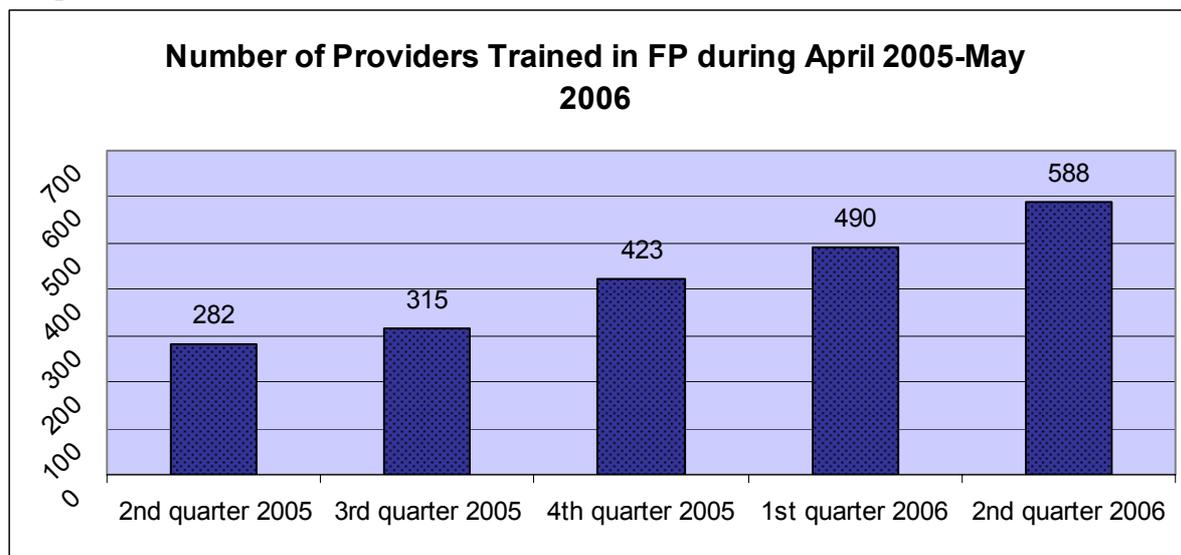
**Table 4: Total Number of Providers and Other Staff Trained, April - June 2006**

Districts	Providers		Others	Total
	Doctors (FP+Ob/Gy)	Nurse Midwife	Supervisors	
Permet	9	26	1	36
Tepelene	10	20	1	31
<b>TOTAL</b>	<b>19</b>	<b>46</b>	<b>2</b>	<b>67</b>

Of the 60 Nurse Midwives, 15 were a community midwife, which increases the community outreach of family planning information and service. Also, it strengthens the link between community midwives and local health centers providing FP services. AFPP is including a limited number of community midwives in FP training as a first step to extending FP services to the community level.

The cumulative increase in the number of providers trained over AFPP's project life is shown in the bar graph below.

**Graph 5**



The achievement of this process is clearly reflected in the PMP table, showing that training targets have been met or exceeded to date.

The following table shows the number of providers trained according to gender. The majority of providers trained (79 %) are female.

**Table 5: Total Number of Providers and Other Staff Trained, April-June 2006**

	Female	%	Male	%	Total
Family Doctors	6	23.08%	20	76.92%	26
Nurses	6	50.00%	6	50.00%	12
Midwives	48	100.00%	0	0.00%	48
Ob-Gyn.	2	50.00%	2	50.00%	4
Other (PHD staff)	5	62.50%	3	37.50%	8
<b>Total</b>	<b>67</b>	<b>68.37%</b>	<b>31</b>	<b>31.63%</b>	<b>98</b>

In order to evaluate change in knowledge after training, a simple pre - and post - test was used. The following table (no. 5) summarizes test scores (a perfect score = 20.)

<b>Table 6: Average Scores of Pre/Post Test by District and Profession (Maximum Score-20)</b>				
Profession	District	Pre-test score average	Post-test score average	Change in %
Family Doctors				
	Has	14.8	17.8	<b>+17</b>
	Kukes	12	16	<b>+25</b>
	Tropoje	13.5	15.5	<b>+13</b>
Midwives				
	Has	10.3	17	<b>+40</b>
	Kukes	11.7	15	<b>+22</b>
	Tropoje	11.7	17	<b>+32</b>
Nurses				
	Has	10	17	<b>+41</b>
	Kukes	10.6	14.4	<b>+26</b>
	Tropoje	11.8	15.8	<b>+26</b>
Ob-Gyn's				
	Has	15.5	19	<b>+19</b>
	Kukes	9	16	<b>+44</b>
	Tropoje	16	19	<b>+16</b>

Specific PMP indicators for this training component are shown below.

Indicators	Quarter 3 January-March 2006	Quarter 4 April-June 2006
<b>IR 2.2</b>		
% of SDPs in 16 target districts with staff trained using national FP curriculum	84.86% (157/185)	100% (188/188)
<b>By Type</b>		
% of Maternities in 16 target districts with staff trained using national FP curriculum	81.3% (13/16)	100% (16/16)
% of WCR in 16 target districts with staff trained using national FP curriculum	100% (18/18)	100% (21/21)
% of Health Centers in 16 target districts with staff trained using national FP curriculum	83.4% (126/151)	100% (151/151)
<b>By Cadre</b>		
% of Doctors in 16 districts trained with FP national curricula (GP+Ob-Gyn.)	77.3% (143/185)	100% (173/173)
% of Nurse/Midwives in 16 targeted districts, trained with FP national curricula	89.2% (330/370)	103.7% (390/376)
<b>IR 3.3</b>		
% of villages in 16 districts with one FP-trained community midwife	16.34% (217/1328)	19.50% (259/1328)

Fourteen **Nurse/Midwives** more than initial target are trained during this period because of local needs for trained providers being capable to offer FP services

**Follow-Up:** The purpose of the Integrated Monitoring & Evaluation Plan is to provide additional data regarding the outcome of Project interventions that currently have more quantitative (process) oriented indicators, rather than qualitative (outcome) indicators. Equally important is providing follow-up visits to facilities with trained Family Planning (FP) providers to provide on-the-job support and teaching when needed. In addition, Albania Family Planning Project (AFPP) has internal indicators (not usually reported to USAID/A quarterly) that help monitor the quality and effectiveness of interventions and the data collected and may be used for revising approaches and activities, providing feedback to the Project team and partners, and for the final report.

The Integrated M&E follow-up tools are divided into three main sources of data: Health Centre (HC) questionnaire, checking selected equipment and supplies/commodities, reviewing selected records; health provider questionnaire and administrating training post-test; observing provider-client visit and conducting client exit interview.

### Methodology

Sampling: The follow-up process had a two-stage sampling design.

First stage: Selection of the overall number of SDPs for each eligible district.

Project resources (human, financial, time) were stretched to meet the follow-up goals, and it was not possible to reach all trainees and health facilities. Due to these constraints, as a minimum, a convenience sample of *33% of the health facilities* and trained health providers was included in the assessment. A sample of health centers was drawn from each intervention district.

The training database was the source of information for sampling. This information includes the number of service providers trained on FP by the project, number and names of service delivery points (SDPs) with at least one service provider trained on FP (table 1).

Second stage of sampling: Selection of Service Delivery Points

Service delivery points were selected randomly through a “blind draw” process. This process was repeated for each district. Table 2 gives the sample of SDPs within each district. All service providers who were trained in family planning at each selected SDP were interviewed.

**Table 7. Number of Providers & Service Delivery Points Trained and Sampled by District**

	Permet		Tepelene		Totals	
	# trained	# sampled	# trained	# sampled	# trained	# sampled
<b>providers</b>	35	11	30	10	65	21
<b>SDPs</b>	11	4	11	4	22	8

Data collection

Data collection took place during a period of 8 days (12-20 July, 2006).

There was only one team composed of three interviewers that conducted follow-up in five districts, spending 1 day in each SDP sampled.

Data analysis

Data analysis was initiated by developing an electronic database in EpiInfo 2002. Data entry was done in parallel with data collection. In order to ensure correct results data cleaning was done before starting data analysis.

There are 21 provider interview records (denominator N=21) and HC monitoring records that is composed by two parts, first part has information about HC FP activities (N=10) and second part which has information about trained providers that work in HC (N=21).

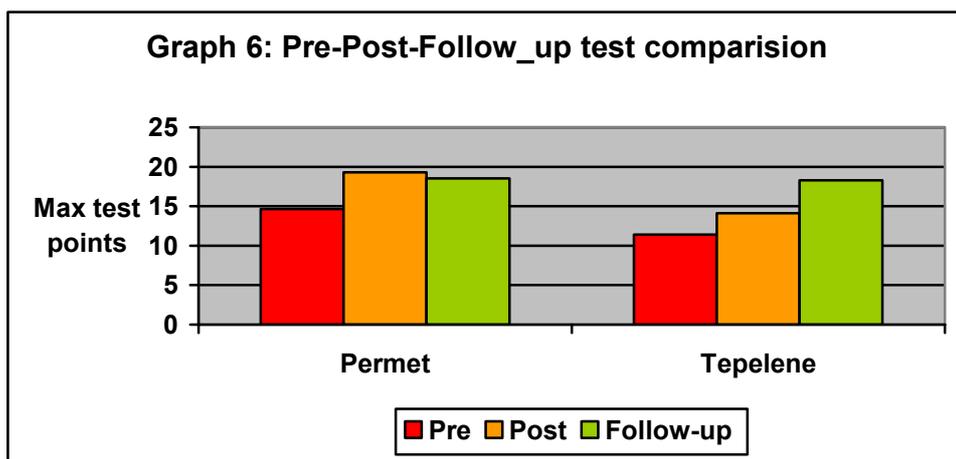
Key findings

There were 21 health providers interviewed, which included all providers who were trained in family planning at 8 selected SDPs.

Follow-up data indicates that the quality of FP service delivery has been greatly improved and expanded, and that the majority of providers’ skills and knowledge are very good. Client exit interviews and observation of counseling sessions confirm most results obtained from provider interviews. The main area of concern is a significant percentage of providers are not informing clients about whether their FP method provides protection from STI/HIV or not. This also was confirmed in client exit interviews. Based on this important issue and other previous follow-up findings, more

emphasis was given on the process of on-job-training and support to providers in this turn. Thus, we spend one full day in each SDP giving more time on-job-training, feedback to providers, daily and total feedback to local health authorities, helping them to build monitoring capacities by being part of follow-up team.

- Not all SDPs can provide clients with a method of their choice because of stock-outs with some methods; DepoProvera having stock-outs in 50% of SDPs. Stock-outs for Depo was expected because of stock-outs in the central level of this method. SDPs all over the country were in shortfall of injections (Depo-Provera) for the last two quarters. Lack of IUDs was appropriate in facilities that do not have a trained provider for insertion. There was supply with IUD in facilities with trained providers for insertion and can provide it any time they are requested. Although in the majority of facilities commodities were stocked according to expiration date and in a proper way to avoid damage there were 2 facilities that had outdated commodities in stock. During LMIS session in FP training, health providers were told to eliminate and not keep outdated commodities in stock. They had to report them as expired commodities and not as usable ones.
- FP records were available in 5 out of 8 SDPs, and all providers who deal with FP services measure and record BP for clients who chose pills, record type of method used and if the method was appropriate to client's medical history. 40% of providers do not record when the client should return to the clinic which can affect the quality of follow-ups for FP clients (Table 10). Of the 8 SDPs visited, 5 of them had FP records to be audited and 3 SDPs didn't have FP records to be checked because of lack of activity.
- Providers do state that Cue Cards are helpful when providing care to clients but actually only 83.3% of them use Cue Cards during the return client counseling. This rate increases to 94 % for new client counseling sessions.
- 93.3 % of the clients continued to use the method they had chosen. The low drop-out rate (6.7 %) may indicate an improvement in the quality of counseling. 100% of providers interviewed stated that if a client is already using a contraceptive method, they routinely ask whether she is satisfied with the method, has any question, problems or concerns. 93.8 of providers ask clients to repeat the important points to check their understanding of the method.
- The pre/post test used during training sessions was administered to health providers during follow-up. The results were significant as they showed that there was no significant decrease in knowledge of family planning gained during the training (compared to post-training scores).



- Providers were asked to demonstrate correct use of a condom in order to see if they are capable of counseling clients correctly. 38 % did not perform correctly the demonstration of the correct condom use. The main mistakes noted during demonstrations were: providers did not pinch the air from the tip of the condom before putting it on the male model and they did not explain that the man should pull his penis out of vagina before losing his erection. It is put more emphasis to correct condom use demonstration in order to correct mistakes noticed during follow-up visits. It happened that sometimes providers feel confident in this process but actually they do neglect some steps for correct condom demonstration. In most of the cases the interviewer explained and corrected mistakes and then the provider was able to demonstrate correctly and with confidence.
- The majority of providers responded correctly to interview questions on selected topics related to counseling clients on family planning methods. But, as in the other follow ups, there is a consistent mistake – not stating correct information with clients at risk for STI/HIV - a significant percentage (66.7 %) did not score well in this point. As part of the interview, all the providers stated that they always counsel clients on whether or not their family planning method offers protection from STI/HIV. Observation of client visits revealed that 82% of clients were told whether their method provided protection from STI/HIV. This means that 71.4% of providers explained to clients that only condoms provide protection from STI/HIV. Providing accurate information on reducing STI/HIV risk remain an area that will be highlighted in discussion with trainers and more emphasis will be placed on possible future trainings carried out from MoH. In these cases the interviewers provided immediate feedback to the providers and clarified what should have been correct responses and the importance of providing complete and accurate information during counseling sessions.

### General satisfaction

All providers stated that they feel confident to provide family planning services and 95 % (20 out of 21) stated that they feel comfortable in discussing family planning and issues related to sexuality with clients.

**Discussion of Findings:** As part of the follow-up assessments of facilities and providers, interviewers did on-the-job-training and took appropriate actions in order to try and resolve

problems faced in the field. Inspectors of Mother& Child of the respective districts were present at follow-up activities in order to increase their capacity to monitor family planning activities, provide support to providers, be more aware of the challenges faced by providers and facilities providing family planning services and help resolve problems (e.g. stockouts). For the first time they monitored two ambulances with regards to FP activities. In these particular villages there was no building for the ambulances. Community midwives used to keep their tools in a bag and went to client's household to provide their assistance. As a result they were not able to keep IEC materials.

#### **Next Steps:**

- Results/findings of the follow-up visits will be presented to and discussed with the master trainers. This will provide a forum for identifying the strengths of the trainings and areas that need strengthening.
- Client data (exit interviews and observations of counseling) is an important part of assessing the effectiveness of trainings and a good and effective family planning program. During the first round of follow-up visits there was not an opportunity to collect client data, so interviewers will return to as many sites as is feasible and make every effort to observe counseling sessions and conduct exit interviews. Findings of client data will be presented to and discussed with master trainers and the Program Manager to identify areas that need strengthening.
- Findings regarding LMIS will be shared with the Program Manager, LMIS Officer and IPH LMIS-responsible staff in order to plan next steps for the strengthening of problem areas (expired commodities, late or inaccurate LMIS reporting, lack of FP records and stock-out SDPs).
- Findings regarding IEC will be shared with the BCC Officer in order to plan further distributions of FP brochures.

#### **C. Behavior Change Communication**

**Broadcasting spots (1May – 18 June 2006):** Based on the Media Recall Survey data, the BCC component developed a new Media Plan for the broadcasting of the TV spots. The previous Media Plan (January – March 2006) succeeded in reaching women (68.4% of female respondents-mainly through soap operas) and on narrower scale the men (48.9%). Also the percentage of urban people who saw the spot was higher than that of the rural ones. The project decided to adjust the Media Plan, to include programs and TV stations which are more preferred for the less covered categories. TVSH has a good portion of male viewers and rural people in general at 20.00 o'clock, with the main news, so we inserted our spots before the main news. Also spots were aired around sporting programs and some very popular shows, aiming to enlarge the reached categories within our primary audience.

The May-June 2006 Media Plan may be found as an attachment to this report.

**Media Recall Survey:** The BCC specialist and the BCC advisor worked on the media survey tool, enhancing the part that directly measures our work indicators. The interviewers are performing another round of interviews in project districts with women and men who are part of our primary audience. From the survey the project will learn about the viewing of the BCC spots by men and women, by rural and urban etc. This will serve to adjust the future media plans of broadcasting. Women are reached mainly at the SDP level, so the analysis of their data will give proxy results of the actual level of the

indicators (percentage of MWRA-s exposed to at least one media material and percentage of MWRA-s able to state at least one FP message).

It is important to state that this media recall survey's findings are going to be presented for only two districts, that of Permeti and Tepelena where the first part of the study was conducted. There are three other districts in northern Albania that were the second part of the media recall survey is taking place. Thus two of the interviewers are collecting data on the districts of Has, Tropoje, and Kukes.

As it can be seen from the respondents, the number of the women respondents is fairly representative. A total of 140 respondents were reached during this phase of the Survey, (112 women and 28 men).

The most important findings of the Survey include:

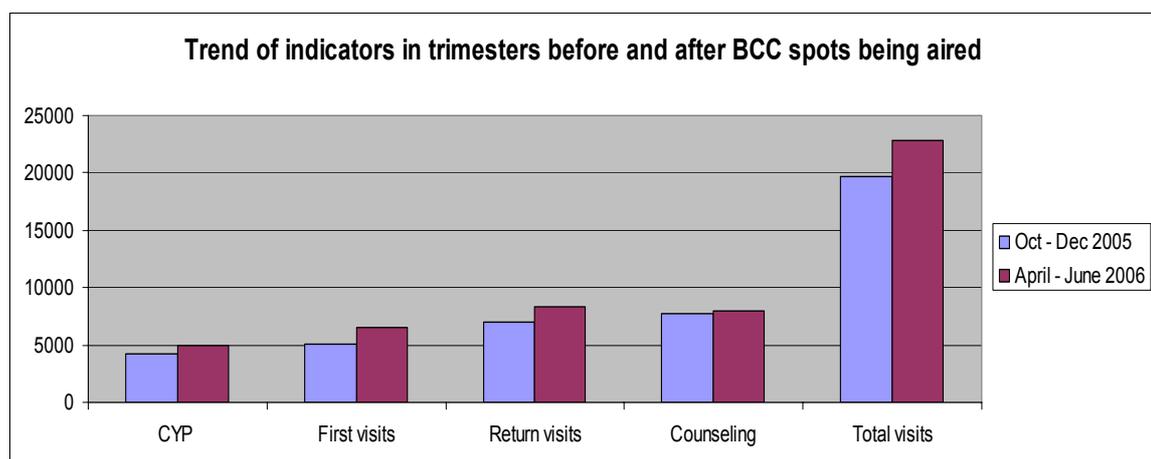
80% of the respondents had seen the at least one FP TV Spot and 20% did not see any FP TV Spot.

83% of women have seen at least one Family Planning TV Spot (42% the rural Spot, 48% the urban one and 10% have seen both spots R&U).

From those women who have seen a FP Spot 43% were able to state at least one FP message, 9% could state more than two messages and 43% could not state any message at all.

From those women who have seen the spot 87% of them had talked to somebody about the spot. 34% of them had talked to their husbands, 30% of them had talked to their friends, and only 6% of them had talked with the nurses and 17% to their sisters.

From the indicators taken through LMIS information we see that there is an increase of indicators from the period before to after the broadcasting the spot. More time is needed to see the results of these indicators but the increase is already obvious.



**Graph 7**

**FP Pins:** The project decided to produce FP pins, which depict the logo and the phrases: "Want more?" "Ask me..." The idea for the pin came out of the requests of community midwives. By the data we have, we know that there is still good logo recognition and high association with family planning and/or contraception. A badge that a provider can wear

would certainly reinforce our TV message that there are trained providers available and would also help with raising logo recognition even higher.

The badge was designed for AFPP, it was tested with FP service providers in villages and it will be produced in US. We expect to have them in our project next quarter.

**Figure 2: The shape and view of FP Pins**



**Press Package:** Family planning is not depicted by the press the way we would hope it to be. There are some sporadic articles which do not describe the actual situation of Family Planning service in country, do not offer up-to-date information regarding the properties and use of modern contraceptive methods, etc. This is due to a non-coordination of FP working agencies and Ministry of Health structures with the media. Additionally, it reflects the non professionalism of journalists and reporters that cover health issues on the other. The project has prepared a press package, which contains articles about Family Planning and modern contraceptive methods status in Albania, summaries of studies and surveys, counseling cards, etc. The project thinks that organizing a training event for the journalists who cover health issues in general and Family Planning ones in particular would be beneficial. The aim is to enable them to have a more realistic and professional presentation of these issues in their printed and/or electronic media.

**Call-in Shows:** Call-in shows are among the most important activities of the BCC component. The project decided to approach the TVSH Health show ("Trupi dhe shëndeti") for the audience and its good reputation. There will be two shows entirely dedicated to Family Planning and contraception. Two family planning specialists have already been contacted. They will be explaining modern contraceptive methods and discuss family planning issues. Also, viewers will be asked to post their questions to the program's box office and the FP specialists will answer their questions "live". In case not many questions come from the audience, the project has made-up some spare questions which are based on the research findings. The call in show will broadcast live and will coincide with the face-to-face communication pilot program.

**Piloting face-to-face communications:** The project aims to communicate face-to-face FP messages to married women and couples. The TIP-s phase of research showed that people can change their current behaviors if they are personally contacted and offered new behaviors, closer to ideal behaviors. The project plans to involve already trained

nurses and midwives in FP in the Fier and Dibër districts. With an additional training in BCC, these community health workers will be able to perform the TIP-s intervention with women and couples. The activities will be supported by TV programs (call-in shows and TV spots, and with Proshëndetit brochures. The project is currently working on the curriculum for the training in BCC of nurse/midwives and for the development of counseling cards, which they will need to carry out the work. The project has brought into the process all the actors that work at the community level for Family Planning. They will contribute towards the development of the training curriculum and counseling cards. After the results of the piloting program, the agencies would like to adopt TIP-s as part of their strategies for the community outreach, and to extend this methodology to a larger scale (more districts)

**BCC portion of Durrës workshop:** On June 7 and 8, the Institute of Public Health supported by AFPP, organized a Workshop about FP services and contraceptive security in the country. Even though the IEC/BCC was not a priority for this activity, a large amount of time and attention was dedicated to this component on the second day. AFPP, Proshëndetit and the American Red Cross presented their work in terms of IEC/BCC in their operation areas. The increased number of visits and contraceptive use in this period supports the effectiveness of the work done from the IEC/BCC components of each agency. Everyone agreed on importance of a powerful joint BCC intervention in country and the need for further coordination was largely discussed. The health promotion and education department within the institute of public health committed to playing a stronger role in coordinating the BCC activities, trying to bring together the actual strategies of each agency with the national strategy for Family Planning health education and promotion.

**Workshop for Community Outreach:** As the Durrës workshop ended, AFPP held another workshop on June 16, 2006. The purpose was to ensure that IPH, MOH, and all USAID-funded projects working in family planning and outreach collaborate fully to produce training and tools for behavior change outreach which all involved organizations will share.

*Objectives were:*

1. Agree on community outreach model for behavior change, including how it will connect with the LMIS and how distribution of commodities will be handled
2. Provide input to the development of training curriculum for community midwives and others
3. Provide input to the development of counseling cards
4. Constitute an Outreach Committee that will continue to provide feedback and will be involved in implementation.

*Participants were:*

1. Luiza Bardhi - Community nurse-midwife from Libofsh Commune - Fier
2. Bedrie Laze - Community nurse-midwife from Zharrez Commune – Fier
3. Brunilda Bacova – Head of Health Promotion Department, Fier District
4. Dhimitraq Stratoberda – Head Health Promotion Department, IPH
5. Ms. Lumturi Merkuri, Specialist of Health Promotion Department, IPH
6. Dr. Miranda Hajdini, LMIS responsible person – IPH

7. Elizana Petrela –Deputy Director, IPH
8. Enkelejda Pellumbi – Health promotion Specialist; MoH
9. Dr. Dorina Toçaj, Proshëndetit
10. Ms. Elda Hallkaj, Proshendetit
11. Mr. Fabian Cenko, ARC
12. UNFPA Representative
13. USAID Representative
14. Dr. Edi Oga, BCC specialist AFPP
15. Dr. Gazment Koduzi, training officer AFPP
16. Ms. Manuela Murthi, AFPP
17. Dr. Laurie Krieger, AFPP

The discussion started with the feasibility of the program, could the AFPP/MANOFF model for community outreach (TIP-s) be applicable from the nurse/midwives in the field?

The AFPP representatives explained the TIP-s process and the requirements for a fruitful performance. The participants agreed that upon a specific BCC/TIP-s training, nurse/midwives would be able to perform face-to-face communication. Contributions provided by the midwives from Fier were beneficial to this discussion.

The second issue was the adaptation of the methodology of the structures for other organizations which deliver FP health education and promotion. Proshendetit and ARC committed to adapting a version of a training curriculum for their health and promotion structures.

The session about recording data concluded by an agreement that a new register/notebook and a specific form are needed to record face-to-face activities. AFPP will produce these.

A longer discussion was dedicated to the challenges and difficulties that program implementation may face. Topics were driven by the nurses/midwives, the level of corruption, the ways of delivering contraceptives up to village level. Solutions were suggested by the participants and they will be applied when the program is implemented.

AFPP introduced the counseling cards and the participants offered their input in refining them. The rest of the counseling cards will be prepared by a BCC expert and AFPP specialists with the participation of all the FP organizations present at the meeting.

Important input was given from the participants regarding the training curriculum, especially from the Fier midwives. They suggested what a nurse/midwife would need the most in terms of counseling skills and all that will be made part of the training curriculum.

The Health Education and Promotion Department at IPH committed to playing a major role in the preparation process and will work to include the TIP-s methodology in the national outreach strategy.

The final session was the constitution of the Outreach Committee. Members of all the agencies present agreed to meet frequently and to work together at every step.

#### Next steps

- Develop BCC training curriculum and counseling cards for community outreach
- Train nurses/midwives for TIP-s in Fier and Diber
- Broadcast the call-in shows
- Broadcast BCC TV spots
- Train journalists and deliver press package

#### IV. SUMMARY OF KEY MEETINGS/ACTIVITIES

**Meeting with MoH Vice Minister – Zamira Sinoimeri:** The Vice Minister confirmed that the round table on FP and the participation of all FP actors is important and valuable in getting the actual status of FP. Also, it allows the FP actors to discuss and share their views regarding future challenges in FP.

**MT Meeting:** This meeting is the quarterly meeting with Master trainers (MT) in order to discuss about past activities, results and planning further steps. This quarter, meeting with MTs focused on improving training sessions in order to have greater impact and higher output. Outcomes of follow-up visits were presented to the MTs. Some points of improvement were discussed, like the presentation of FP history to participants, better explanation of FP concepts, more use of effective participatory training techniques, and be more supportive in the engagement of new trainers in training process. Next steps were discussed with the MTs regarding training in three remaining districts and follow-up in five remaining districts.

**Meetings with Agim Shehi & Nedime Ceka – PHC Directory MoH:** This meeting tried to touch on different ongoing issues such as contraceptive, training issues, discussion of data from the previous quarter and the work should be done to improve them. An important part of the meeting has been those meetings held prior to and after the workshop. Assisting and helping IPH to overcome the problems that they face in the field and giving them their due time to understand the complexity of the problem were other issues brought up for discussion. The Director promised to look for some ways to improve LMIS, especially by making the districts structures a priority.

**Participation in the workshop organized by URC on the possible initiatives and further interventions in HISs. (April 12-13):** One of the objectives of this workshop was to explore the possible cooperation of different partners and resources for better development of HMIS. In this context AFPP discussed the possibilities to synchronize the elements of it with LMIS.

The main important points of AFPP presentation were:

Stages for link of LMIS with HMIS

- First phase - Link part of it
  - Produce the output
  - Comparing system outputs
  - Coordinate the human resource
  - Define flow-information chart
- Second phase- Integrate
  - Work to manage stock

**APPENDIX A**

**AFPP Plan of Activities, January – March 2006**

**Training Activities for Next Quarter, April – June 2006**

## AFPP Training Plan of Activities, April - June 2006

APRIL	Weeks																														
	5							6							7																
	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
KUKES															1 <sup>st</sup>																
KUKES																															
MAY	Weeks																														
	9							10							11																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
HAS																															
TROPOJE																															
JUNE	Weeks																														
	14					15					16																				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PERMET																															
TEPELENE																															

- FP Training
- Weekend
- Follow-Up
- Holidays

## AFPP Follow-Up Plan of Activities for Next Quarter, July - September 2006

Districts	July (Weeks)													
Follow-up activities	29						30							
	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Kukes														
Has														
Tropoje														

- Follow-Up
- Weekend

**APPENDIX B**  
**AFPP Media Plan, April - June 2006**

**01 - 07 MAY 2006**

BCC	Monday - 01/05/06			Tuesday - 03/05/06			Wednesday - 03/05/06			Thursday - 04/05/06			Friday - 05/05/06		
	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program
Top Channel										U	19.00	Soap Opera	U	17.00	Soap Opera
				U	22.20	Before News									
Klan				R	16.15	Soap Opera				U	16.15	Soap Opera	R	16.15	Soap Opera
				R	19.30	Before News	R	17.00	Before News	R	23.00	Before News			
TVSH				R	20.00	Main News				R	17.00	Health Program			

**08 - 14 MAY 2006**

BCC	Monday - 08/05/06			Tuesday - 09/05/06			Wednesday - 10/05/06			Thursday - 11/05/06			Friday - 12/05/06		
	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program
Top Channel				U	17.00	Soap Opera							U	19.00	Soap Opera
				U	16.15	Soap Opera				R	16.15	Soap Opera	R	16.15	Soap Opera
Klan	R	19.30	Before News				R	17.00	Before News	U	23.00	Before News			
	R	20.00	Main News				R	20.00	Main News	U	17.00	Health Program	R	20.00	Main News
TVSH															

**15-21 MAY 2006**

BCC	Monday - 15/05/06			Tuesday - 16/05/06			Wednesday - 17/05/06			Thursday - 18/05/06			Friday - 19/05/06		
	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program
Top Channel				U	17.00	Soap Opera	U	17.00	Soap Opera						
										U	22.20	Before News			
Klan				R	16.15	Soap Opera				R	16.15	Soap Opera	R	16.15	Soap Opera
	U	19.30	Before News				R	17.00	Before News	R	23.00	Before News			
TVSH				U	20.00	Main News				R	17.00	Health Program			

**22- 28 MAY 2006**

BCC	Monday - 22/05/06			Tuesday - 23/05/06			Wednesday - 24/05/06			Thursday - 25/05/06			Friday - 26/05/06		
	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program
Top Channel				U	19.00	Soap Opera	U	17.00	Soap Opera						
										U	22.20	Before News			
Klan				R	16.15	Soap Opera				R	16.15	Soap Opera	R	16.15	Soap Opera
	R	19.30	Before News				R	17.00	Before News	R	23.00	Before News			
TVSH	R	20.00	Main News				R	20.00	Main News	R	17.00	Health Program	U	20.00	Main News

**29 MAY – 4 JUNE 2006**

BCC	Monday - 29/05/06			Tuesday - 30/05/06			Wednesday - 31/05/06			Thursday - 01/06/06			Friday - 02/06/06		
	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program
Top Channel				U	17.00	Soap Opera	U	19.00	Soap Opera				U	17.00	Soap C
	U	22.20	Before News							U	22.20	Before News			
Klan				R	16.15	Soap Opera				R	16.15	Soap Opera	R	16.15	Soap C
	U	19.30	Before News				R	17.00	Before News	R	23.00	Before News			
TVSH				R	20.00	Main News				R	17.00	Health Program			

**5 – 11 JUNE 2006**

BCC	Monday - 05/06/06			Tuesday - 06/06/06			Wednesday - 07/06/06			Thursday - 08/06/06			Friday - 09/06/06		
	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program
Top Channel	U	17.00	Soap Opera				U	19.00	Soap Opera				U	17.00	Soap
										U	22.20	Before News			
Klan				U	16.15	Soap Opera				R	16.15	Soap Opera	R	16.15	Soap
	R	19.30	Before News				R	17.00	Before News	U	23.00	Before News			
TVSH	U	20.00	Main News				R	20.00	Main News	U	17.00	Health Program	R	20.00	Main

**12-18 JUNE 2006**

BCC	Monday - 12/06/06			Tuesday - 13/06/06			Wednesday - 14/06/06			Thursday - 15/06/06			Friday - 16/06/06		
	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program	U/R	Time	Program
Top Channel				U	17.00	Soap Opera							U	19.00	Soap C
										U	22.20	Before News			
Klan				R	16.15	Soap Opera				U	16.15	Soap Opera	R	16.15	Soap C
	U	19.30	Before News				R	17.00	Before News	R	23.00	Before News			
TVSH				U	20.00	Main News				R	17.00	Health Program			

 Urban Spot (59 times)

 Rural Spot (79 times)

**APPENDIX C**  
**Contraceptive Stock Out and LMIS Reporting Summary**

**Percentage of SDP's in AFPP Districts Reporting LMIS Data, April 2006**

<b>District</b>	<b>Total of SDP's</b>	<b>Reported SDP's</b>	<b>% of reported SDP's</b>
Delvinë	5	5	100
Devoll	6	6	100
Dibër	16	16	100
Fier	19	19	100
Has	5	5	100
Kolonje	8	8	100
Kukës	16	15	93.8
Lezhë	11	10	90.9
Lushnje	17	16	94.1
Mirditë	8	8	100
Përmet	11	11	100
Pukë	11	10	90.9
Skrapar	10	10	100
Tepelenë	11	9	81.8
Tropojë	9	9	100
Vlorë	17	17	100
<b>TOTAL</b>	<b>180</b>	<b>174</b>	<b>96.7</b>

**Note:** As You can see from the table below, the percentage reporting rate is very good. Only two remote SDPs couldn't report on time this quarter, but they will report a little late.

## Contraceptive Stock-Outs in AFPP Districts, January – March 2006

District	# of SDP's Reported	Low Dose		Injection		Condom		POP	
		# SDPs Stocked Out	%	# SDPs Stocked Out	%	# SDPs Stocked Out	%	# SDPs Stocked Out	%
Delvinë	5	2	40.0	1	20.0	0	0.0	3	60.0
Devoll	6	5	83.3	5	83.3	2	33.3	5	83.3
Dibër	16	0	0.0	11	68.8	0	0.0	1	6.3
Fier	19	11	57.9	5	26.3	1	5.3	6	31.6
Has	5	0	0.0	3	60.0	1	20.0	1	20.0
Kolonje	8	6	75.0	1	12.5	0	0.0	8	100.0
Kukës	15	0	0.0	11	73.3	0	0.0	0	0.0
Lezhë	10	2	20.0	7	70.0	1	10.0	3	30.0
Lushnje	16	12	75.0	8	50.0	3	18.8	15	93.8
Mirditë	8	3	37.5	0	0.0	0	0.0	4	50.0
Përmet	11	1	9.1	11	100.0	5	45.5	1	9.1
Pukë	10	3	30.0	9	90.0	0	0.0	2	20.0
Skrapar	10	1	10.0	0	0.0	0	0.0	0	0.0
Tepelenë	9	1	11.1	1	11.1	1	11.1	2	22.2
Tropojë	9	0	0.0	8	88.9	0	0.0	0	0.0
Vlorë	17	13	76.5	7	41.2	2	11.8	15	88.2
<b>Total</b>	<b>174</b>	<b>60</b>	<b>34.5</b>	<b>88</b>	<b>50.6</b>	<b>16</b>	<b>9.2</b>	<b>66</b>	<b>37.9</b>

**Note:** The stock out situation in general has pegorated. This is because the national stockout in Low dose and in Depoprovera. A quantity of depoprovera bought by MoH arrived in Albania near the end of the second quarter. There was not enough time to distribute it in each SDP. There is also a national stockout in Low dose for which is already made an order from UNFPA and we expect it to arrive soon. The situation is meliorated on POP. The stock out level has decreased by 33%.

**ANNEX D**

ALBANIAN MOH ROUND TABLE ON FP

AGENDA

&

REPORT ON ALBANIAN MOH ROUND TABLE ON FP

## **P R O G R A M**

### Quality Service of Family Planning in Albania, Achievements and challenges for the future 07-08 June 2006

#### **Objectives:**

- ▶ At the end of the seminar, all participants will be informed with activities carried out from main key players in regard to FP
- ▶ At the end of the seminar, all participants will be informed with transferring process to Institute of Public Health (IPH) the management of reporting system (LMIS).
- ▶ At the end of the seminar, all participants will have shared their views regarding future challenges in Family Planning.

#### **Participants:**

Representatives from Ministry of Health and Institute of Public Health  
Albania Family Planning Project (AFPP);  
Representatives from USAID mission in Tirana,  
Representatives from USAID projects (URC, ARC);  
Representatives from UNFPA;  
Master trainers from MoH;  
Representatives from Social Marketing;  
Representatives from Private Sector.

#### **Meeting venue:**

Kompleksi, Mak Albania - Durrës

**First day: 07. June 2006**

- 12.30** Departure form Tirana – Meeting to the seminar place.
- 13.00 - 15.00** Lunch
- 15.00 - 15.15** Opening of the seminar –  
**Zamira Sinoimeri**, vice/minister of health  
**Zhaneta Shatri**, representative of USAID
- 15.15 – 15.30** Sharing with seminar’s objectives  
**Manuela Murthi**, Director of AFPP
- 15.30 – 16.00** Family Planning services in Albania  
**Dr. Nedime Ceka**, Head of Reproductive Health,  
Ministry of Health
- 16.00 - 16.30** Presentation of the report for Contraceptive Security  
Committee, April 2006,  
**Ela Petrela**, Vice Director IPH
- 16.30 – 17.00** Management of National Program of Family Planning.  
**Gazmend Bejtja**, Head of Department of Indicators and  
Reproductive health, IPH
- 17.00 – 17.15** Coffee - break
- 17.15 – 17.45** Presentation of follow up results about  
the FP quality service in Albania.  
**Gazmend Koduzi**, Training officer, AFPP
- 17.45 – 18.15** Achievements and challenges during the implementation  
process of LMIS from IPH.  
**Miranda Hajdini**, Specialist of Department of Indicators  
and Reproductive health, IPH
- 18.15 – 18.45** Discussions
- 18.45** Closure of first day
- 20.00** Dinner

## **Second Day – 08 June 2006**

- 09.00 – 09.30** Piloting of expansion of Family Planning Service down to village level in Diber prefecture (ACSP)  
**Fabian Cenko**, Program Manager ACSP
- 09.30 – 10.00** Demand increase for a qualitative service in FP.  
Achievement and barriers  
**Eduard Oga**, Representative of AFPP  
**Dorina Tocaj**, Representative of URC
- 10.00 – 10.20** Questions and Discussions
- 10.20 – 10.35** Coffee break
- 10.35 – 12.00** Working groups
- Group I Integration of FP into Reformed Primary Health Care Service. Access and link amongst HCs in LMIS system.
- Group II Tendency of usage regarding modern methods provided. What, who and how it could be provided
- Group III Health promotion as an important element for increasing awareness and behaviour change for the individual regarding family planning
- 12.00 – 13.00** Plenary session: Presentation of the results and closure of the seminar.
- 13.00** Lunch

## REPORT ON ALBANIAN MOH ROUND TABLE ON FP

On June 7 – 8, MoH (Ministry of Health) with the support of AFPP organized a two days seminar (roundtable) with important national stakeholders on Family Planning like: IPH (Institute of Public Health); UNFPA; URC, ACSP (Albanian Child Survival Project), representatives from Social Marketing<sup>12</sup>, private sector etc.

The seminar's objectives were sharing with all participants:

### 1. the current status of FP activities as performed by all key players;

Ministry of Health (MoH) gave an overview of FP service in Albania mentioning the steps and activities through the process and stages of implementation of this service. MoH presentation and discussion brought the successes but also the challenges related with access and quality of this service. Technical problems such as the *new appointed untrained staff* on SDPs; the need for *refreshment of knowledge*, the need for training of service providers on interpersonal communication skills on FP were some points brought as technical problems from representative of RH specialist in MoH. *Having a Strategy* of RH was brought as an important point from MoH. This strategy will help in implementing the right intervention (quite often segmented) in the IEC and community awareness. *Management and continuous supervision* including on-job training were also noted from MoH as important actions which are linked with quality and access of FP. *Studies and researches* in the field of family planning will further help MoH to be efficient and strategies in providing contraceptives to different groups of population.

The issue of contraceptive security was the pivotal theme, especially in the first plenary session.

MoH and IPH focused their discussion in the importance of Contraceptive Security priorities set on the April 2006. Beside mentioning what was achieved until now – the most important the payment of MoH for the year 2006 and 2007 and the shifting process of LMIS to IPH – the discussion enhanced the rest of priorities especially the establishment of the Contraceptive Security Working Group (Technical Working Group) under RH Commission. Market segmentation was recalled as an important study to carry out for better government management resources. While discussing the market segmentation, an interesting discussion was on the relation of Cost and CYP for the contraceptives distributed from Public Sector. MoH shows that more should be done in reinforcement in the long term contraceptives such as the case of IUD which provide a very high CYP for a very low cost.

In regard with training the AFPP brought for the audience the latest result of follow-up. Participants raised as an important point during discussions, continues education of health personnel in generally, and FP providers in particular. Participants suggested incorporation of FP curricula in Nursery University. This will make the new personnel graduated to be skillful in offering FP services.

A national training center created from MoH will be very useful in managing training capacities of MoH (MT and RT) and coordinating training activities.

Participants raised the need of more community outreach strategies in FP curricula. This will help health providers to learn more techniques for reaching community in order to raise their awareness and foster them to leave in healthy way.

<sup>12</sup> NESMARK who receives funding from German government to conduct social marketing of FP in pharmacies;



## 2. the updating process about transferring responsibilities amongst key players regarding LMIS (Logistic Management Information System)

Many of the presentations centered on the new role of IPH in taking over the LMIS, which was previously the responsibility of MoH and subject of support from JSI. IPH representatives shared their experience in the process of complying with this new role which was assessed in regard to *human resources available, technical expertise* required and other *administrative support* needed.

Human resource available and their technical expertise to perform the work were discussed for all the levels involved in LMIS. In the central level IPH discussed the support needed to do a professional work in managing the LMIS. So IPH with assistance of AFPP has already carry out the management of LMIS, and warehousing but is not able yet to deal independently on preparing the forecasting for new quarters distribution. Also IPH is planning to implement under the assistance of UNFPA the electronic system of LMIS after having computerized a considerable number of districts.

Dealing with the reporting process in relation with time and accuracy was a very important issue while assessing the technical expertise. Reporting problems has the main role in the steady problem of stock out. Representatives of MoH noted that a very important role in this process has to play the district directors. To get more involved in monitoring of this process, MoH informed the audience that soon this ministry is issuing a guideline for the role of director of PH. Through this guideline the directors have to be more responsible for the reports from local to central level.

Different administrative part and operational issue were brought on, stating that they require attention to ensure contraceptive storage, distribution and better function of LMIS.

## 3. discussion and views on future challenges and potential solutions for improving and expanding qualitative FP services on behalf of community.

DEMAND was the main KEY worked of this session. Community promotion and BCC component was brought from AFPP, URC and ACSP describing the community promotion activities and correlated its influence with FP indicators in the relative areas. In additional AFPP explained the most important activity in the upcoming months which will be focused on the “community outreach” component aiming to increase the demand from client side. AFPP explains that will address the FP activities from both sides: PROVIDERS (training component) and community side (community outreach). The “community outreach” strategy is being developed and will use findings from TIPS survey<sup>13</sup>.

Specific project’s barriers and experiences were discussed amongst participants and potential solutions/suggestions were given. The presence of MoH in the discussion should ensure compliance of next steps based on the conclusions of the seminar. The coordination role, MoH is leading in FP component, should be facilitated by participation in those round tables where current problems are discussed from different views (NGO’s or governmental institutions).

<sup>13</sup> TIPS (Trial of Improved Practices) carried out last year in the process of TV spots finalization.

ACSP was represented in that seminar by PM and HPO and shared a presentation which was focused on the idea to pilot the FP expansion services down to village level. This meeting gave ACSP a chance to formally introduce idea with more details that have not been previously mentioned in other meetings.

The advocacy was done using data from two districts<sup>14</sup> (Mat and Diber) through the following steps:

- emphasizing some interesting findings coming from FP baseline survey in project area. Significant differences on FP indicators found amongst Mat and Diber districts were discussed related to the diverse extension stages of FP extension;
- providing data about activities ACSP is carrying out in community level which relate with community mobilization and health promotion in order to increase FP demand;
- developing a programmatic piloting process, highlighting challenges and addressing them to key players currently active in FP and Diber area;
- following up in close coordination with MoH in order to ensure the sustainability of the related activities and document the process for further extension.

The discussion that followed the presentation of this session in regard to the above mentioned issues/concerns, were as following:

- Administrative aspect: The law states that FP services should be provided down to the community level as long as the provider is a certified FP provider. Thus, as long as we have trained VNMs using MoH approved guidelines, and there are conditions, equipment, supplies, etc. for providing confidential and private counseling and services to the client, than they are approved for being a SDP.
- Documenting / Reporting aspect regarding NMs: At this moment it should be discussed the WHO, WHAT, WHERE, HOW, WHEN, and WHY regarding the reporting at the village level upward the system. (i.e. what reporting/documentation will the VNM be responsible for, how frequently will it be required, who will receive it, etc). Currently, at all existing levels<sup>15</sup> where FP commodities are distributed, the provider completes the LMIS (quarterly), FP registry book, and maintains a file on each FP user.
- Quality of FP service provided. Surprisingly, the issue monitoring/ensuring quality family planning was not mentioned neither regarding the extension phase. Referring other presentations in the seminar, it was highlighted the strong correlation amongst the concerning quality of the services provided in the current levels with the low indicators in the field. In addition, the JSI component of “community outreach” has been assigned for addressing part of it. What I can say, is that quality ensuring need to be addressed whatever be the level of extension of FP services.

The relative objectives were the focus of different presentations which were followed by interesting and arguing discussions after each of them. The community side benefit from this expansion should be weigh up carefully with other factors like:

- government politics and guidelines;
- logistic factors (sufficient availability the CC stock)
- advocate with local health authorities;
- quantifying the additional efforts through relative activities like monitoring, supervision, reporting, documenting;
- coordinating with other local and national key players.

The very critical context to be kept in mind is that this process, although in a piloting format, should be lead by local health authorities. Sustainability need to be the main objective to guide through the implementation process, although the significant effort put into place from different projects in the starting phase.

The audience of the seminar was an excellent opportunity to share, discuss and develop a plan of action for implementation.

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<sup>14</sup> Mat and Diber district, at the time of the survey, represented two different stages of the extension of FP services; Mat provided the FP in all urban and health centers level (where living 45% of district population) while Diber had a FPSDP only in urban centre (Peshkopi city which include 20% of district population);

<sup>15</sup> These levels are located in urban area (maternity and women counseling centers) and rural (health centers);

**APPENDIX E**  
**Detailed Summary of Providers Trained by AFPP,**  
**January - March 2006**

Kukes district					
Urban area			Ob-Gyn	N/M	FD
	WCR	2	0	2	
	Maternity	3	1	2	
	Policlinic	3	0	0	3
Rural area			FD	N/M	
HC	Arren	1	0	1	
HC	Bicaj	3	1	2	
HC	Bushtric	2	1	1	
HC	Caje	3	1	2	
HC	Kalis	2	1	1	
HC	Kolshe	3	2	1	
HC	Shemri	3	1	2	
HC	Shishtavec	2	1	1	
HC	Shtiqen	2	1	1	
HC	Surroj	2	1	1	
HC	Terthor	1	1	0	
HC	Topojan	2	1	1	
HC	Ujmisht	2	1	1	
HC	Zapod	1	1	0	
Village level					
Ambulanca	Bardhoc	2	0	2	
Ambulanca	Barre	1	0	1	
Ambulanca	Brekij	1	0	1	
Ambulanca	Kalimash	1	1	0	
Ambulanca	Novosej	1	0	1	
Ambulanca	Orcikel	1	0	1	
Ambulanca	Palush	1	0	1	
Ambulanca	Qinamat	2	0	2	
District Total trained		47	19	28	

Has district					
Urban area			Ob-Gyn	N/M	FD
	WCR	4	0	3	1
	Maternity	5	2	3	
Rural area			FD	N/M	
HC	Fajze	1	0	1	
HC	Gjinaj	2	1	1	
HC	Golaj	1	0	1	
Village level					
Ambulanca	Kishaj	1	0	1	
Ambulanca	Tregtan	1	1	0	
Ambulanca	Vranisht	1	0	1	
District Total trained		16	5	11	

Tropoje district					
Urban area			Ob-Gyn	N/M	FD
	WCR	2	0	2	
	Maternity	3	1	2	
Rural area			FD	N/M	
HC	Bujan	3	1	2	
HC	Bytyc	3	1	2	
HC	Fierz	2	1	1	
HC	Lekbibaj	1	1	0	
HC	Llugaj	1	0	1	
HC	Margegaj	3	1	2	
HC	Tropoje	2	0	2	
Village level					
Ambulanca	Batashe	1	0	1	
Ambulanca	Breg Lumi	1	0	1	
Ambulanca	Cernice	1	0	1	
Ambulanca	Tetaj	1	0	1	
District Total trained		24	6	18	



GHS -I-00-03-00026-00



MINISTRY OF HEALTH

# QUARTERLY PROGRESS REPORT

July 1 – September 30, 2006



## Albania Family Planning Project 2004 – 2007

October 2006



The Albania Family Planning Project is implemented by John Snow, Inc. in collaboration with The Manoff Group

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## ACRONYMS

<b>AFPP</b>	<b>Albania Family Planning Project</b>
<b>ARC</b>	<b>American Red Cross</b>
<b>BCC</b>	<b>Behavior Change Communication</b>
<b>CS</b>	<b>Contraceptive (or Commodity) Security</b>
<b>COC</b>	<b>Combined Oral Contraceptive</b>
<b>CYP</b>	<b>Couple Year of Protection</b>
<b>FP</b>	<b>Family Planning</b>
<b>FY</b>	<b>Fiscal Year</b>
<b>HC</b>	<b>Health Center</b>
<b>HIS</b>	<b>Health Information System</b>
<b>HMIS</b>	<b>Health Management Information System</b>
<b>IEC</b>	<b>Information Education Communication</b>
<b>IPH</b>	<b>Institute of Public Health</b>
<b>IUD</b>	<b>Intrauterine Device</b>
<b>JSI</b>	<b>John Snow, Inc.</b>
<b>LMIS</b>	<b>Logistic Management Information System</b>
<b>Manoff</b>	<b>The Manoff Group (JSI subcontractor for BCC)</b>
<b>MCH</b>	<b>Mother and Child Health</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MT</b>	<b>Master Trainer</b>
<b>NM</b>	<b>Nurse Midwife</b>
<b>PHC</b>	<b>Primary Health Care</b>
<b>PMP</b>	<b>Performance Management Plan</b>
<b>POP</b>	<b>Progesterone Only Pill</b>
<b>RH</b>	<b>Reproductive Health</b>
<b>RHU</b>	<b>Reproductive Health Unit (MOH)</b>
<b>SDP</b>	<b>Service Delivery Point</b>
<b>STI/HIV</b>	<b>Sexual Transmitted Infection/ /Human Immunodeficiency Virus</b>
<b>TIP</b>	<b>Trial of Improved Practices</b>
<b>UNFPA</b>	<b>United Nations Population Fund</b>
<b>URC</b>	<b>University Research Corporation</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>WCR</b>	<b>Women's Consultancy Room</b>

## I. EXECUTIVE SUMMARY

During the quarter July 1–September 30, 2006, **USAID granted the Albania Family Planning Project (AFPP) a nine-month, cost extension;** the project’s new end date is now June 30, 2007. The extension period will be used to consolidate the projects achievements and to assist the MOH re-evaluate its FP/RH services and focus on barriers to increased use of modern contraception. See *AFPP Extension Work Plan, October 2006-June 2007* in Attachment C.

The Institute of Public Health completed the take over of the Logistics Management Information System (LMIS) and the central warehousing and distribution of government contraceptives. **Contraceptive stock outs continued during the quarter but began to decline from the high levels of April-June 2006.** Stock outs are expected to continue to decline next quarter because the IPH store now holds a two-year supply of contraceptives. AFPP estimates that stock outs in the public sector will reach the project’s target levels by next quarter. To prevent future stock outs, AFPP is assisting the MOH to improve contraceptive forecasting using *PipeLine* software linked to existing LMIS data.

An AFPP consultant, Paul Dowling, conducted a successful assessment in September using a “Total Market Approach” to contraceptive security. Mr. Dowling identified key policy issues and bottlenecks affecting the contraceptive market in Albania and their impact on long-term availability of contraceptives. The **temporary shutdown of NESMARK’s condom and oral pill sales** (social marketing) due to a pricing dispute with the MOH has persisted for almost a year, and has greatly reduced the availability contraceptives through commercial outlets. At the end of quarter, NESMARK and MOH seemed on the verge of reaching a compromise that would allow social marketing sales to resume. AFPP collaborates with NESMARK and is following the issue closely because of the huge implications for contraceptive availability.

**Family Planning visits declined slightly** during the quarter, and AFPP is investigating the reasons. Follow-up visits to graduates of the FP training courses were stepped up this quarter, with the focus on trainees in three of the sixteen project districts. In **Behavior Change Communication**, television spots promoting family planning aired between May 1 and June 18. Air time was paid by UNFPA at reduced rates due to the efforts of the MOH Vice Minister who convinced the TV stations that these were “public service announcements.”

During this quarter, AFPP continued its good working relationship with ProShedetit, the Ministry of Health and the Institute of Public Health, all of which are participating as active partners with AFPP.

## PERFORMANCE MANAGEMENT PLAN (PMP)

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (April. – June 2006)	Current Quarter (July – Sept. 2006)	Target FY 2007
% of service delivery points providing family planning services	# of SDPs with commodities, trained provider(s), IEC materials/ total # of SDPs  SDP's = 440 MOH facilities (Maternities, WCRs, HCs); 300 currently providing FP and 140 additional sites will provide FP services Unit: %	LMIS Reports; project reports  Quarterly	16 Project Districts	LMIS Officer	0 % (2004 LMIS)	100% (188/188 <sup>16</sup> )	100% (188/188)	90 %
			National		68 % (2004 LMIS)	99.78% (456/457)	99.78% (456/457)	99 %
Couple years of protection (CYP) *	Total number of contraceptives distributed by type (method) in a given period with weights applied to different methods.  1 CYP = 15 Packets Oral Pills 1 CYP = 4 Depo Injections 3.5 CYP = 1 IUD 1 CYP = 120 Condoms Unit: #	LMIS Reports  Quarterly	16 Project Districts	LMIS Officer	774 per quarter (2004 LMIS)	1449.7	1659	1600
			National		3,750 per quarter (2004 LMIS)	4914	5191	5000

\*When calculated annually means average quarterly CYP

<sup>16</sup> The denominator of this indicator was adjusted upwards from 185 to 188 because there are three more SDPs than originally planned (one additional SDP each in Kukes, Has and Tropoje).

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (April. – June 2006)	Current Quarter (July – Sept. 2006)	Target FY 2007
% of service delivery points stocked out of condoms, POP, injectables and low dose contraceptives in 16 target districts	# of SDPs reporting zero stock of specific commodities/ # of SDPs reporting  Unit: %	Routine LMIS Reports  Quarterly	Project 16 districts	LMIS Officer				
			Condoms		28 %	9.2 %	10.9	10 %
			POP		64 %	37.9 %	22.3	10 %
			Low dose		22 %	34.5 %	35.4	10 %
			Injectables		14 %	50.6 %	12.6	10 %
% of SDPs in 16 target districts with staff trained using national FP curriculum	# of SDPs in target districts with at least one staff person trained using national FP curriculum/ total # SDPs in intervention districts  SDP = MOH facilities (maternities, WCRs, health centers) Unit: %	Training Records; Quarterly	<b>By type of SDP:</b>	Training Officer				
			Maternity		0 %	81.3% (13/16)	100 % (16/16)	90 %
			WCR		0 %	100% (18/18)	100 % (21/21)	90 %
			Health Center		0 %	83.4% (126/151)	100 % (151/151)	90 %
			<b>By cadre:</b>					
			Doctors		0 %	68.9% (124/180)	100 % (173/173)	90 %
			Nurses/ midwives		0 %	89.2% (330/370)	100 % (390/376)	90 %

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Last Quarter (April – June 2006)	Current Quarter (July – Sept. 2006)	Target FY 2007
Total # of family planning visits in 16 target districts	Total clients visits to SDPs for first FP visits, re-visits, and counseling  Unit: #	LMIS Reports;  Quarterly	First visits  Re-visits  Counseling only	LMIS Officer	750 per quarter  1339 per quarter  686 per quarter  (2004 LMIS)	2416  2550  3266	2169  2988  2784	1500  2680  1370
% MWRA attending SDPs, who have been exposed to at least one campaign material and can state at least one message	# of MWRA attending SDPs, who state that they have been exposed to at least one campaign material and can state at least one message/ # of MWRA interviewed. Unit: % Campaign materials = TV spots or programs, events, pamphlets/ brochures). MWRA attending SDPs that provide MCH services are MWRA attending target facilities for maternal or routine child health care	Exit interview at SDPs; during campaign; end of project		BCC Officer	0 %	38 %		55 %

**IR3.3: Community participation in health promotion activities increased**

<b>Indicator</b>	<b>Indicator Definition and Unit of Measure</b>	<b>Data Source/ Frequency</b>	<b>Disaggregation</b>	<b>Person Responsible</b>	<b>Baseline (Year)</b>	<b>Quarter (April-June. 2006)</b>	<b>Current Quarter (July- Sept 2006)</b>	<b>Target FY 2006</b>
% of villages which have FP service provided by at least one community midwife in 16 districts	# of villages which have FP service provided by at least one community midwife in 16 districts / total # of village in the 16 districts  Unit: %	Training Records;  Quarterly	16 Project Districts	Training Officer	0	19.50% (259/1328)	19.50% (259/1328)	

## II. SUMMARY OF MAJOR ACTIVITIES THIS QUARTER

### A. Project Management

Planned Action	Status at End of Quarter	Comments
Maintain effective communication with USAID and JSI Headquarters	Ongoing	<b>USAID:</b> AFPP maintains good communication with USAID using informal update meetings, and by inviting Mission representatives to participate in project activities. <b>JSI HQ:</b> AFPP has regular and frequent communication with JSI headquarters, by email and phone.
Submit deliverables on schedule	Done	<ul style="list-style-type: none"> <li>• Weekly reports</li> <li>• Ongoing reports</li> <li>• Extension Work Plan</li> <li>• Market Segmentation Executive Summary</li> </ul>

### B. Programmatic Activities

Component 1: Contraceptive Security	Status at End of Quarter	Comments
Conduct Market Segmentation Strategy	Done	<b>Total Market Approach to Contraceptive Security Introduced.</b> In September 2006, AFPP consultant (Paul Dowling) analyzed the Albania contraceptive market, including how well the market is segmented among the sectors, and identified policy issues affecting market segmentation and their impact on the long term availability of contraceptives in Albania.
Provide ongoing technical support to the LMIS	Ongoing	AFPP assisted the IPH and MOH in managing and successfully overcoming barriers affecting the LMIS, as well as contraceptive storage and distribution.
Support implementation of the National Contraceptive Security Strategy	Ongoing	Worked with the MOH to prepare for the upcoming first meeting of the Contraceptive Security Committee (it is replacing the now-abolished National CS Commission.)
Component 2: Family Planning Training	Status at End of Quarter	Comments
Conduct training follow-up visits	Ongoing	Follow-ups conducted in three districts: Kukes, Has and Tropoje. The follow-up provides additional data regarding the outcome of AFPP interventions, assessment of the effectiveness of training, and provides on-the-job support and teaching when needed.

<b>Component 3: Behavior Change Communication</b>	<b>Status at End of Quarter</b>	<b>Comments</b>
Draft curricula & counseling cards for Outreach Negotiation Counseling	On going	Curricula and counseling cards completed with assistance from Manoff consultant; awaiting review and comments from partners before implementation.
Airing TV spots	Ongoing	Two TV spots aired on four national channels; this was the third round of showing these spots, and this time UNFPA paid the broadcasts.
Implement other media activities	On going	<p><b>TV “Call-In” Show</b> aired -- two RH experts answered questions about family planning and contraceptive issues. Some questions were prepared in advance based on the findings of qualitative research and providers’ experiences with FP clients.</p> <p><b>Other Media Coverage.</b> In 2006, family planning and modern contraception are increasingly the topic of articles and TV programs outside those supported/planned by AFPP.</p>
Monitor and evaluate impact of BCC intervention	On going	The third Media Campaign May 1 – June 18, 2006, which was aired during this quarter was followed by the third Media Recall Survey conducted on five cities: Përmet, Tepelenë, Has, Torpojë, Kukës. Results will be published and used to guide future TV campaigns

### III. PROGRESS MADE THIS QUARTER

#### A. Contraceptive Security and LMIS

**Total Market Approach to Contraceptive Security.** In September 2006, AFPP consultant Paul Dowling analyzed Albania's contraceptive market and identified market segmentation policy issues affecting the long-term availability of contraceptives. A total market approach looks at the entire contraceptive market, examining the public, social marketing and commercial sectors in terms of their comparative advantages in delivering FP products and services. A total market approach often leads to improved coordination among sectors so that more clients are reached and government subsidies go to those who most need them, while allowing the commercial sector to thrive alongside the subsidized sectors. See Appendix B.

**LMIS established in the Institute of Public Health.** AFPP worked closely with IPH to ensure LMIS data collection and processing, forecasting, warehousing and distribution were firmly established within the IPH. LMIS achieved an outstanding high reporting rate this quarter under IPH management:

% of FP service delivery points reporting LMIS data this quarter	In sixteen (16) project districts	97.2 %
	In all FP SDPs in Albania	92.1 %

**Declining Contraceptive Stock Outs.** Stock outs at service delivery points have been a serious problem nationwide since early 2006 due to a national contraceptive stock out that resulted from a lack of timely procurement. There was miscommunication between the MOH and UNFPA (the MOH's sole procurement agent for contraceptives) and timely orders were not placed with UNFPA/New York. Fortunately, these problems were overcome, and by September, the MOH contraceptive stocks had been replenished. The effect of this replenishment is clearly seen in the declining stock out levels this quarter. **The MOH expects contraceptive stock outs to decline to 10% or less by the end of next quarter** (condoms and injectables are already near the 10% target.) With the MOH increasingly paying for its own contraceptives, and with IPH now monitoring national stock levels carefully, the serious contraceptive stock outs of 2006 are unlikely to be repeated.

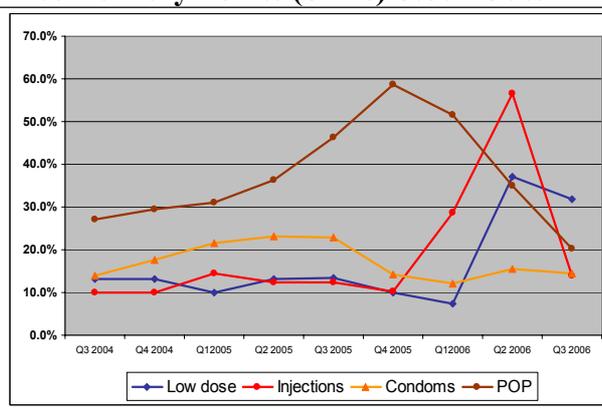
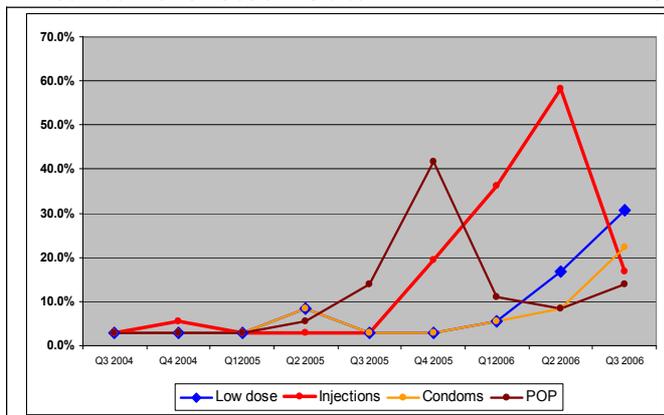
Contraceptive Stock-Outs at SDPs in 16 AFPP Districts						Target 2007
	Q3 2005	Q4 2005	Q1 2006	Q2 2006	Q3 2006	
Low dose OC	13.4%	9.9%	7.4%	37.2%	35.4%	10%
Injectable	12.4%	10.2%	28.7%	56.7%	12.6%	10%
Condom	22.8%	14.3%	12.2%	15.4%	10.9%	10%
POP Oral C.	46.3%	58.8%	51.7%	34.9%	22.3%	10%

Referring to the graphs below, we see stock outs of low dose pills and condoms beginning to decline at SDPs, but not at District Level. Such a pattern is common in supply chains recovering from prolonged stock outs, because districts rush all available stock to the SDPs and retain few contraceptives in district stores. This is an indicator that the supply system is

working well by giving priority to getting contraceptives out to SDPs and postponing the replenishment of districts stores.

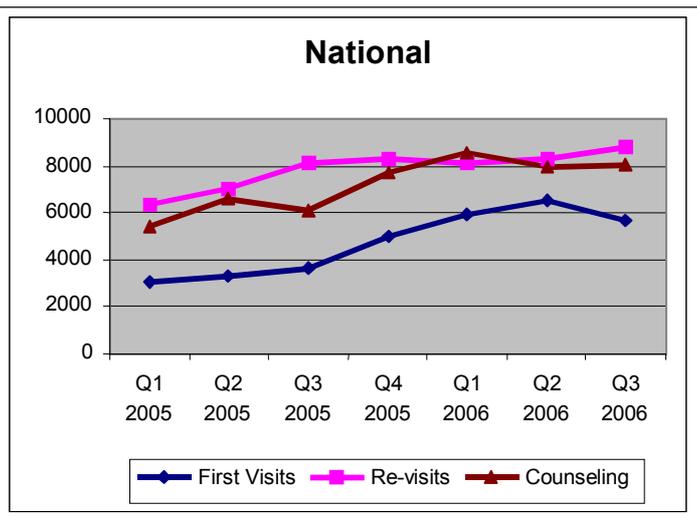
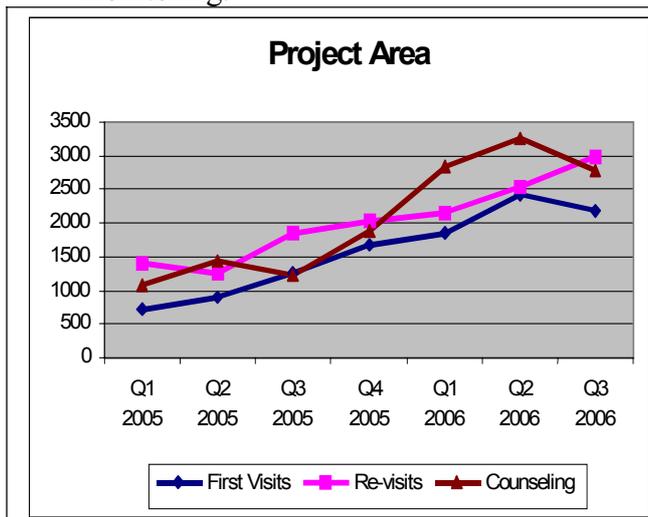
**District Level Stock Outs**

**Service Delivery Points (SDPs) Stock Outs**



**Improved Contraceptive Distribution.** This quarter the IPH assumed full control of public sector contraceptive distribution (UNFPA had distributed contraceptives on behalf of the MOH for many years.) Under the new distribution system, IPH instructed districts to visit the IPH warehouse in Tirana and collect their required contraceptives. AFPP will assist IPH to monitor the effectiveness of this new distribution system.

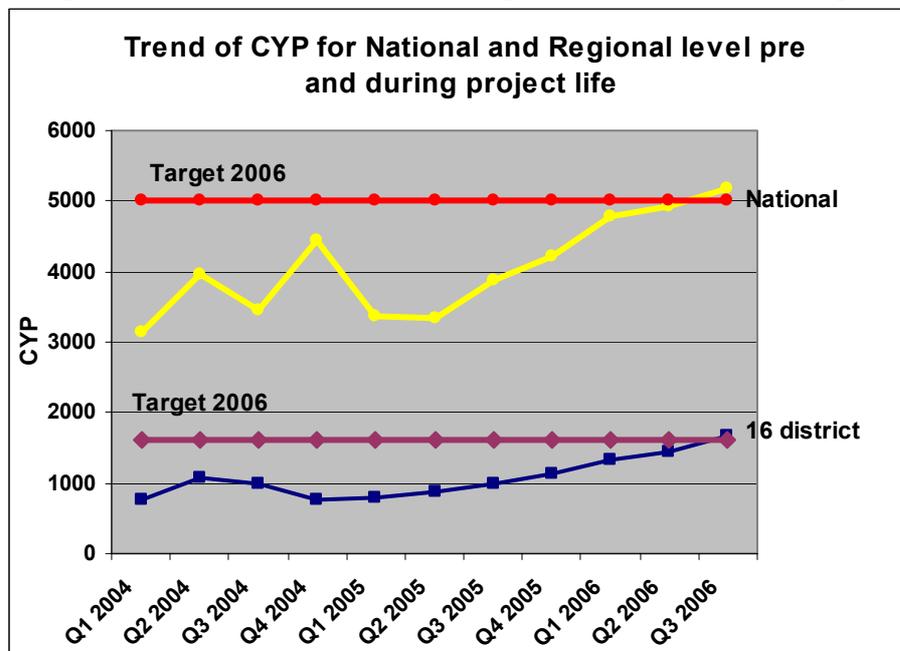
**Declining Utilization of MOH Family Planning Services:** While the number of re-visits continued the long-term upward trend, first visits and counseling visits declined slightly this quarter. With FP services being expanding in the project area, and with a nationwide mass media campaign (TV spots) underway, we would expect FP service utilization to increase. Why the decline this quarter? We attribute it to the widespread contraceptive stock outs at MOH service delivery points, which discouraged clients from seeking services. The existing stock in the SDPs seems to have been used more for the existing clients. So the re-visits have kept increasing. We predict the upward trend in FP service utilization will reassert itself in the coming quarters as contraceptive stock outs decline. This indicator deserves close monitoring.



**Couple Years of Protection:** The steadily upward CYP trend beginning in 2005 continued this quarter, both nationally and in the 16 target districts. This upward trend is due to

- 1) AFPP's emphasis on increasing the number of FP service delivery points;
- 2) More complete LMIS reporting of FP service statistics;
- 3) More Albanians using modern contraception.

This positive CYP trend is remarkable given the serious contraceptive stock outs in 2006.

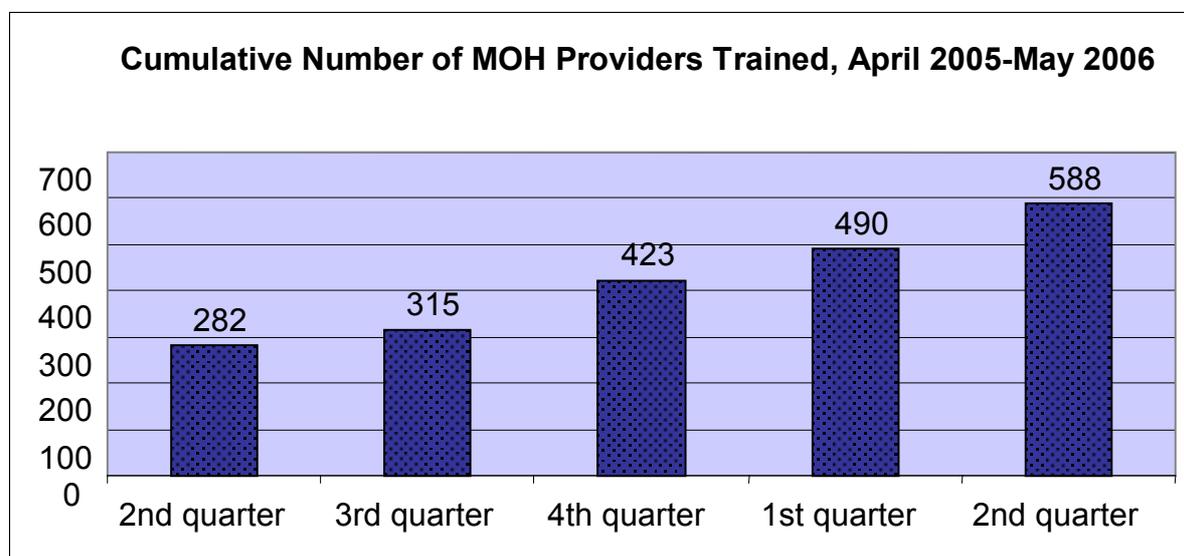


#### Next Steps for the Contraceptive Security and LMIS Component:

- Organize and provide external technical assistance for a strategic re-assessment of family planning/reproductive health in Albania that will offer policy options to the MOH.
- Assist the MOH in implementing the National Contraceptive Security Strategy revised in 2006.
- Assist the Institute of Public Health in troubleshooting the LMIS and contraceptive distribution system; specifically, analyze the lessons learned from the past two quarters of LMIS and distribution operations.
- Provide refresher LMIS training for LMIS staff in 36 districts.
- Introduce electronic LMIS data reporting in 20 districts.

## B. Family Planning Training

AFPP-sponsored FP training was completed this quarter in the last of the 16 target districts. The cumulative increase in the number of providers trained is shown below.



Trained providers have assisted the MOH to gradually expand the number of service delivery points offering family planning services. By the end of this quarter, 188 MOH service delivery points in the target districts were providing family planning services.

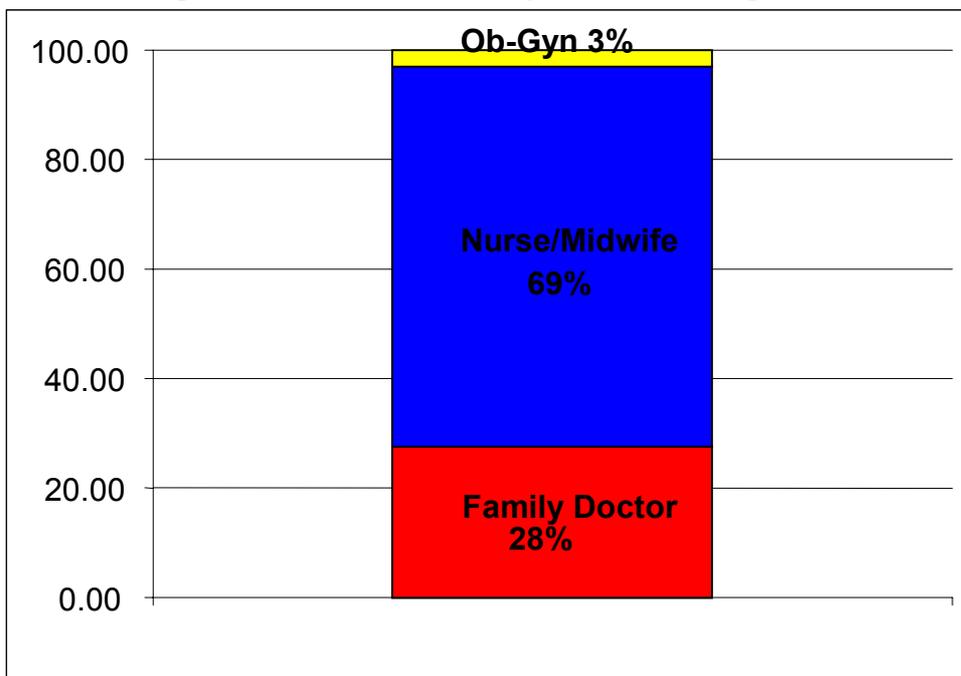
### MOH Service Delivery Points in 16 Target Districts with Trained FP Staff September 2006 (cumulative)

Number of SDP by Type			Total
Health Center	Women's Consultancy Room	Maternity	
151	21	16	188

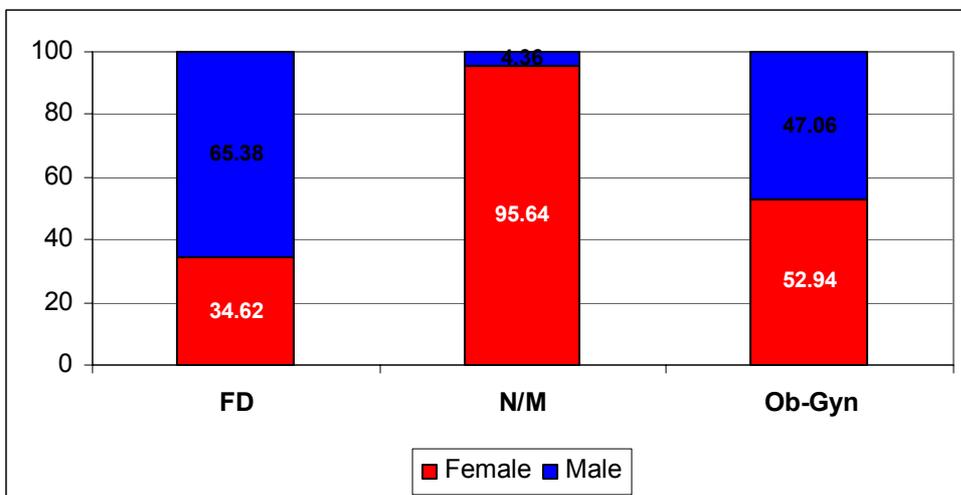
The project focuses on health centers because the majority of under-served Albanians live in rural areas where health centers are the first point of contact.

FP training is focused on nurse/midwives because this cadre provides the bulk of family planning services in Albania, and likewise, the majority of trainees are female.

**Percentage of Providers Trained by Cadre as of September 2006**



**Gender of MOH Providers Trained as of September 2006**



**Training Follow-Up:** With the FP training now completed in all 16 districts, AFPP’s focus has shifted to on-site follow-up visits to gather data regarding the outcome of project interventions. Equally important, the follow-up visits offer an opportunity to provide on-the-job support and teaching to the recent graduates.

AFPP follow-up includes 1) administering a Health Center Questionnaire covering FP services offered, equipment, commodities and record keeping; 2) administering a post-test to staff who are former FP trainees; 3) observing FP providers during a client visit to see how

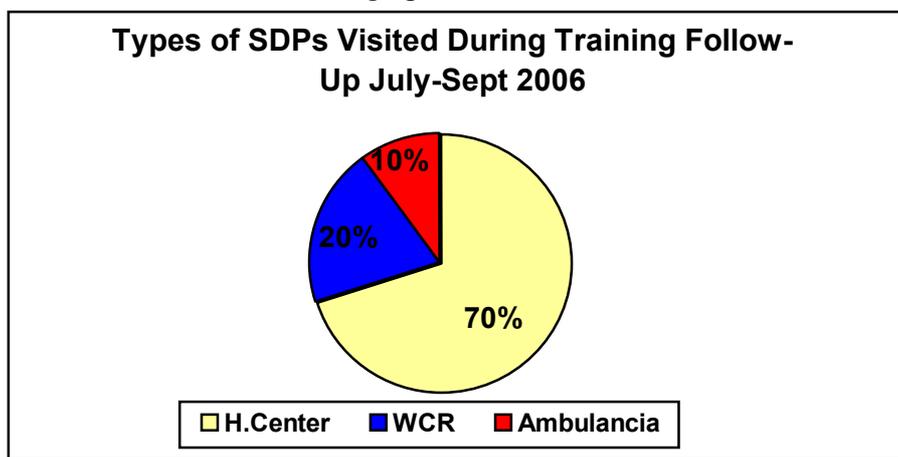
well they apply their FP skills; and 4) conducting a client exit interview to determine the level of client satisfaction with the FP service.

AFPP is aiming for a follow up 33% of the health facilities with newly-trained FP providers (100% follow-up would be ideal, but time and resources do not permit). The table below summarizes follow-up for this quarter.

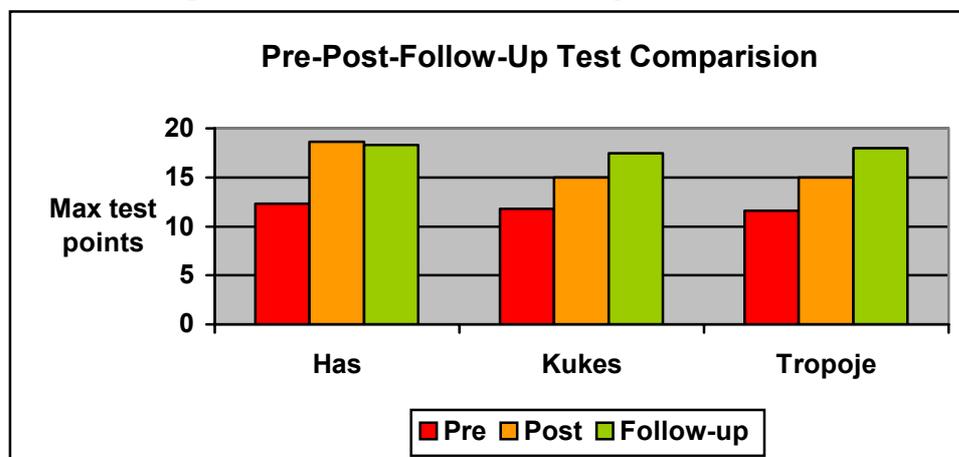
**Number of Providers/Service Delivery Points Sampled by District During this Quarter**

	Kukes		Has		Tropoje		Totals	
	# trained	# sampled						
<b>Providers</b>	47	TBD	16	TBD	24	TBD	87	TBD
<b>SDPs</b>	16	5	5	2	9	3	30	10

Follow-up data collection took place during the period July 17-27, 2006, and the data collection team consisted of three interviewers who spent one day at each SDP. The types of facilities visited are shown in the graph below.



Below is a summary of preliminary results of the pre-post training test administered during the follow-up visits in three districts. In this small sample, it is encouraging that knowledge levels are being maintained (and even increasing) after trainees return to their work sites.



### Next Steps for the Family Planning Training Component

- Continue with follow-up visits according to the project work plan schedule.
- Present follow-up results/findings to the master trainers to identify the strengths of the FP training program and areas that need strengthening.
- Discuss follow-up findings regarding LMIS with IPH to plan next steps for the strengthening of problem areas.
- Strengthen coordination between training follow-up and the BCC component to enhance results.

## C. Behavior Change Communication

**Media Recall Survey.** AFPP conducts a Media Recall Survey after each round of TV spots. The third round of TV spots aired during this quarter, followed by the third Media Recall Survey conducted in five cities (Përmet, Tepelenë, Has, Tropojë, Kukës.) The results of the third media campaign are interesting and optimistic.

### Important Findings from the Media Recall Survey (June 12 - July 27, 2006)

- 456 persons were interviewed (318 female and 138 male).
- 67% of all respondents reported having seen at least one of the TV spots.
- 55% of respondents (35% female and 20% male) had seen the rural spot, but only 34% (32% female and 2% male) had seen the urban TV spot. Approximately 11% of respondents (6% female and 5% male) reported seeing both spots.
- 42% of respondents were able to state at least one FP message from the TV spots.

**BCC Proxy Indicator.** AFPP includes one proxy indicator in measuring media recall: *Number and percentage of respondents who saw at least one TV spot and discussed it with another person.* AFPP chose this indicator because people almost always need to discuss new information in order to process and internalize it. Therefore, if the majority of people who saw at least one of the TV spots discussed it with someone, it would indicate that the process of social/behavioral change has begun. The first media recall showed that 65.2% of respondents discussed an AFPP spot with someone. The second media recall showed 75.4% of respondents had discussed it with someone. Most men and women who saw at least one AFPP spot reported discussing it with their spouses: 56% of women discussed it with their husbands and over 52% of men with their wives. Since one of the messages of both spots was to discuss family planning with your spouse, this is another indication that viewers are acting on the message.

**Television “Call-In” Show.** AFPP sponsored a TV call-in show where two recognized RH experts answered questions about family planning and contraceptive issues. Some questions were prepared in advance based on the findings of a qualitative research study conducted by AFPP. The aim of the call-in program was to increase public knowledge about modern contraceptive methods available in Albania. The program lasted for 45 minutes, and two professionals - Gynecologists Dr. Vjollca Tare and Dr. Fedor Kallajxhi - were the experts who answered questions. See Call-In clips below.

**“Call-In” Clips**

**Other Media Coverage.** In FY 2005-2006, family planning and modern contraception were increasingly the topic of articles and TV programs outside those supported/planned by AFPP. AFPP regularly monitors the local media for FP-related content. In August 2006, for example, there were four articles on FP issues in the newspapers *Shekulli* and *Panorama*. Next quarter, APFF plans to conduct an orientation for local journalists on family planning issues in an effort to improve the accuracy and quality of local reporting.



**Outreach Negotiation Counseling (ONC).** AFPP began preparations for a community outreach program in two rapidly urbanizing “hot spots” within the project’s 16 districts (Fier and Diber.) An intensive BCC/community outreach approach will be tested in these two districts with the aim of increasing access to information about the benefits of family planning and methods available to help women/couples achieve their reproductive health goals. Community midwives will be the focal point of the outreach program which is based upon face-to-face communication between the midwife and the client in the community, usually at home.

#### Next Steps in Behavior Change Communication

- Conduct TOT for Outreach Negotiation Counseling Activities
- Implement the pilot face-to-face communication intervention in Fier and Diber
- Plan and conduct an orientation training on FP issues for local journalists/media
- Prepare the next “Call-In” show and one new family planning TV spot
- Conduct Media Recall Survey III after round three of the TV spots ends on Oct 20

#### IV. SUMMARY OF KEY MEETINGS/ACTIVITIES

**July 13, 2006 Preparation for the AFPP-Sponsored Call-In Show**

Met with two local RH experts, Dr. Fedor Kallajxhi and Dr. Vjollca Tare, plus the Program Leader Dr. Flamur Topi. The specific issues to be discussed during the TV program were agreed, and a rehearsal session was carried out.

**July 14, 2006 AFPP/Red Cross and Diber Public Health Directory re ONC**

Discussed the Community Outreach Negotiation Counseling program to be implemented in Diber, especially the training preparations. ONC concept and process explained, and a supervisory group established to oversee the implementation of ONC in Diber.

**August 21, 2006 AFPP – UNFPA**

The agenda included:

- Contraceptive procurement to overcome stock outs
- Contraceptive shipments and distribution plans once commodities arrive in Tirana
- Preparation for the third round of the TV spots

Lida Nuri represented UNFPA; M. Murthi; A. Kasaj, A.Peshkatari attended for AFPP.

**September 12, 2006 Agim Shehi & Nedime Ceka – PHC Directorate, MOH**

The agenda included:

- Contraceptive security, especially the stock out situation at MOH facilities
- FP training issues
- Review of LMIS data from previous quarter
- Preparation for the market segmentation consultant (Paul Dowling)

**September 15, 2006 Contraceptive Market Segmentation Workshop (see Appendix A)**

Workshop presented results of Paul Dowling's consultant report on the contraceptive market in Albania, and the implications for long-term contraceptive security. Important discussions on closer integration of AFPP and Proshendetit activities re contraceptive security.

Key participants including senior officials from the MOH, USAID/Zhaneta Shatri, URC/Richard Stugis, AFPP/Paul Dowling and Manuela Murthi.

**September 28, 2006 LMIS Team at Institute of Public Health**

Set priorities for contraceptive distribution and LMIS. Planned upcoming LMIS training for all the district LMIS focal persons - tasks et for all members of the team to prepare materials and infrastructure for this LMIS training. The IPH Deputy Director attended this meeting.

## **APPENDIX A**

### **Contraceptive Security and a Total Market Approach Workshop in Tirana**

**September 15, 2006**



Projekti “Planifikimi  
Familjar në Shqipëri”  
Rr. Budi 41/1  
Tiranë  
Tel. +4 370736



## Workshop Contraceptive Security & a Total Market Approach

Albania faces several challenges in ensuring contraceptive security. Contraceptive use is increasing but most couples still use less effective traditional methods with recourse to abortion to fulfill their fertility desires, with negative consequences for maternal health.

The Ministry of Health is committed to ensuring access to contraceptives for all. A total market approach to contraceptive provision can help ensure access and at the same time help the Ministry to use their resources more efficiently; in other words, to concentrate government resources on those who are unable to afford to pay for contraceptives.

A total market approach looks at the entire market, examining the different sectors -public, social marketing and commercial - in terms of their comparative advantages in delivering products and services. A total market approach can improve coordination between the sectors, ensure that subsidies go to those that need them, and that the commercial sector can continue to thrive alongside subsidized sectors. The ultimate goal is sustainable, long-term contraceptive security for all Albanians.

*Purpose:* This workshop will present the findings of a recent analysis of the Albanian contraceptive market, including how well the market is segmented between the sectors, and present policy issues that impact market segmentation and the operations of the sectors. Participants will discuss the current situation and future priorities.

*Time:* **Friday, September 15, 2006 from 10 am - 12.am**

*Venue:* **Hotel DIPLOMAT**

*Participants:*

- |                      |   |                                    |
|----------------------|---|------------------------------------|
| 1. Zamira Sinoimeri  | - | Deputy Director / MoH              |
| 2. Zhani Shatri      | - | USAID, Health Advisor and AFPP CTO |
| 3. Manuela Bello     | - | UNFPA                              |
| 4. Elida Nuri        | - | UNFPA                              |
| 5. Agim Shehu        | - | Public Health Director / MoH       |
| 6. Nedime Ceka       | - | Reproductive Health Unit / Moti    |
| 7. Ana Lipe          | - | Financial Unit / MoH               |
| 8. Nazmi Alibali     | - | Pharmaceutical Directory / MoH     |
| 9. Ira Armiri        | - | Price Unit / MoH                   |
| 10. Eudard Kakarriqi | - | Director/IPH                       |
| 11. Elizana Petrela  | - | Deputy Director / IPH              |
| 12. Gazmend Bejtja   | - | Statistical Unit / IPH             |
| 13. Miranda Hajdini  | - | LMIS Responsibel / IPH             |

14. Arti Cicolli	-	LMIS IT Specialist
15. Dritan Isaraj	-	Director/ARSH
16. Arben Runa	-	Deputy Director / HII
17. Ilir Teneqexhi	-	Private Sector – SCHERING
18. Adrian Paravani	-	NESMARK
19. Richard Strugers	-	COP / Proshendeti
20. Dorina Toçe	-	Proshendetit
21. Fabian Cenko	-	ARC
22. Collin Elias	-	ARC
23. Vladimir Margjeka	-	NCDC (Nacional Center for Drug Control)
24. Djana Toma	-	Head of Pharmaceutical Association
25. Pirro Trebicka	-	KFW
26. Elona Gjebrea	-	ACPD
27. Agim Kasaj	-	AFPP
28. Manuela Murthi	-	AFPP
29. Paul Dowling	-	AFPP

## **APPENDIX B**

### **Executive Summary A Total Market Approach to Contraceptive Security in Albania**



## **A Total Market Approach to Contraceptive Security in Albania**

### **Executive Summary of Evaluation by Albania Family Planning Project**

#### **Background**

Based on current growth, existing low fertility rates, and widespread use of traditional family planning methods, Albania will likely see significant growth in the use of modern family planning methods over the immediate future. This has financial implications for the Government of Albania.

A *total market approach* looks at the characteristics of existing and likely future markets, to define the comparative advantage of commercial, social marketing, and public actors in terms of ability and efficiency in delivering a range of products and services to different market segments, including the poorest. It can enable better collaboration between commercial, public and non governmental organizational sectors and aid the gradual shifting of consumers with sufficient purchasing power out of the public sector. Ultimately it can help assure *contraceptive security* – a guaranteed long-term supply of quality contraceptives for every Albanian who wants them.

#### **Future Scenarios**

In 2002, the public sector supplied about two-thirds of contraceptive products and services and the private sector one-third (mainly NESMARK social marketing program and some Schering commercial contraceptives, both sold through private pharmacies. Based on current procurement costs, and estimates of program costs from 2004, estimates were prepared for the cost to the public sector of providing family planning products and services, using two growth patterns: modest, i.e., contraceptive use increasing to 26 percent by 2016, and rapid, i.e., contraceptive use reaching 50 percent by 2016. For each growth pattern, estimates were made based on the current public sector share remaining constant (at 67 percent), and declining to 22 percent. If the public sector share remains constant, the total estimated program costs are between US\$6.1 million and US\$11.9 million, depending on growth in contraceptive use, for the period 2006 -2016. If the private sector share were to increase, the costs would be between US\$3.4 and US\$6.6 million for the same period.

Growing the private sector share will have a number of potential benefits apart from reducing the cost to the public sector, including:

- Increasing consumer choice;
- Allowing the public sector to concentrate more on stewardship of the health sector and less on service delivery;
- Allowing the public sector to concentrate its resources on those segments underserved by the private sector: low income and rural groups; and
- Enhancing program sustainability.

## Current Market Situation

**Products:** A wide range of contraceptive products is available in all sectors. The main gaps are for alternative long-term methods to IUDs – implants etc. - and female condoms. Most unmet need is for limiting rather than spacing births, suggesting a large unmet need for long term methods in particular. Access to IUDs is limited since only OB/GYNs are allowed to insert an IUD. The commercial sector is constrained in offering longer-term methods since there are few private sector providers restricting the sector mainly to resupply methods like pills, injectables and condoms. Social marketing offers a range of resupply methods, including two methods – injectables and emergency contraception (EC) – unavailable commercially, but their products have been off the market for about a year due to disagreements over pricing policies. The impact of this is being felt in the private sector as pharmacists complain of the absence of affordable products, and in the public sector where demand for products is up by 43 percent for the first half of 2006 over the same period in 2005. Some of this demand is linked to the expansion of public sector facilities offering contraceptives, but some is without doubt linked to the absence of social marketing products.

**Prices:** Public sector products are available free of charge, and while there are probably informal payments these are likely to be modest. Social marketing products, while affordable for most income groups, have been off the market for approximately one year. The price of commercial products makes them unaffordable for most Albanians. The lowest priced commercial oral contraceptive is priced at just under 500 Lek/cycle whereas the social marketing equivalent was priced at about 100 Lek. Contraceptives are especially price sensitive since they need to be purchased repeatedly and may be perceived as a discretionary purchase. The commercial sector pricing strategy for contraceptives targets the upper income groups in Albania, and mainly for health purposes; many pharmacists reported demand for higher priced commercial products – c. 700 to 1,300 Lek/cycle – for menstrual cycle regulation, with clients being referred from providers with prescriptions for a specific brand. For injectables –popular among rural populations - there is no commercial product on the market. Given the pricing strategy of the commercial sector there is a need for low priced products at a price point of around 100 Lek /cycle for pills or 200-300 Lek for a 3-month injectable. This is affordable for most low income Albanians, offering them an alternative source of supply, reducing the load on the public sector and making easier an eventual transition from the public to the commercial sector.

**Place:** Contraceptives are now available in about 428 public sector facilities. Commercial products are sold in over 600 pharmacies and over 200 pharmaceutical agencies, the latter found mostly in rural areas. Condom accessibility is greatly limited since they are generally available in pharmacies only. While there are no restrictions on where they can be sold, stigma makes retailers reluctant to stock condoms and they are found in only a handful of supermarkets in Tirana.

**Promotion:** Given the current low demand, lack of knowledge, and misinformation and concerns regarding side effects, there is need for significant investment in promotional activities for contraceptives and family planning. Various donors such as USAID and UNFPA are engaged in advertising family planning and various methods. Social marketing provides training to pharmacists although their activities have been restricted over the past year. Hopefully, with new donor funding, and sales revenues, they will recommence. Training for pharmacists and IEC for users on EC is a particular need. When EC was on the market, it was being used for routine contraception as an alternative to condoms or other contraceptives rather than for true “emergencies.” Consumer education and provider training is preferable to restricting access through strict enforcement of prescription regulations.

## **Recommendations**

- The Ministry of Health and NESMARK should work together to ensure that social marketing products are back on the market as soon as possible. As noted above, currently there is no oral contraceptive on the market affordable to most Albanians and no injectable contraceptive available at any price, although relatively affordable commercial condoms have appeared. There is probably a need for social marketing for promotion and direct distribution of low priced products for the immediate future (3 to 5 years.) Social marketing should be allowed to set prices that reflect the ability of low income consumers to pay and assure program financial sustainability rather than be subject to a price control system designed for the business model of international drug manufacturers.
- The Contraceptive Security Commission provided a valuable forum to enable multi-sectoral partners to work together and communicate regularly on issues pertinent to the contraceptive market. The group needs to be reactivated as soon as possible, probably as a subgroup of the proposed Reproductive Health Committee.
- One of the first actions of the commission should be to review barriers to the use of long term methods, and explore ways to ensure contraceptive security for priority groups such as low income rural populations and young people.

## **APPENDIX C**

### **AFPP Extension Work Plan October 2006 – June 2007**



GHS -I-00-03-00026-00



MINISTRY OF HEALTH

# Extension Work Plan

October 1 – June 30, 2007



## Albania Family Planning Project 2004 – 2007

August 2006



The Albania Family Planning Project is implemented by John Snow, Inc. in collaboration with The Manoff Group

## **Background**

John Snow, Inc. (JSI) was awarded a two-year, cost-plus-fixed fee Task Order, Albania Family Planning Activity (referred to as the Albanian Family Planning Project, or AFPP.) The project aims to improve access to and use of modern family planning in Albania. AFPP works with the Ministry of Health (MOH) to increase contraceptive security, train health providers in family planning in 16 districts, and implement a mass media/BCC program that raises awareness of FP choices and promotes the use of modern contraception and the barriers to their use. AFPP's interventions are evidence-based and aimed at filling gaps in the national family planning program as documented in the USAID-supported Albanian Reproductive Health Survey and AFPP research.

## **Purpose of the Extension**

USAID has invested significant resources in family planning over the past ten years, and the purpose of this extension is to maximize the benefits of this assistance by extending the Albania Family Planning Activity for nine months to consolidate and institutionalize FP service improvements made during the past two years.

## **Strategic Approach During the Extension**

Family planning is a core PHC service, and therefore this extension will support the achievement of the Missions Strategic Objective, "Improved selected primary health care services."

The specific objectives of this nine-month extension are to

- 1) continue AFPP support for strategic activities (e.g., contraceptive forecasting, FP training for community midwives, television spots) that will enhance the quality and use of family planning services in Albania;
- 2) consolidate and further institutionalize AFPP's achievements-to-date in contraceptive security, family planning training and behavior change communication.

Now that all districts in Albania have been covered with the basic package of FP training and LMIS (funded by USAID 2001-2006), a major AFPP strategy during this extension will be to organize and provide technical assistance for a strategic re-assessment of the family planning situation in Albania. Given the low contraceptive prevalence rate (CPR) for modern methods, AFPP will assist the MOH to identify the major remaining barriers to increased contraceptive use and the next steps for improving the national FP program.

Contraceptive market segmentation is a key strategy, and AFPP will assist Albania in achieving the optimum balance among the public, social marketing and commercial sectors in the supply of contraceptives.

Another strategy will be logistics and technical support for the national contraceptive security forum (formerly called the National Contraceptive Security Commission) that oversees progress toward Albania's goal of contraceptive independence (no reliance on donors for contraceptives or the technical assistance to manage contraceptive supplies.)

AFPP's primary training strategy during the extension will be to follow up and provide on-the-job support to the facilities/health providers in the 16 target districts to reinforce skills.

The project will also expand family planning community outreach by providing FP training for an additional group of community midwives.

A key new strategy during this extension will be to identify two rapidly urbanizing “hot spots” within the project’s 16 districts where BCC/community outreach will be intensified with the aim of increasing access to information about the benefits of family planning and methods available to help women/couples achieve their reproductive health goals. BCC and training will work together to further train community midwives and their supervisors (for sustainability) in these two pilot areas so that they can carry out the BCC/community outreach, and thus demonstrate a model that may be useful to the MOH. In addition, AFPP will continue airing the two BCC television spots already developed, and shoot one new television spot aimed at a key barrier to the use of modern contraception in Albania.

For sustainability, AFPP will seek to 1) build capacity within the MOH and Institute of Public Health, 2) mobilize other donors (e.g. UNFPA) to support the national FP program, and 3) integrate selected AFPP activities into the ProShendetit Project.

AFPP will submit a final report at the end of the project in lieu of the annual report that would have been due in October 2006. Quarterly reports will be submitted in Oct 2006, January 2007, April 2007, and a final report in July 2007. See the Deliverables Table for a summary of reports.

## AFPP Extension Work Plan 2006-2007

	Activities	2006 -2007				Person Responsible	Output at End of Program
		Jul-Sep 06	Oct-Dec 06	Jan- Mar 07	Apr- Jun 07		
<b>Component 1: Contraceptive Security</b>							
1	Conduct Market Segmentation Study	X	X			STTA (P. Dowling)	Market Segmentation Guidelines
2	Provide ongoing technical support to the LMIS (contraceptive forecasting, storage & distribution)	X	X	X	X	LMIS Officer	Increased IPH ability to manage LMIS; reduced stock outs
3	Provide on-site LMIS training in districts with chronic data reporting problems			X		LMIS Officer	Improved contraceptive logistics management at district level
4	Provide refresher training for LMIS staff in 36 districts		X		X	LMIS Office	Improved contraceptive logistics management at district level
5	Introduce electronic LMIS data reporting in 20 districts		X	X	X	LMIS Officer	Improved contraceptive logistics management at district level
6	Support MOH implementation of the National Contraceptive Security Strategy 2006, including facilitating meetings of the National Contraceptive Security Forum	X	X	X	X	Project Director	Institutionalized contraceptive security process within MOH
7	LMIS TOT for IPH and master trainers			X		LMIS Officer Training Officer	Enhanced capacity of FP master trainers
<b>Component 2: Family Planning Training</b>							
8	Conduct on-going, supportive sessions with master trainers to share experience, provide updates and plan up-coming training activities	X	X	X	X	Training Officer	Enhanced capacity of FP master trainers
9	Conduct FP training for community midwives in two "hot spots" with potential for rapid CYP increase		X	X		Training Officer	Increased number of FP providers
10	Conduct follow-up visits to FP trainees in all 16 project districts	X	X	X	X	Training Officer	Enhanced FP skills among providers
11	Conduct final training assessment				X	Training Officer	Lessons learned & strategic recommendations

## AFPP Extension Work Plan 2006-2007

	Activities	2006 –2007				Person Responsible	Output at End of Program
		Jul-Sep 06	Oct-Dec 06	Jan- Mar 07	Apr- June 07		
	<b>Component 3: Behavior Change Communication</b>						
12	Develop new TV spot on FP		X	X		BCC Officer & STTA (L. Krieger)	New TV spot; changed FP behavior
13	Implement FP Outreach Negotiation Counseling (draft training curriculum and counseling cards)	X				BCC Officer & STTA (L. Krieger)	Improved FP outreach counseling training
14	Air three TV spots (2 old and one new)	X			X	BCC Officer	Increased discussion and acceptance of modern methods
15	Monitor and evaluate impact of BCC interventions	X	X	X	X	BCC Officer	M&E tools and results
16	Conduct training for community nurse midwives & their supervisors on FP Outreach Negotiation Counseling	X	X			BCC Officer	Improved access to FP counseling
17	Pre-test counseling cards, revise and print	X	X			BCC Officer & STTA (L. Krieger)	Counseling cards widely available and used
18	Implement community outreach activities		X	X	X	BCC Officer	Increased access to counseling and modern methods
19	Hold press workshop for print, radio, and TV journalists	X				BCC Officer	More accurate media reporting on FP issues
20	Conduct BCC follow up survey			X	X	BCC Officer & STTA (L. Krieger)	Extent of behavior change; lessons learned from BCC interventions
	<b>Component 4: Program Management/Planning</b>						
21	Finalize Extension Work Plan & PMP with USAID	X				Senior Adviser	
22	Maintain communication with USAID/JSI HQ	X	X	X	X	Project Director	Effective project implementation
23	Submit quarterly progress reports	X	X	X		Project Director	Achievements/lessons documented
24	Submit final reports				X	Project Director	Achievements/lessons documented
25	Conduct Strategic Re-Assessment of FP in Albania		X	X		STTA: L. Cappa	Strategic Guidelines to reduce FP barriers & increase CPR in Albania
26	Study tours/international conferences (8participants)			X		Project Director	Receptive policy framework for FP

## Performance Management Plan (PMP) for AFPP Extension 2006-2007

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Original Baseline (Year)	June 2006 Baseline	Current Quarter (enter dates for quarterly reports)	Expected & Actual Achievements during the Extension (Oct 2006–Sept 2007)	
								Expected	Actual
% of service delivery points providing family planning services	# of SDPs with commodities, trained provider(s), IEC materials/ total # of SDPs  SDP's = 440 MOH facilities (Maternities, WCRs, HCs); 300 currently providing FP and 140 additional sites will provide FP services Unit: %	LMIS Reports; project reports  Quarterly	16 Project Districts	LMIS Officer	0 % (2004 LMIS)	100% (188/188 <sup>17</sup> )		100%	
			National		68 % (2004 LMIS)	99.78% (456/457)		100%	
Couple years of protection (CYP) *	Total number of contraceptives distributed by type (method) in a given period with weights applied to different methods.  1 CYP = 15 Packets Oral Pills 1 CYP = 4 Depo Injections 3.5 CYP = 1 IUD 1 CYP = 120 Condoms Unit: #	LMIS Reports  Quarterly	16 Project Districts	LMIS Officer	774 per quarter (2004 LMIS)	1449.7		1700	
			National		3,750 per quarter (2004 LMIS)	4914		5500	

\*When calculated annually means average quarterly CYP

<sup>17</sup> The denominator of this indicator was adjusted upwards from 185 to 188 because there are 3 more SDPs more than originally planned (1 SDP in Kukes, 1 SDP in Has and 1 SDP in Tropoje)

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Original Baseline (Year)	June 2006 Baseline	Current Quarter (enter dates for quarterly reports)	Expected & Actual Achievements during the Extension (Oct 2006–Jun 2007)	
								Expected	Actual
% of service delivery points stocked out of condoms, POP, injectables and low dose contraceptives in 16 target districts	# of SDPs reporting zero stock of specific commodities/ # of SDPs reporting  Unit: %	Routine LMIS Reports  Quarterly	Project 16 districts	LMIS Officer					
			Condoms		28 %	9.2 %	10%		
			POP		64 %	37.9 %	10%		
			Low dose		22 %	34.5 %	10%		
			Injectables		14 %	50.6 %	10%		
% of SDPs in 16 target districts with staff trained using national FP curriculum	# of SDPs in target districts with at least one staff person trained using national FP curriculum/ total # SDPs in intervention districts  SDP = MOH facilities (maternities, WCRs, health centers) Unit: %	Training Records; Quarterly	<b>By type of SDP:</b>	Training Officer					
			Maternity		0 %	100% (16/16)	100%		
			WCR		0 %	100% (21/21)	100%		
			Health Center		0 %	100% (151/151)	100%		
			<b>By cadre:</b>						
Doctors	0 %	100% <sup>18</sup> (173/173)	100%						
Nurses/ midwives	0 %	103.70% <sup>19</sup> (390/376)	100% (428/428)						

<sup>18</sup> Denominator is corrected from 180 to 173 because 16 out of 21 WCR had not Ob-Gyn provider working there

<sup>19</sup> There are trained 14 N/M more than initial target because of local health services need for trained providers to offer FP services

<b>IR 3: Use of PHC services increased</b>									
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Original Baseline (Year)	June 2006 Baseline	Current Quarter (enter dates for quarterly reports)	Expected & Actual Achievements during the Extension (Oct 2006–Jun 2007)	
								Expected	Actual
<b>IR 3.1 Access to PHC services increased</b>									
Total # of family planning visits in 16 target districts	Total clients visits to SDPs for first FP visits, re-visits, and counseling  Unit: #	LMIS Reports;  Quarterly	First visits	LMIS Officer	750 per quarter	2416		3500	
			Re-visits		1339 per quarter	2550		3100	
			Counseling only		686 per quarter (2004 LMIS)	3266 (2006 LMIS)		4500	
<b>IR3.2 Awareness of PHC services increased</b>									
% MWRA attending MCH SDPs, who have been exposed to at least one campaign material and can state at least one message	# of MWRA attending MCH SDPs, who state that they have been exposed to at least one campaign material and can state at least one message/ # of MWRA interviewed. Unit: % Campaign materials = TV spots or programs, events, pamphlets/ brochures). MWRA attending SDPs that provide MCH services are MWRA attending target facilities for maternal or routine child health care	Exit interview at SDPs; during campaign; end of project		BCC Officer	0%	38%		55 %	

IR3.3: Community participation in health promotion activities increased									
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Original Baseline (Year)	June 2006 Baseline	Current Quarter (enter dates for quarterly reports)	Expected & Actual Achievements during the Extension (Oct 2006–Jun 2007)	
								Expected	Actual
% of villages which have FP service provided by at least one community midwife in 16 districts	# of villages which have FP service provided by at least one community midwife in 16 districts / total # of village in the 16 districts  Unit: %	Training Records; Quarterly	16 Project Districts	Training Officer	0	19.50% (259/1328)		32% (420/1328)	

<b>Albania Family Planning Program</b>		
<b>Deliverables Timeline</b>		
<b>Due Date</b>	<b>Report / Deliverables</b>	<b>Submission Details</b>
<b>Project Year 1</b>		
October 30, 2004	Annual Workplan	Send to CTO, file, Hashem; electronic copy to DEC
November 17, 2004	Interim Foreign Tax Report	Send to CO, file
November 18, 2004*	October 04 Invoice	Send to CO, file
December 18, 2004*	November 04 Invoice	Send to CO, file
January 18, 2005*	December 04 Invoice	Send to CO, file
January 30, 2005	Quarterly Progress Report (Finance & LOE)	Send to CTO, file, Hashem; electronic copy to DEC
February 18, 2005*	January 05 Invoice	Send to CO, file
March 18, 2005*	February 05 Invoice	Send to CO, file
April 16, 2005	Final Foreign Tax Report	Send to CO, file
April 18, 2005*	March 05 Invoice	Send to CO, file
April 30, 2005	Quarterly Progress Report	Send to CTO, file, Hashem; electronic copy to DEC
May 18, 2005*	April 05 Invoice	Send to CO, file
June 18, 2005*	May 05 Invoice	Send to CO, file
July 18, 2005*	June 05 Invoice	Send to CO, file
July 30, 2005	Quarterly Progress Report	Send to CTO, file, Hashem; electronic copy to DEC
August 18, 2005*	July 05 Invoice	Send to CO, file
September 18, 2005*	August 05 Invoice	Send to CO, file
<b>Project Year 2 Oct '05 - Sep '06</b>		
October 18, 2005*	September 05 Invoice	Send to CO, file
October 30, 2005	Annual Report	Send to CTO, file, Hashem; electronic copy to DEC
October 30, 2005	Annual Workplan	Send to CTO, file, Hashem; electronic copy to DEC
November 17, 2005	Interim Foreign Tax Report	Send to CTO, file
November 18, 2005*	October 05 Invoice	Send to CO, file
December 18, 2005*	November 05 Invoice	Send to CO, file
January 18, 2006*	December 05 Invoice	Send to CO, file
January 30, 2006	Quarterly Progress Report	Send to CTO, file, Hashem; electronic copy to DEC
February 18, 2006*	January 06 Invoice	Send to CO, file
March 18, 2006*	February 06 Invoice	Send to CO, file
April 16, 2006	Final Foreign Tax Report	Send to CO, file
April 18, 2006*	March 06 Invoice	Send to CO, file
May 18, 2006*	April 06 Invoice	Send to CO, file
June 18, 2006*	May 06 Invoice	Send to CO, file
July 18, 2006*	June 06 Invoice	Send to CO, file

July 30, 2006	Quarterly Progress Report	Send to CTO, file, Hashem; electronic copy to DEC
August 18, 2006*	July 06 Invoice	Send to CO, file
September 18, 2006*	August 06 Invoice	Send to CO, file
October 18, 2006*	September 06 Invoice	Send to CO, file
<b>Extension Period Oct '06 - Sep '07</b>		
<b>Administrative Deliverables</b>		
October 31, 2006	Quarterly Progress Report	Send to CTO, file, Hashem; electronic copy to DEC
November 18, 2006*	October 06 Invoice	Send to CO, file
December 18, 2006*	November 06 Invoice	Send to CO, file
January 18, 2007*	December 06 Invoice	Send to CO, file
January 31, 2007	Quarterly Progress Report	Send to CTO, file, Hashem; electronic copy to DEC
February 18, 2007*	January 07 Invoice	Send to CO, file
March 18, 2007*	February 07 Invoice	Send to CO, file
April 16, 2007	Final Foreign Tax Report	Send to CO, file
April 18, 2007*	March 07 Invoice	Send to CO, file
April 30, 2007	Quarterly Progress Report	Send to CTO, file, Hashem; electronic copy to DEC
May 18, 2007*	April 07 Invoice	Send to CO, file
June 30, 2007	Final Report	Send to CTO, file, Hashem; electronic copy to DEC
<b>Major Program Deliverables</b>		
September 30, 2006*	Market Segmentation Guideline	Send to CTO, file
October 2006*	Strategic Guidelines to reduce FP barriers & increase CPR in Albania	Send to CTO, file
End of Project	Electronic LMIS reporting in 20 districts	Document in Quarterly Report
End of Project	428 community midwives trained in FP	Document in Quarterly Report
December 2006*	New TV Spot	Document in Quarterly Report
September 2006*	Counseling Cards on FP Outreach Negotiation	
September 2006*	Curricula on FP Outreach Negotiation	
End of Project	300 midwives trained in FP outreach negotiation	
October 2006*	10-15 trained journalist oriented to FP issues	Document in Quarterly Report
April 2007*	Report on BCC/PMP	Send to CTO, file

\* The submission date might not be necessary exact, it might range up to 30 days

# DJIBOUTI

**Expanded Coverage of Essential Health Services  
in Djibouti**

**Annual Report**

**Project Year 2: May 1<sup>st</sup> , 2005- April 30<sup>th</sup> , 2006**



Health Post Dedication with the Minister of Health, US Ambassador,  
USAID/REDSO Regional Director, USAID Representative and  
JSI/PECSE COP

**Submitted by Dr. Stanislas P. Nebie, Chief of Party  
John Snow, Inc.**

**New updated version in July 2006**

**B.P. 86 Djiboutiville, Djibouti**

**USAID Contract IQC GHC-I-00-03-00026-00, Task Order 800**

**This Annual Report of the USAID/ Djibouti Expanded Coverage of Essential Health Services Project implemented by John Snow, Incorporated was made possible through support provided by USAID/ Djibouti under the terms of USAID Contract IQC GHC-I-00-03-00026-00, Task Order 800. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.**

**PECSE**

**John Snow, Inc.**



**B.P. 86  
Djiboutiville, Djibouti**

**USAID Contract IQC GHC-I-00-03-00026-00, Task Order 800**



Trained Midwife immunizing children at the Rehabilitated Health Post in Medeho

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## Acronyms

BCC	Behavior Change Communication
CA	Cooperating Agency
CHC	Community Health Center
CME	Continuing Medical Education
CMH	Centre Medico Hospitalier (District Hospital)
COP	Chief of Party
CS	Child Survival
CTO	Cognizant Technical Officer
DEPCI	Direction of Studies, Planning, and International Cooperation
DHMT	District Health Management Team
EOC	Emergency Obstetrical Care
EPI	Extended Program of Immunization
FHI	Family Health International
FP	Family Planning
HGP	Pelletier General Hospital
HIS	Health Information System
HMIS	Health Management and Information System
HP	Health Post
IEC	Information, Education et Communication
IMCI	Integrated Management of Childhood Illness
IST	In-service Training
JSI	John Snow Inc.
MCH	Maternal and Child Health
MHC	Medical Hospital Center
MOE	Ministry of Education
MOH	
	Ministry of Health
NGO	Non-governmental Organization
PECSE	Projet d'Extension de la Couverture des Soins de Santé Essentiels (Expanded Coverage of Essential Health Services)
PMP	Performance Monitoring Plan
PY	Project Year
QA	Quality Assurance
RH	Reproductive Health
RMT	Regional Management Team
STIs	Sexually Transmitted Diseases
TA	Technical Assistance
UGP	Project Management Unit of the Ministry of Health
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
WHO	World Health Organization

## EXECUTIVE SUMMARY

During this second year of the Expanded Coverage of Essential Health Services in Djibouti Project (PECSE), activities have accelerated at all levels.

The rehabilitation of health service delivery sites continues and the project has rehabilitated a total of ten health posts in rural areas. PECSE has also co-funded the rehabilitation of an urban health post in Djibouti (Ambouli) in order to contribute to the development of national child and maternal health activities.

Procurement of medical materials and equipment for all health facilities and a small additional reserve stock continued at a fast pace. The project utilised procurement expertise from JSI/Boston for the finalisation of the technical request for proposal, and also the launching of the process at an international level. The complexity of USAID rules and regulations made this assistance necessary and moved the process forward as quickly as possible. Before the end of this second project year, the Memorandum of Negotiation was submitted for approval to the PECSE Contracting Officer based at REDSO/Nairobi.

In order to support routine immunization (EPI) services, a joint program for EPI has been developed in collaboration with WHO, UNICEF and the Ministry of Health. Its implementation will contribute to the effective coordination of the capacity building for EPI implementation. Expert technical support to EPI has been obtained from ImmunizationBASICS, a centrally funded USAID project implemented by JSI, and began in PY2.

Quality of services continues as a top priority. The training of health providers continued with two rounds of training for clinical providers in all five districts and the first round of training of District Health Management Teams in supervision.

At the same time, the health information system (HMIS) tools have been revised and duplicated for the health facilities. The HMIS support plan implementation was delayed due to the weakness of the MOH unit responsible for HMIS activities and the PECSE Project supported the MOH in revising the HMIS Work Plan. JSI provided expert assistance in HMIS development through USAID's MEASURE/Evaluation Project, with consistent help from the same high-level technician throughout the first two years of PECSE. A new head for the HMIS Department was named towards the end of PY 2, increasing the likelihood of fast progress.

Social mobilization activities gained impressive momentum this year. After the experiences and results of the study tour to Ethiopia and Madagascar were shared, a new consensus about the importance of community mobilization began to emerge.

Activities to build national capacity in this area were implemented, including a Training-of-Trainers (TOT) workshop in Djiboutiville and the district capitals for selected community mobilizers. These community agents participated in the orientation and training of all health committee members and community health workers, not only in the five model sites, but in all communities around health posts in the five regions as planned for the extension of these activities to near national-scale.

Seven new radio spots about seven of the different basic health themes supported by PECSE were developed, prepared in three languages and pretested, and broadcast on national radio. Flipcharts on many health themes supported by the project were also developed, tested and printed.

During the 3rd quarter of PY 2, the Performance Monitoring Plan (PMP) was modified to take into consideration USAID/REDSO and USAID/Djibouti recommendations, including updating baseline data in order to make indicators more realistic. JSI deeply appreciates the assistance in this area. The

PECSE Work Plan has also been modified to reflect changes since the initial planning of the project in 2004.

PECSE conducted an evaluation of potable water sources in all health posts in order to identify and estimate the cost of feasible actions to ensure potable water supply in health facilities. USAID and PECSE continue to study the results.

The regular coordination meetings between health partners and the MOH continued during this second project year, as well as specific meetings on different important themes of the project implementation, such as the social mobilisation, the routine immunization and the health management information system.



DonorCoordination Meeting, December 2005

## 1. INTRODUCTION INCLUDING MAJOR HIGHLIGHTS

JSI was awarded the TASC II contract for Djibouti “Expanded Coverage of Essential Health Services” in late April 2004. This report covers progress from April 1<sup>st</sup> 2005 until May 31<sup>st</sup> 2006, or Program Year 2 (PY 2) of the project.

The contract stipulates the following anticipated results for the three-year implementation period:

- Service delivery areas and water systems in targeted health facilities will be rehabilitated and facilities equipped to support the provision of essential services;
- Training programs will be enhanced and expanded to improve and maintain skills of health care providers;
- Service management systems will improve and sustain the quality and efficiency of health services;
- Health facilities will be linked to community health aides and community health committees;
- Communities will be engaged in supporting, managing and mobilizing health activities.

In addition, USAID expects to achieve the following Intermediate Results (IR):

- IR 1: Increased Supply of Essential Health Services;
- IR 2: Improved Quality of Services;
- IR 3: Enhanced Local Capacity to Sustain Health Services.

Each of these IRs will be measured by project benchmarks, and has been finalized and included in the Performance Monitoring Plan (PMP). This PMP was developed during the third quarter (PY 1), and revised after the visit of Dr. Vathani from USAID/REDSO and according to additional comments by Mr. Tom Hall, CTO.

USAID recently informed JSI in March 2006 that the following four indicators are the main focus for USAID work in the health sector:

1. Number of targeted health facilities refurbished providing essential services package
2. Number of training modules implemented
3. Number of health facilities linked to community health committees
4. DPT3 Coverage<sup>1</sup>

Following Dr Vathani’s second update on the USAID PMP (April 2006) these indicators were switched to

1. DPT3 Coverage
2. Percentage of health facilities linked to community health committees with both male and female representation
3. Percentage of health posts rehabilitated with a water system
4. Number of training modules implemented

Highlights of second project year include:

- Seven additional facilities being refurbished and the technical plans for six remaining facilities requiring renovation were completed;
- Second round of health provider training was completed and District Health Management Teams trained in supervision;
- Health Committees linked to health facilities with trained community health volunteers extended beyond the five model sites and will continue during the third project year in order to complete coverage all the 23 project sites;

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<sup>1</sup>USAID has noted that they will use Ministry of Health data for this indicator.

- A Joint Program Plan for EPI was developed in collaboration with WHO, UNICEF and the Ministry of Health. Its implementation will contribute to the effective coordination of capacity building for EPI implementation.



Training for Community Volunteers' Work Plan Development



Nurse Training Sessions

## 2. CONTEXT

Djibouti's population ranges between 500,000 and 700,000 (for political reasons, a national census has not been conducted in decades). It is estimated that 75 per cent of the total population of Djibouti lives in the capital city. 83 per cent live in urban areas (the capital and other cities – e.g. Ali Sabieh, Dikhil, and Tadjoura), and approximately 15 per cent of the total population is composed of refugees from Somalia and Ethiopia. Djibouti's poverty, high unemployment and chronic humanitarian and social needs make it susceptible to instability and social and economic collapse (based on information from USAID/Djibouti in 2005). The physical environment is challenging, outside of the capital and normal temperatures from May to September of over 40 degrees Celsius. In addition, there is significant population movement out of Djibouti and some secondary cities during this period, to both rural areas and to Ethiopia, Eritrea and Yemen.

Djibouti's fairly high per-capita income of US \$900 (World Bank 2003) relative to the average Sub-Saharan Africa country, and the high proportion of its population living in urban areas, are belied by its poor health indicators, including high rates of infant, child and maternal mortality, total fertility, and malnutrition. Access to quality health services across Djibouti, particularly outside Djibouti, is challenged by its poor health infrastructure (which was further worsened by the civil war from 1991 – 1994); a lack of equipment, supplies, and human resources in health facilities, particularly for conducting outreach activities; inadequately trained staff; and poor management of health facilities. In addition, anecdotal evidence suggests that the financial cost of accessing services, even where physical access exists, is a major barrier to improving health.

Administratively, Djibouti divides the country into health management zones of Djibouti, and five health districts of Arta, Ali Sabieh, Dikhil, Obock and Tadjoura. Four of the five districts have district hospitals; Arta, closest to Djibouti, does not have a district hospital. At this time, each district has one physician based in the district capital. Each district has several health posts, and most have a mobile clinic staffed by one expatriate physician. Some districts have other specialized health care facilities including military or refugee health facilities that are not open to the general public or staffed by the Ministry of Health.

A relatively poor knowledge of health among its population, coupled with a general lack of engagement of communities and civil society to participate in health and development issues, affect both the supply and demand sides of the health service equation. Low literacy rates especially among women and girls, very limited access to mass media, low school attendance rates, regular population movement and multiple languages make improving basic health knowledge a major challenge.

Djibouti suffers from a lack of reliable health statistics, in large part due to the denominator problem as well as a weak and inconsistent reporting system. The available data provide only a partial picture of the situation, and existing data show a poor health situation overall. After 1990, in large part due to civil unrest in the country that began in 1991, health indicators, including reported immunization coverage, decreased drastically.

The Ministry of Health struggles with low levels of trained staff, a historical concentration of physicians and other trained staff in tertiary care facilities in Djibouti, and little success in implementing primary health care measures throughout the country. The Government of the Republic of Djibouti (GORD) is well aware of these challenges and has undertaken a health reform program which emphasizes a decentralized management system, rationalized use of existing personnel, and an increased emphasis on prevention and primary care throughout the system.

### 3. COMPLETED ACTIVITIES: PROJECT YEAR TWO

The PECSE Work Plan developed in 2004, approved by both the Ministry of Health and USAID, has been modified to reflect changed circumstances and USAID priorities, and continues to be one of the two primary guiding documents for the implementation of PECSE. The PECSE Performance Monitoring Plan (PMP) is the monitoring and evaluation plan for the PECSE Project. It was developed with the MOH and with technical assistance from MEASURE/Evaluation to track PECSE and MOH performance; MEASURE/Evaluation continues to provide technical support for implementation. It was developed during PY1 and was recently updated following suggestions and guidance from Mr. Tom Hall, CTO, and Dr Vathani from USAID/REDSO. The adjustment harmonised PECSE project indicators and the finalized USAID annual report indicators.



PECSE has also provided support to improving the MOH's Health Management Information System (HMIS). Generally, the MOH department known as "DEPCI" is recognized as the structure responsible for HMIS management, including such as data collection, dissemination, recording and analysis. This includes not only routine HMIS data from the health facilities, but also non-routine data collection methods such as periodic surveys. This department is also responsible for the management of the computer system for the HMIS, including hardware and appropriate software. Like much of the MOH, the DEPCI is not currently staffed sufficiently to perform these functions at the central and district levels. Neither routine data nor surveys are consistently completed and the plan to improve performance of the HMIS is delayed due to lack of human capacity at the MOH. Following technical assistance from MEASURE/ Evaluation to assist in the development of the HMIS, PECSE provided a frank assessment of obstacles to the Ministry. The Minister of Health then determined that naming a new manager for the HMIS was necessary, and pronounced clear guidelines for the improvement of the HMIS.

#### IR 1: Increased Supply of Essential Health Services

PECSE has an ambitious program of actions to increase health service supply. Many of the activities under this IR are prerequisites for improved quality of care (IR 2).

- PECSE continued to work closely with WHO and UNICEF to develop a joint program of support for routine immunization;
- District Management Teams received support from PECSE to develop a draft job description for the teams and to begin to develop skills (and willingness) to take on the role of

management of the health districts;

- Rehabilitation work continued in both the north and the south districts including also a site in urban area (Djibouti District). At the end of this second year, only six sites will remain to be rehabilitated, a task foreseen for the third project year.
- During this second project year, a long procurement process for medical materials and equipments was conducted. This required technical support from JSI headquarters, and required USAID Contracting Officer approval is anticipated shortly; the materials should arrive in Djibouti in the fall of 2006.
- PECSE supported the initiatives of the MOH to organise a National Health Forum for the Decade Health Plan, and a Regional Conference against Female Genital Mutilation (FGM). Participants from the districts and several associations came and discussed main issues related to cost recovery, community mobilisation, health sector decentralisation, FGM, etc.
- The essential health package identified by PECSE in collaboration with USAID and the MOH was modified in order to correspond with USAID's performance monitoring system by also adding the encouragement of assisted deliveries. The essential health package for PECSE includes:
  - Recognition of danger signs for pregnant women and prevention activities against malaria, anaemia and tetanus;
  - Child growth monitoring and breast feeding;
  - IMCI (integrated Management of Childhood Illnesses) focusing on diarrhoea control, ARI, and immunization;
  - Treatment of common diseases, such as malaria;
  - IEC and Health Education;
  - Counselling for HIV/AIDS Prevention;
  - School health ( prevention of diseases);
  - Community based services;
  - Assisted deliveries.

## IR 2: Improved Quality of Services

Activities under this IR have focused on human resource development and improvement of support to rural service providers including increased supportive supervision. Key achievements include:

- Members of the District Management Teams in the five districts were trained in improving quality of services and technical supervision.
- The training of service providers in the districts that was begun during PY 1 continued, primarily on themes of maternal and child health.
- The PECSE Project team assisted the Head Physician (Medical Director) of each district to supervise personnel in the Health Posts in their districts. PECSE expects the District Health Management Teams to take ownership of supervision activities, which will add to the sustainability of services.



PECSE Project also trains Nurses in Hand Washing  
And Glove Use for Infection Prevention



### IR 3: Enhanced Local Capacity to Sustain Health Services

Following the study tour to Madagascar and Ethiopia to share the social mobilisation experiences developed in these countries by JSI, MOH interest in social mobilisation increased. Currently, the MOH is working with the PECSE Project team in order to develop National Strategy for Social Mobilisation. The framework of this strategy was proposed by PECSE, and the MOH invited all other health partners for a discussion for this new approach. One of the challenges for the development of this activity is the lack of a MOH department in charge of social mobilisation, which leads to weakness in the organisation and coordination of these activities.

PECSE's community mobilization specialist found far more enthusiasm for education and mobilization at the community level itself, although in remote areas concerns for basic survival were foremost for the population due to the years of severe drought conditions that have followed years of minimum survival among the semi-nomadic tribes.

A framework for five communities has been constructed and community health workers selected to work with the MOH through the health posts in their vicinity. At the end of the second year, the PECSE Project started with the extension of social mobilization activities in all health posts in the rural area and now 15 health posts are linked with community health committees with both male and female representation.

- Community members, especially those on Health Committees, were trained in social mobilization techniques. This training will be expanded to all Health Committees in health posts during PY 3.
- Seven radio spots were produced and broadcast during the year, in three different languages.
- Flipcharts for use in the community, representing all key PECSE themes, were pre-tested in the field and duplicated.
- Voluntary community workers were assisted in developing monthly Activity Plans for outreach and community education.

#### **4. PROGRESS TO DATE: ON-GOING ACTIVITIES**

**Procurement:** The procurement process is well underway. This complex process took more time than expected and will allow PECSE to equip all the health posts covered by the project at one time. In addition, PECSE will equip other health facilities rehabilitated by partners such as the WHO or US Military that are not completely equipped.

**Collaboration with the Education Sector:** Development of school workbooks and posters with messages for the promotion of the health is complete and materials ready to be printed.

**Support to Supervision:** Not all the health posts supervised by the district health management team due to lack of logistics. The health posts' supervision is indispensable for the improvement of quality of service, management of the Health Information System and broad community participation. Lack of adequate transportation at the MOH means that this activity is difficult to conduct; the only supervision regularly taking place is conducted with PECSE Project logistical support. Discussions with USAID/Djibouti about procuring additional cars for District Health Management Team use resulted in a request being made to the project's USAID Contracting Officer to procure additional

vehicles; the response is pending.

HMIS: The development and finalisation of the data collection tools had a significant delay due to the DEPCI department of the MOH. Training on the utilization of these tools is ongoing, and database development and implementation is planned for the third year of the project.

Rehabilitation of Health Posts: The rehabilitation works of the health posts took more time than foreseen due to the MOH technicians' lack of availability. Therefore, the work plan was respected and PECSE will complete the rehabilitation work in all the project sites during the third project year.

Community Mobilization: The expected extension of social mobilisation activities in the project sites was planned for 11 sites during this second year and the project reached 15 sites and went beyond the target. However, the training of community health animators did not take place, because the technical assistance from the social mobilisation specialist was not available as planned.

STI/HIV/AIDS: As one of the key concerns for PECSE, STI and HIV/AIDS are part of the service delivery package to be offered at each MOH site. PECSE is becoming increasingly concerned about the complete lack of training, equipment and drugs to face STIs and HIV in the districts. While the FHI is implementing an HIV/AIDS prevention project in two sites along the major transportation corridor, the PECSE Project plans to add the same prevention activities in the other health posts in next year. In the meantime, some primary prevention materials have been designed and pre-tested.

## **5. QUARTERLY PERFORMANCE INDICATOR ACHIEVEMENT SUMMARY**

### **5.1 *USAID Report Indicators***

#### **Indicator 1: DPT 3 Coverage**

The PECSE Project team collected and analyzed the MOH data on DPT3 by using the available data at the MOH level in which the quality cannot be trusted (see attached). The basic rate is estimated at 11% in rural zones. According to the revised PECSE project PMP, the target of this indicator for the second year of the project is 13%. As this indicator is recorded annually, the current rate is estimated at 16% in the rural areas, which is higher than the PECSE PY 2 target. The national average will be obtained by USAID from the MOH data. There is, however, a need for the health partners to work with the Ministry of Health to agree upon the status of current national indicators.

#### **Indicator 2: Number/percentage of health facilities targeted by PECSE and equipped that provide the basic package of services**

The basic package of services include: Immunization, growth monitoring, breastfeeding promotion, antenatal services, assisted deliveries and /or family planning. The current numbers of facilities which have been rehabilitated and completely equipped are zero since the procurement process is still ongoing. Therefore, the 13 health posts refurbished until this quarter waiting for equipment and furnishings. In order to complete this indicator equipping must be completed, which will take place during next quarter.

#### **Indicator 3: Number/percentage of health facilities linked to community health committees with both male and female representation**

The project reached the target of 23 sites (out of 23) that were functioning with community health committees with both genders represented. The target of the third year was 61% (14 Health Posts) but the Project developed health committee with both male and female representation in all the health posts (100%) in this quarter.

#### Indicator 4: Number/percentage of communities with trained community health workers

The target for the third year was 80%, which means a total of 18 health committees with trained community health workers. At the end of this first quarter of the third year, the project reached his target by training community health workers in all the sites which means 100%. The PECSE Project also trained two or three community health workers for each of the 23 health post communities.

#### **5.2 Indicators by Expected Results:**

##### IR 1: Increased Supply of Essential Health Services

- IR 1.1 Population Coverage rates: This indicator remains difficult to obtain for each facility because the population covered by each facility is not officially known. The current rate is estimated to 38%. (Catchments area population need to be estimated )
- IR-1.2 Number/percentage of health facilities targeted by PECSE and equipped that provide the basic package of services.  
The basic package of services include: Immunization, growth monitoring, breastfeeding promotion, antenatal services, assisted deliveries and /or family planning. The current numbers of facilities which have been rehabilitated and completely equipped are zero since the procurement process is still ongoing. Therefore, the ten health posts refurbished as planned for the second project year target are all rehabilitated and waiting for equipment and furnishings. In order to complete this indicator equipping must be completed, which will take place during PY 3.

##### IR 2: Improved Quality of Services

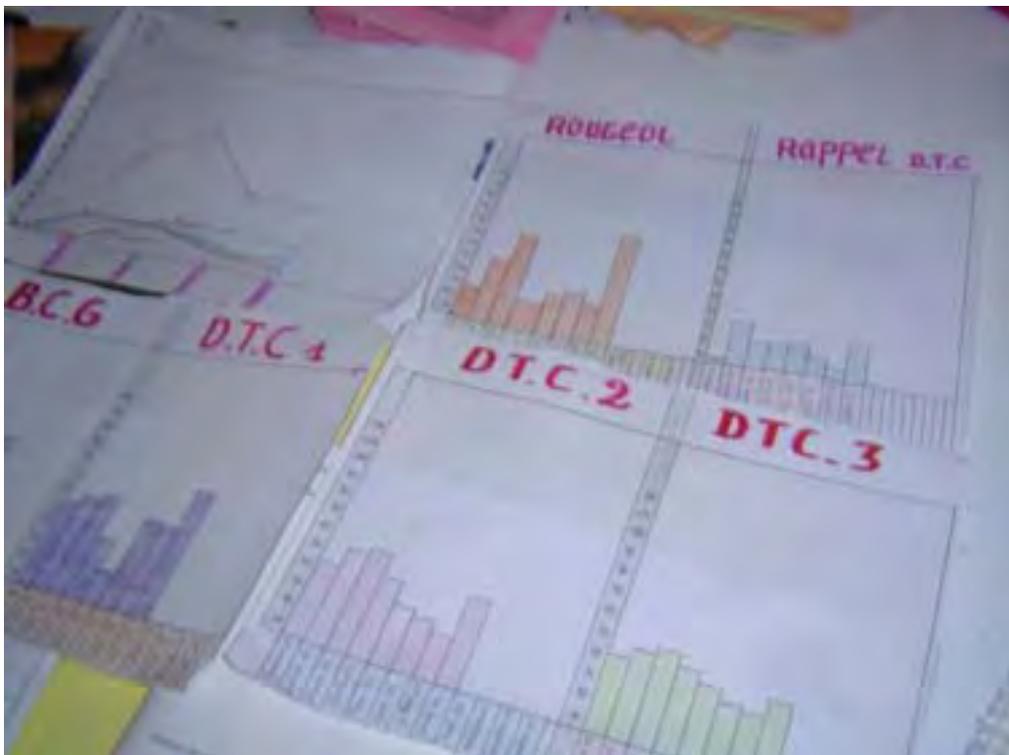
- IR 2.1 Number of trained health workers (including community health workers and community health committee members) in the Project Area: The PY 2 target was at least 250 health workers to be trained and the project reached a total of 259 health workers (including community members) trained.
- IR 2.2 Number/Percentage of health posts supervised according to MOH guidelines for supervision and management. The target of the second year is 35% (8 health posts). Currently, only the five model sites (21%) are supervised with the PECSE project logistical support.

##### IR 3: Enhanced Local Capacity to Sustain Health Services

- Number/percentage of communities with trained community health workers  
The target for the second year was 22%, which means a total of 5 health committees with trained community health workers. At the end of the second year, the project reached this target by training community health workers in the fives model sites. The PECSE Project plans to train two or three community health workers for each of the 23 health post communities during the next two quarters. Additional training sessions were planned for new health committees in the 3<sup>rd</sup> quarter of the second program year, but for administrative reasons the TA was unable to take place and this activity will be conducted early in the third project year.



Trained Nurse in Tadjoura District collecting Data for the Monthly Report



## **6. SUMMARY OF PLANNED ACTIVITIES FOR NEXT YEAR AND EXPECTED RESULTS**

The next Annual Report, for PY 3, will cover the period from May 1<sup>st</sup> 2006 to April 30<sup>th</sup>, 2007. The following main activities have been planned for the year:

### **IR 1: Increased Supply of Health Services**

- Implementation of joint support plan for routine vaccination
- Technical Assistance for routine immunisation from ImmunizationBASICS
- Rehabilitation of health posts
- Equipping all concerned health facilities (health posts and MCH clinics)

### **IR 2: Improved Quality of Services**

- Supervision of health posts providers in the rural districts
- Supplying health information system tools to all health posts and district hospitals
- Train the health providers in use of new tools for Health Management and Information System (HMIS) and begin implementation of the system
- Technical Assistance from MEASURE/Evaluation to develop the Health Management and Information System and national database including human resource development at the central MOH.

### **IR 3: Enhanced Local Capacity**

- Training of health providers in social mobilization and health information systems
- Broadcast additional radio spots on the health priority themes supported by PECSE per its work plan
- Distribution of school workbooks and posters, and provision of any needed technical support for their use
- Implementation of flip charts especially for the community health workers
- Extend social mobilisation activities around the health posts
- Organise meetings on HMIS development, routine immunization program support and development of social mobilisation strategy.

For more information about planned activities, please see the revised PECSE Work Plan for 2006-2007.

## **7. Management and Cost Control**

PECSE has been a well-managed project from the beginning, prudent in its use of resources and transparent in its relations with the Ministry of Health, USAID and other local and donor partners.

### Coordination with USAID and the US Military:

Regular meetings and routine sharing of information and issues has reinforced on-going positive coordination with USAID. PECSE continues to enjoy excellent technical and administrative support from USAID in Djibouti and USAID/REDSO in Nairobi. In 2005 and 2006, USAID's long-term Senior Health Advisor (Davis) arrived in Djibouti and also Dr Vathani, REDSO Director of Population, Health and Nutrition.

The PECSE Project works closely with the US Military in Djibouti, sharing information and coordinating efforts whenever possible. Specifically, PECSE coordinates renovation work with the US Military and will be equipping the health posts that they have refurbished. Recent discussions about avian influenza management are another case in point.

Unfortunately, a serious delay in payment of invoices by USAID/REDSO required many weeks to resolve; at this time, not all-outstanding payments have been received by JSI but the underlying problem has been identified and USAID is resolving it.<sup>2</sup>



Mouloud Health Post Dedication (Refurbishment done by the US Military and site equipped by the PECSE Project). From left: US Military General, US Ambassador, Minister of Health, USAID Reptive.

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<sup>2</sup>USAID changed part of its processing system and in the transfer, data was lost or transferred incorrectly including JSI's bank deposit information.

## Cost Control and Savings:

The PECSE Project uses all available means to provide good value to the US Government and quality services to the population of Djibouti. The management philosophy, applied to PECSE, is to both control costs and to seek ways to reduce costs whenever possible. During PY 2 of PECSE, a number of actions were taken to contain costs.

1. **Leveraging:** Whenever possible, PECSE shares funding for activities with the MOH and other donors or projects. For example, cost-sharing for training activities initiated by Immunization Basics were supported by additional funds provided USAID through WHO. National Immunization activities continued to be funded by multiple partners including PECSE. PECSE has also contributed to the commemoration of World Health Days in Djibouti with other partners (UNICEF, WHO, et al).
2. **Negotiating:** PECSE's Administrative and Financial Officer worked closely with the project's local bank to lower costs in a number of areas including wire fees, exchange rates and banking charges.
3. **Identifying Best Local Value:** When finalizing arrangements for the purchase of materials and equipment, PECSE went outside of the usual suppliers to find additional options, saving the project funds and obtaining a better model at a lower price. At the same time, PECSE has purchased the medical equipment by using a Request for Proposal in order to obtain the best price and quality.
4. **Using Local Government Resources:** Although the PECSE contract stipulated use of outside experts for engineering and architectural work on clinic rehabilitation, PECSE identified qualified experts within the MOH to do some of the work and increasing MOH ownership of the activities.
5. **Identifying Appropriate Resources:** Whenever possible, PECSE uses experts internal to JSI to provide needed technical support. Some of these experts come from other USAID-funded projects, such as MEASURE/Evaluation thus using US government resources whenever possible. PECSE has also utilized experts from other JSI projects overseas, who have first hand knowledge of similar conditions (Madagascar, Ethiopia). In both these cases, costs are usually lower than hiring independent consultants and results have been excellent to date.

Overall, PECSE has found a variety of ways to limit or reduce costs to the US government under this contract. These are in addition to following procurement and competition regulations and requirements, and also provide an excellent example to the Ministry of Health in how to best utilize available resources.

## **8. Challenges And Lessons Learned**

There were many challenges for the PECSE Project during PY 2, many of them stemming directly from overall human resource limitations in Djibouti. In addition, political issues including regional elections and changes in key MOH created delays and additional work.

### **Human Resources:**

In almost all health districts, key personnel have changed over the past two quarters. Most of the Head Physicians have changed, after they had received training from PECSE. This means redundancy in building relationships, training and coaching for supervision skills.

The good news is that newly assigned nurses in many health posts have, for the most part, adjusted easily and worked well with PECSE from the start.

Progress on renovations was significantly slowed by the Ministry of Health, when their engineers were no longer able to provide timely support to finalize renovation plans. PECSE was forced to look to the private sector, and expend considerable time and effort to identify high-quality, reasonably priced technical support. The health post rehabilitation process takes more time than planned. Equipment procurement processes have taken longer than expected; expert technical assistance in USAID procurement was needed from JSI to complete the work.

Capacity building for the health information system was significantly delayed due to the weakness of the MOH unit in charge of the HMIS. (The delay was for the approval of registration books and other daily, weekly and monthly reports for data collection.) The PECSE Project will support the HMIS teams at the central or at the district level, so that health data will be regularly collected analysed and its quality assessed. Computer materials and vehicles will be supplied by the project. PECSE will also support the development of electronic database for the data management of the HMIS and epidemiological surveillance.

Strong support for PECSE within the MOH led the Minister of Health to assign a new head manager for HMIS and to provide clear guidelines for the acceleration of training and baseline data collection. In parallel, PECSE will reinforce the HMIS with computer materials and senior staff from MEASURE/Evaluation will assist in the development of a national database.

As mentioned above, the regular mobility of the staff in charge of districts is a big concern, as is the low skill level of many staff in Health Posts. While the MOH has increased the level of staff in peri-urban and rural health posts, it is still inadequate. The MOH has promised to assign additional staff, particularly Midwifery Assistants, when they become available. Priority will be to staff recently renovated health posts.

The change in Ministers during PY 2 has led to some encouraging developments. Much of the slow pace of implementation of PECSE activities was due to the lack of MOH staff's motivation and to different ethnic considerations played out within the Ministry. The new Minister of Health is committed to pushing things forward; the technicians of the MOH involved in PECSE implementation are doing their best now to contribute to activities, but their low level of competency is a big challenge.

### Community Mobilization.

The Community Mobilization Study Tour was a success in several ways. The people who participated came back with renewed energy and a stronger commitment to their efforts. It may have also shifted opinions at the Ministry of Health, and the MOH began looking at community mobilization as an activity that could assist them in meeting their objectives.



Community Mobilization Activities

### Food Security.

The continued and worsening food security situation in parts of Djibouti, including a number of PECSE Project zones, have made any efforts at community mobilization difficult. Communities with serious food and water shortages are more concerned with basic survival than with preventive health measures.

Many children suffer from malnutrition, and PECSE has been involved in assisting the MOH to respond to this problem. In co-ordination with the MOH, PECSE included the preparation of a space for nutrition education and the recovery of malnourished children in health posts rehabilitation plans when possible. PECSE also supplied cooking materials for 33 health nutrition centres in rural areas as well as in District health centres. In addition, arrangements have been made at many health posts to prepare and secure areas for storage of food aid.

### Access to Safe Water.

Resolving the potable water issues at health posts is extremely complicated and fundamentally different at almost every site. The technical report commissioned by PECSE and completed this quarter details the options and costs for providing a permanent source of potable water at health posts; in many cases, it will be expensive.



Critical Struggle for Water in Djibouti

## Gender.

Concerning the gender approach, PECSE Project staff consists of both women and men in both technical and administrative functions. PECSE also works with the Ministry for the Promotion of Women and with the UNFD (National Union of Djiboutian Women) to create a Task Force in social mobilization and to train community health volunteers.

## Environment.

An environmental impact assessment completed by USAID early in PY 2 raised a number of concerns, maybe being addressed directly by PECSE. PECSE has adjusted its plans to meet suggested actions, and is supporting the creation of incinerators in all the health posts per USAID guidelines. In addition, PECSE is working with USAID to prioritize actions to improve access to potable water; accordingly, PECSE will fund drinking water supply mechanisms for some health posts.



Waste Management and Disposal Before and After Rehabilitation by the PECSE Project

## 10. A Success Story

To complete the supportive supervision training for the District Management Teams, Yoboki Health post (Dikhil District) was chosen for the practical exercises. When the population understood that the PECSE Project team and nurses were coming, women and children came out early in the morning expecting health care. The trainers were surprised to see so many people waiting for them, but they took this opportunity to consult the patients first and show quality care to the participants before doing the Yoboki nurse supervision.



Yoboki Village Women and Children Awaiting Care



The District Medical Officer (Dr Mohamed Hachi) providing care in Yoboki before Completing Supervision

## Summary Statement

The PECSE Project has made significant gains in a number of areas during this second year of project implementation, including measurable progress towards meeting each of the main intermediate results defined by USAID and operationalized through defined indicators. PECSE went beyond most of its targets for this second year, in a challenging context with numerous obstacles.

Some slight delays occurred in the training of community health animators, due to the regional elections and some administrative difficulties that delayed technical support. The long process of procurement of appropriate equipment and furniture to support the provision of essential services has caused PECSE much concern but is close to completion.

Several activities planned by the project in its 2004 work plan could not be implemented due to external reasons:

- the rehabilitation works for Arta District will not be covered by the project, following a request from the MOH, who have other sources of funding to cover this district. Even though the Project will equip the Arta district health posts.
- The support planned for the National Training Centre could not be conducted, since the MOH did not identify the needs the project could take into consideration.
- The health provider guidelines planned for all the health facilities could not be developed due to lack of local human capacity.
- Other planned support for the MOH could not take place, such as the installation of an intranet in the MOH office, the supply of a generator in case of a power failure. On the other hand, the rehabilitation works foreseen at the district hospital (Dikhil) were postponed by the MOH due to unknown reasons, etc.

PECSE works with the MOH to improve service management systems to sustain the quality and efficiency of health services, including supporting the development of the District Management Teams and supervision of health posts. However, the lack of human and material resources available to districts and motivational issues for many district teams cause supervision to be late or of poor quality.



PECSE COP Welcoming the President of Djibouti, the Minister of Health and Distinguished Guests at the PECSE Project Exhibition Stand.

PECSE prides itself on strong and consistent management, innovations in the Djiboutian context including non-discriminatory employment practices, and cost savings for the US government. Significant progress was made in improving overall health sector coordination and collaboration, and reinforcing within the MOH its primordial role as the ultimate source of health improvements for the country.

## *ANNEXES*

# ANNEXE I

## PECSE PROJECT INDICATORS STATUS UPDATE APRIL 2006

Indicators	Activities/ Mode of calculation of the indicator	Source of the data / Base line / Target	Timing	Annual Targets			Remarks
				Year 1	Year 2	Year 3	
<b>SPECIFIC OBJECTIVE (SO)</b> <b>To increase the expanded coverage of essential health services packages in Republic of Djibouti so that individuals have access to Health service that enable to reduce infant and maternal mortality and morbidity rate</b>							
Indicator 1 : DPT3 coverage	Numerator: number of children by 12 months having received DPT3 in a specified program year in PECSE areas Denominator: total population of child <12 months in PECSE areas	Routine Data Base line: 11 % target: 10% increasing from the second year	Annual	11%	13% <b>16%</b>	15%	In agreement with the definition of the cases worked out by the MOH The base line data in rural area was based on Djibouti Strategic framework against poverty 2004
Indicator 2: Number/ Percentage of Health Posts linked to functional community health committees with both male and female representation	Numerator :Number of Health Post in PECSE areas that are formally linked to a functional health committees with both male and female representation Denominator : Number of Health Posts in PECSE areas	Routine Data Base line : 0 Target: 61% of the 23 health posts ( 14 Health Posts) N= 23	Annual	5 22%	11 48% <b>15</b>	14 61%	- year 1: 5 - year 2: 6 - year 3: 3
Indicator 3: Number/Percentage of health posts rehabilitated , including a water system	Numerator: number of health posts rehabilitated with water system X 100 Denominator: Total health posts to be rehabilitated by PECSE	Rehabilitation report of PECSE Base line = 0 N= 16 Target = 100%	Quarter	3 17 %	10 63 % <b>10</b>	16 100%	16 Health Posts will be rehabilitated by the project ( other partners will rehabilitate the remaining 6 ) - year 1: 3 HP - Year 2: 7 HP - Year 3: 6 HP
Indicator 4: Number of training modules implemented	Number of training Modules developed and implemented in all the project districts	PECSE report Base line data =0 Target = 1 8	Quarter	10	15 <b>15 (2 other written but not used)</b>	18	- year 1: 10 - year 2: 5 - year 3: 3

<b>IR 1. INCREASED SUPPLY OF ESSENTIAL HEALTH SERVICES</b>							
IR : 1.1 Population Coverage rates	Numerator: total consultations (New + old) X100 Denominator: Total population in the health post catchments areas	Routine Data Project Documents Base line: 10-15% Target: 40 %	Quarter	10 %	20 % <b>38%</b>	40 %	Given the difficulties to obtain data from each facility for this indicator because of the unavailability for the demographic data for each health facility, we made an estimation for rural areas in collaboration with the HMIS team
IR : 1.2 Number/ Percentage of Health posts rehabilitated and equipped, providing a basic package of essential health services in PECSE targeted areas	Numerator : number of rehabilitated health posts in PECSE targeted areas that have essential equipment and provide a basic package of essential health services X100 Denominator: Number of health posts in PECSE areas	Routine Data Project Documents Base line: 0  Target: 19  N= 19 health Posts	Annual	3	10  <b>0</b>	19	- Year 1: 3 - Year 2: 7 - Year 3: 9  <b>10 Health posts are rehabilitated but still not equipped</b>
<b>IR 2: IMPROVED QUALITY OF SERVICES</b>							
IR: 2.1: Number of trained health workers (including community health workers and community health committee members) in the Project Area	Numerator : number of health workers trained X 100  Denominator: total of health providers targeted in the Project area.	PECSE documents Base line = 0  Target = 300	Quarter	<b>150</b>  <b>50 %</b>	<b>250</b>  <b>83%</b> <b>259</b>	<b>300</b>  <b>100%</b>	At least 300 Health workers will be trained till the end of the Project
IR- 2.2 Number/Percentage of health posts supervised according to MOH guidelines for supervision and management	Numerator : Number of health post supervised at least once every quarter X 100  Denominator : total health posts in the project area	PECSE report Level of base=0 N = 23  Target = 100 %	Quarter	50 %	35% <b>20%</b>	45%	PECSE aims at ; Organizing the supervision of the teams of all health posts in rural areas (N=23) Developing a supervision guide
IR-2.3 Number/Percentage of women seen at least once during their pregnancy	Numerator: number of women seen at least once during their pregnancy X 100 Denominator: a number of expected pregnancies	Routine Data Base line: 24% Target: 10% of increase per annum	Annual	24%	26% <b>24%</b>	28%	N.B.: numbers expected pregnancies $\cong$ total expected birth The base line of this indicator was estimated based on MOH Documents 2003

IR-2.4: Number/Percentage of births attended in a health facility	Numerator: Number of deliveries in a health facilities X 100 Denominator : Total number of expected pregnancies	Routine Data Base line: 20% Target: 20% of increase per annum	Annual	20 %	22% <b>23%</b>	26%	The base line of this indicator was estimated based on PAPFAM 2002 page 146
<b>IR3. ENHANCED LOCAL CAPACITY TO SUSTAIN HEALTH SERVICES</b>							
IR-3.1 Number of radio spots developed and broadcasted	Number of radio spots developed and broadcasted	Project Document	Annual	2	5 <b>7</b>	7	Year 1: 2 Year 2 : 3 Year 3 : 2
IR-3.2: Number/percentage of communities with trained community health workers	Numerator : Number of community with at least one trained community health volunteer Denominator : Number of Community within Health Posts in PECSE areas	Routine Data Base line : 0 Target: 87% of the 23 health posts ( 20 Health Posts) N= 20	Annual	0	5 22 % <b>5</b>	20 87%	- year 1: 0 - year 2: 5 - year 3: 15

**In red: updated situation as of April, 30<sup>th</sup> 2006**

**ANNEXE II: SUMMARY TABLE OF PECSE TRAININGS (April 2006)**

<b>DISTRICTS</b>	<b>Number of trainers trained 19-24 Mars 2005</b>	<b>Number of health providers trained 1st round</b>	<b>Number of health providers trained 2<sup>nd</sup> round</b>	<b>Number District Health Management Team (DHMT) trained</b>	<b>Number of DHMT members who trained the health providers</b>	<b>Number of the training centre members who supervised the DHMT training</b>	<b>Number of trainers trained in social mobilization and BCC</b>	<b>Number of health committee members and community volunteers trained</b>	<b>Number of health providers trained in HMIS</b>	<b>TOTAL</b>
<b>Ali-Sabieh</b>	4	10 24-27/04	17 13-15/10	6 18-21/11	4	4	11	10	2	60
<b>Dikhil</b>	4	14 17-19/05	13 12-14/10	3 18-21/11	6	4	6	21	2	63
<b>Arta et Périphérie</b>	1	16 05-07/07	14 01/02/06	3 18-21/11	1	4	3	10	1	58
<b>Obock</b>	4	11 11-13/07	15 20-22/10	4 12-15/11	6	4	9	12	2	56
<b>Tadjourah</b>	4	12 18-20/07	16 20-22/11	5 12-15/11	6	4	11	14	2	64
<b>Ville de Djibouti</b>	10+3	-	-	40	2	-	5+3	-	13	74
<b>TOTAL</b>	<b>30</b>	<b>63</b>	<b>61</b>	<b>61</b>	<b>23</b>	<b>18</b>	<b>48</b>	<b>57</b>	<b>22</b>	

*NB : The yellow columns were not included in the totals*

*In total, 259 persons were trained by the project consisting of health providers (154) community health workers (105), 106 health providers had a second round of training and 18 supervisors from the Training Centre (CFPS) have been utilised.*

*DHMT: District Health Management Team*

*HMIS: Health Management and Information System*

**ANNEXE IV: SUMMARY TABLE OF HEALTH FACILITIES REHABILITATIONS (April 2006)**

Region	Health Facility	Kind	Rehabilitation status
ALI-SABIEH	<b>ALI-SABIEH</b>	<b>CMH</b>	<b>NA</b>
	1. Holl Holl	Health Post	<b>Ongoing by PECSE</b>
	2. Dasbyo	Health Post	<b>Ongoing by PECSE</b>
	3. Ali-Addé	Health Post	<b>In preparation PECSE</b>
	4. Assamo	Health Post	<b>In preparation PECSE</b>
	5. Goubetto	Health Post	<b>Done by PECSE</b>
ARTA	<b>6. Arta</b>	<b>Health Post</b>	Will be done with World Bank / Islamic Bank funds
	7. Wea	Health Post	Will be done with World Bank / Islamic Bank funds
	8. Damerjog	Health Post	Will be done with World Bank / Islamic Bank funds
	<b>PK 20</b>	<b>Health Post</b>	Will be done with World Bank / Islamic Bank funds
DIKHIL	<b>DIKHIL</b>	<b>CMH</b>	<b>Ongoing by PECSE</b>
	9. Gorabouss	Health Post	<b>Ongoing by PECSE</b>
	10. Gallamo	Health Post	<b>In preparation PECSE</b>
	11. As-Eyla	Health Post	Done by Partner US Military
	12. Yoboki	Health Post	Done by Partner US Military
	13. Mouloud	Health Post	<b>Ongoing by Partner US Military</b>
<b>DJIBOUTI</b>	<b>PK 12</b>	<b>Health Post</b>	<b>Partner French Coop (AFD)</b>
	<b>CSC Ambouli</b>	<b>Health Post</b>	<b>Done by PECSE and World Bank finds</b>
OBOCK	<b>OBOCK</b>	<b>CMH</b>	<b>NA</b>
	14. Medeho	Health Post	<b>Done by PECSE</b>
	15. Alaili-Dada	Health Post	<b>Done by PECSE</b>
	16. Waddi	Health Post	<b>Done by PECSE</b>
	17. Daley Aff	Health Post	<b>Done by PECSE</b>
TADJOURAH	TADJOURAH	CMH	<b>NA</b>
	18. Adaylou	Health Post	<b>Done by PECSE</b>
	19. Day	Health Post	<b>In preparation PECSE</b>
	20. Sagallou	Health Post	<b>Done by PECSE</b>
	21. Randa	Health Post	<b>Done by Partner</b>
	22. Dorra	Health Post	<b>In preparation PECSE</b>
	23. Assagueyla	Health Post	<b>In preparation PECSE</b>
	<b>Guirori</b>	<b>Health Post</b>	<b>Done by Partner WHO</b>

- *View of the 23 Health Posts targeted by the PECSE Project in Rural Areas*
- *The sites in green are not the PECSE Project sites*
- *The PECSE Project will also equip health posts in Ambouli (Djibouti), Guirori, Mouloud and 4 health posts in the Arta District which will be rehabilitated by other partners.*

**ANNEXE V:**  
**THEMES OF TRAINING MODULES and RADIO SPOTS DEVELOPED BY PECSE**  
**(April 2006)**

**TRAINING MODULES**

- Training Modules developed by the PECSE Project :
  - Child diarrhea management
  - Acute respiratory Infections
  - Malaria Management
  - Tuberculosis
  - Infection prevention, Waste management, Universal precautions hand washing
  - Pregnancy risk prevention (anaemia, haemorrhage, Hyper tension)
  - Antenatal and Post natal care
  - Family planning: CIP/Counselling et contraceptive methods
  - MAMA and Breast feeding
  - RH Services and the schedules management
  - Integrated Nutrition
  - Child Growth monitoring
  - Health Management and Information System : Statistical data collection and analyse
  
- Training Modules developed by the PECSE Project for the District Health Management Team :
  - Training of Trainers
  - District development: Management planning and Integrated supervision
  - Social mobilization and community participation
  - Vaccine and cold chain management

NB: In April 2006, the HMIS and vaccine modules were not used to train all the health providers in all the districts

- Remaining modules to be developed :
  - Counseling in STI/HIV
  - Eyes, Ears, Mouth and Skin infections management
  - IEC and BCC
  - Traumatism and snake bite

**RADIO SPOTS TOPICS**

- Pregnancy risk prevention (anaemia, malaria, Hyper tension)
- Child diarrhea and dehydration management
- STI and HIV Prevention
- Malaria in Pregnancy prevention
- Acute respiratory Infections prevention
- Child immunization
- Breast feeding
- Tetanus prevention
- Nutrition and child growth monitoring

**Expanded Coverage of Essential Health Services  
in Djibouti**

**QUARTER REPORT**

**Project Year 3, Quarter 1: May 1st – July 31st , 2006**



Since Quality Care is now Available,  
Women and Children are Coming to Health Posts.

**Submitted by Dr. Stanislas P. Nebie, Chief of Party  
John Snow, Inc.**

**August 2006**

**B.P. 86 Djiboutiville, Djibouti**

**USAID Contract IQC GHC-I-00-03-00026-00, Task Order 800**

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## Acronyms

AIDS	Acquired immono-deficiency syndrome
BCC	Behavior Change Communication
CA	Cooperating Agency
CHC	Community Health Center
CME	Continuing Medical Education
CMH	Centre Medico Hospitalier (District Hospital)
COP	Chief of Party
CS	Child Survival
CTO	Cognizant Technical Officer
DEPCI	Direction of Studies, Planning, and International Cooperation
DHMT	District Health Management Team
EOC	Emergency Obstetrical Care
EPI	Extended Program of Immunization
FHI	Family Health International
FP	Family Planning
HGP	Pelletier General Hospital
HIS	Health Information System
HIV	Human Immuno-deficiency virus
HMIS	Health Management and Information System
HP	Health Post
IEC	Information, Education et Communication
IMCI	Integrated Management of Childhood Illness
IST	In-service Training
JSI	John Snow Inc.
MCH	Maternal and Child Health
MHC	Medical Hospital Center
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-governmental Organization
PECSE	Projet d'Extension de la Couverture des Soins de Santé Essentiels (Expanded Coverage of Essential Health Services)
PMP	Performance Monitoring Plan
PY	Project Year
QA	Quality Assurance
RH	Reproductive Health
RMT	Regional Management Team
STIs	Sexually Transmitted Diseases
TA	Technical Assistance
TB	Tuberculosis
UGP	Project Management Unit of the Ministry of Health
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
WHO	World Health Organization

## EXECUTIVE SUMMARY

This is the first quarterly report of the third year of the PECSE Project. The Project's final year started with the consolidation of all PECSE activities. Rehabilitation work is in its last phase in all project sites, with connection to the villages' water system complete or being planned. All medical materials and equipment procured in the second year by international RFP have been delivered, as well as the photovoltaic materials. There are only six sites remaining for the rehabilitation out of twenty-three (23) health posts in the rural areas, and PECSE is working with the US military to assess and complete well-drilling for the water supply in several sites identified to be a priority.

During this quarter, the project was also involved in several activities of the MOH, including:

- the national consultation on the immunization which allowed the development of the a work plan for the EPI in Djibouti,
- national consultations on the social mobilisation, and
- the preparation of the up-coming health meeting by the Horn of Africa countries planned in Djibouti in November 2006.

For the quality of services, the health providers training continued and all followed a third round of trainings in quality of services. At the same time, all the health providers (urban and rural) benefited from training on statistical data collection and analysis. All the health posts have been supervised by the district health management team, supported by the project team. The health providers are al ready to serve and more and more people come to health posts to have a quality health care. The computer package to reinforce the data analysis of the health information system were delivered. In the next quarter, the users of the computers will be trained and the data base will be put in place with the JSI/ Measure Evaluation team.

Social mobilisation activities have been extended to all the project sites (100%) going beyond the target for the third year, which is 87%. In every village with a health post, there is a Health Committee composed of both men and women, and trained community health workers. Flipcharts have been developed to support the community health workers' activities and seven radio spots were rebroadcast in three local languages on key health promotion themes.

The recent Avian Influenza (H5N1) epidemic allowed PECSE to include messages to the communities during their training about influenza symptoms and actions to take. The whole country benefited from the favourable environment created by the Health Committees put in place by PECSE in order to reach almost all of the population with key messages.

The PECSE Project continued to participate in coordination meetings with USAID, the MOH, as well as in smaller groups of specialised partners, including for immunization, social mobilisation and the programs for HIV/ AIDS and tuberculosis (TB).

### 1. INTRODUCTION INCLUDING MAJOR HIGHLIGHTS

JSI was awarded the TASC II contract for Djibouti "Expanded Coverage of Essential Health Services" in late April 2004. This report covers progress from May 1<sup>st</sup> 2006 until July 31<sup>st</sup> 2006, or Quarter 1 of Program Year 3 (PY 3) of the project.

The contract stipulates the following anticipated results for the three-year implementation period:

- Service delivery areas and water systems in targeted health facilities will be rehabilitated and facilities equipped to support the provision of essential services;

- Training programs will be enhanced and expanded to improve and maintain skills of health care providers;
- Service management systems will improve and sustain the quality and efficiency of health services;
- Health facilities will be linked to community health aides and community health committees;
- Communities will be engaged in supporting, managing and mobilizing health activities.

In addition, USAID expects to achieve the following Intermediate Results (IR):

- IR 1: Increased Supply of Essential Health Services;
- IR 2: Improved Quality of Services;
- IR 3: Enhanced Local Capacity to Sustain Health Services.

Each of these IRs will be measured by project benchmarks, and has been finalized and included in the Performance Monitoring Plan (PMP). This PMP was developed during the third quarter (PY 1), and revised after the visit of Dr. Vathani from USAID/REDSO during PY 2 and according to additional comments by Mr. Tom Hall, CTO.

The four focus indicators for USAID work in the health sector are:

5. DPT3 Coverage
6. Percentage of health facilities linked to community health committees with both male and female representation
7. Percentage of health posts rehabilitated with a water system
8. Number of training modules implemented



Nurses and midwives provide quality care in the rehabilitated health posts.

Highlights of the First Quarter, Third Project Year include:

- Seven additional facilities are being refurbished and the technical plans for six remaining facilities requiring renovation have been completed;
- Third round of health provider training was completed and District Health Management Teams trained in supervision;
- In all the Health Posts, the nurses are providing care to the community;
- Health Committees linked to health facilities with trained community health volunteers now exist in all the PECSE Project sites (23 health posts = 100%);
- A Joint Program Plan for EPI was developed in collaboration with WHO, UNICEF and the Ministry of Health. Its implementation will contribute to the effective coordination of capacity building for EPI implementation.

## 2. PROGRESS ON TARGET ACTIVITIES ACCOMPLISHED THIS QUARTER

The PECSE Work Plan developed in 2004, approved by both the Ministry of Health and USAID, has been modified to reflect changed circumstances and USAID priorities, and continues to be one of the two primary guiding documents for the implementation of PECSE. The revised version has been approved by USAID. The PECSE Performance Monitoring Plan (PMP) is the monitoring and evaluation plan for the PECSE Project. It was developed with the MOH and with technical assistance from MEASURE/Evaluation to track PECSE and MOH performance; MEASURE/Evaluation continues to provide technical support for implementation. It was developed during PY1 and was recently updated following suggestions and guidance from Mr. Tom Hall, CTO, and Dr Vathani from USAID/REDSO. The adjustment harmonised PECSE project indicators and the finalized USAID annual report indicators.

PECSE has also provided support to improving the MOH's Health Management Information System (HMIS). Generally, the MOH department known as "DEPCI" is recognized as the structure responsible for HMIS management, including such as data collection, dissemination, recording and analysis. This includes not only routine HMIS data from the health facilities, but also non-routine data collection methods such as periodic surveys. This department is also responsible for the management of the computer system for the HMIS, including hardware and appropriate software. The reinforcement of the health information system by PECSE continues with the procurement of a computer package, installation and the training of district focal points for the database. MEASURE/Evaluation will also work with the MOH to put into place the data base, specifically adapted to the Djiboutian context and needs. A users guide for the database will be developed.

### IR 1: Increased Supply of Essential Health Services

PECSE has an ambitious program of actions to increase health service supply. Many of the activities under this IR are prerequisites for improved quality of care (IR 2).

- The joint immunization (EPI) plan developed by the MOH, PECSE, UNICEF and WHO was signed and is being implementation. In this framework, a national meeting was co-facilitated by PECSE's COP in order to identify all national needs for immunization.
- Guidelines for health providers on basic services under development, and will include clinical algorithms as needed.
- Rehabilitation work continued in the remaining six project sites. In this quarter, some health posts with completed rehabilitation were dedicated and will be completely equipped shortly.
- During PY2, a long procurement process for medical materials and equipment was conducted. This required technical support from JSI headquarters, and required USAID Contracting Officer approval for several steps; the materials started arriving in Djibouti during this quarter and will all be in-country next quarter.
- PECSE supported the initiatives of the MOH to organise a National Immunisation Forum for the Decade Immunisation Plan, and a Regional Conference against Malaria, TB and HIV is foreseen for the next quarter.

### IR 2: Improved Quality of Services

Activities under this IR have focused on human resource development and improvement of support to rural service providers including increased supportive supervision. Key achievements include:

- The training of service providers in the districts continued, and each nurse in the district had received a third round of key training on themes of maternal and child health, nutrition

and immunization.

- The PECSE Project team continued assisting the Head Physician (District Medical Director) of each district to supervise personnel in the Health Posts in their districts. PECSE expects the District Health Management Teams to take ownership of supervision activities, which will add to the sustainability of services. One issue is the changing of District Medical Directors.

Data Collection is included in Nurses' and Midwives' Planning Work



### IR 3: Enhanced Local Capacity to Sustain Health Services

All PESCE Project sites have been reached with social mobilization activities. At the end of this quarter, the PECSE Project extended social mobilization activities to all health posts in the rural area and now 23 health posts are linked to community Health Committees with both male and female representatives who have been trained.

- Community members, especially those on Health Committees, were trained in social mobilization techniques in all Health Committees in 23 health posts. Themes on the Avian Influenza prevention were developed during the training of community members in order to prevent disease spread or a larger possible epidemic.<sup>3</sup>
- Seven radio spots were produced and broadcast during the second year, in three different languages.
- Flipcharts for use in the community, representing all key PECSE themes, were pre-tested in the field and duplication is ongoing

<sup>3</sup>The first human case of H5N1 avian influenza was confirmed in Djibouti in June, 2006.

- Voluntary community health workers were assisted in developing monthly Activity Plans for outreach and community education.
- Community health workers were supervised.



A Village Chief Appreciates the Flip Chart Pictures

### 3. PROGRESS TO DATE OF ONGOING ACTIVITIES NOT ACCOMPLISHED THIS QUARTER

**Procurement:** The procurement process is well underway. This complex process took more time than expected and will allow PECSE to equip all the health posts covered by the project at one time. In addition, PECSE will equip other health facilities rehabilitated by partners such as the WHO or US Military but which are not completely equipped.

**HMIS:** The development and finalisation of the data collection tools and the training of nurses training has been completed. The tools are currently being replicated. The computers have been bought and the database development, installation and implementation is planned for the next quarter.

**Rehabilitation of Health Posts:** The rehabilitation work will be completed in all the PECSE Project sites during the next quarter. At the six remaining sites, work is ongoing.

**Community Mobilization:** The extension of social mobilisation activities in the project sites is completed in all the 23 sites. The training of community health animators supervision is ongoing.

**School Health:** Changes in personnel at the education project have slowed some collaborative efforts, but the flip charts and posters for schools will be produced next quarter.

STI/HIV/AIDS: As one of the key concerns for PECSE, STI and HIV/AIDS are part of the service delivery package to be offered at each MOH site. PECSE is becoming increasingly concerned about the complete task of training, providing equipment and drugs to face STIs and HIV in the districts. Data for use in designing interventions is almost entirely lacking. While the FHI is implementing an HIV/AIDS prevention project in two sites along the major transportation corridor, the PECSE Project plans to add the same prevention activities in the other health posts this year. In the meantime, some primary prevention materials have been designed and pre-tested, and are ready to be reproduced.

#### **4. QUARTERLY PERFORMANCE INDICATOR ACHIEVEMENT SUMMARY**

##### ***USAID Report Indicators***

##### Indicator 1: DPT 3 Coverage

The PECSE Project team collected and analyzed the MOH data on DPT3 by using the available data at the MOH level; the quality of this data cannot be trusted (see attached). The basic rate is estimated at 11% in rural zones. According to the revised PECSE Project PMP, the target of this indicator for the second year of the project is 13%. As this indicator is recorded annually, the current rate is estimated at 16% in the rural areas, which is higher than the PECSE PY 2 target. The national average will be obtained by USAID from the MOH data. There is, however, a need for the health partners to work with the Ministry of Health to agree upon the status of current national indicators. Current rates cited by the MOH and other partners are higher than the rates shown by available MOH data.

##### Indicator 2: Number/percentage of health facilities targeted by PECSE and equipped that provide the basic package of services

The basic package of services include: Immunization, growth monitoring, breastfeeding promotion, antenatal services, assisted deliveries and /or family planning. The current numbers of facilities which have been rehabilitated and completely equipped are zero since the procurement process is still ongoing. Therefore, the 13 health posts refurbished before this quarter are waiting for complete equipment and furnishings. In order to complete this indicator, equipping must be completed, which will take place during quarter 2 of PY2.

##### Indicator 3: Number/percentage of health facilities linked to community health committees with both male and female representation

PECSE reached the target of 23 sites (out of 23) that were functioning with community health committees on which both genders are represented. The target for the third year was 61% (14 Health Posts) but the Project developed health committee with both male and female representation in all the health posts (100%) by the end of this quarter.

##### Indicator 4: Number/percentage of communities with trained community health workers

The target for the third year was 80%, which means a total of 18 health committees with trained community health workers. At the end of this first quarter of the third year, the project reached his target by training community health workers in all the sites which means 100%. The PECSE Project also trained two or three community health workers for each of the 23 health post communities.

##### ***4.1 Indicators by Expected Results:*** These indicators are recorded quarterly

##### IR 1: Increased Supply of Essential Health Services

- IR 1.1 Population Coverage rates: The current rate is estimated to 38%. (Catchment

area population needs to be estimated )

- IR-1.5 Number/Percentage of health posts rehabilitated, including a water system storage, by PECSE. The target of the third year is 16 which mean 6 new health posts rehabilitated. These 6 health posts refurbishment is ongoing and waiting also for a complete set of equipment. In addition to this indicator, USAID asked the PECSE Project to provide a permanent water supply by drilling wells in proximity to some health posts. The PECSE Project worked with the US military to solve this issue and six sites have been identified for drilling.

### IR 2: Improved Quality of Services

- IR: 2.1 Number of trained health workers (including community health workers and community health committee members) in the Project Area: The PY 3 target was at least 300 health workers to be trained and the project reached a total of 568 health workers (including community members) trained at the end of this quarter.
- IR 2.2 Percentage of health posts supervised according to MOH guidelines for supervision and management. The target of the third year is 35% (8 health posts). During this quarter, all the health posts (23=100%) were supervised with the project logistical support.

### IR 3: Enhanced Local Capacity to Sustain Health Services

- Number/percentage of communities with trained community health workers (see SO Indicator 4).

## **SUMMARY OF PLANNED ACTIVITIES FOR NEXT QUARTER AND EXPECTED RESULTS**

The next Quarter Report, second quarter of PY 3, will cover the period from August 1<sup>st</sup> to October 31<sup>st</sup>, 2006. The following main activities have been planned for this period:

### IR 1: Increased Supply of Health Services

- Implementation of joint support plan for routine vaccination
- Technical Assistance for routine immunisation from ImmunizationBASICS
- Rehabilitation of remaining health posts including solar panel and water connections
- Equipping all concerned health facilities (health posts and MCH clinics)

### IR 2: Improved Quality of Services

- Supervision of health posts providers in the rural districts
- Train the Health Management and Information System (HMIS) focal persons in data base management
- Equip the HMIS with computers in districts and central level.
- Technical Assistance from MEASURE/Evaluation to develop the national database including human resource development at the central MOH.

### IR 3: Enhanced Local Capacity

- Supervision of community health workers in social mobilization
- Broadcast radio spots on the health priority themes supported by PECSE per its work plan
- Distribution of school workbooks and posters, and provision of any needed technical support for their use
- Implementation of flip charts especially for the community health workers

For more information about planned activities, please see the revised PECSE Work Plan for 2006-2007.

## 6. CHALLENGES AND LESSONS LEARNED

There were many challenges for the PECSE Project during PY 2, many of them stemming directly from overall human resource limitations in Djibouti. In addition, political issues including regional elections and changes in key MOH created delays and additional work. Project Year 3 began with similar challenges, and the addition of more procurement related to collaboration on well-drilling with the US military.

At the MOH level, the Heads of Departments are less used to activities in the field and have had difficulty following PECSE's rhythm for supervision, the development of the health information system, and the training of health providers.

The lack of a public health vision in the MOH does not allow for priority to be given to the basic health of the population and to public health. Most of the MOH services (in the capital or districts) give the bulk of resources and energy to curative care and neglect preventive care. The organization of the activities like supervision, data collection and analysis, etc. are not priorities. PECSE has already heard an MOH manager telling a health post nurse that the data collection and analysis were not a part of his job.

### Site Work.

The health post rehabilitation process takes more time than planned. Equipment procurement processes have taken longer than expected; expert technical assistance in USAID procurement was needed from JSI to complete the work. On the other hand, the first rehabilitated health posts in 2004 do not still have qualified staff personnel at the maternity wards, so the counterpart package has not yet been provided by the Government of Djibouti.

### HMIS.

The PECSE Project will support the HMIS teams at the central or at the district level, so that health data will be regularly collected analysed and its quality assessed. Computer materials were supplied by the project. PECSE will also support the installation of the electronic database for data management, HMIS and epidemiological surveillance.

### Community Mobilization.

The social mobilisation component has been developed during this quarter with the technical assistance of a consultant from the JSI program in Madagascar. All the communities around health posts were sensitized, they put in place their health committees, as well as identifying community health workers who were trained later. The supervision of these community workers has been conducted and PECSE is preparing the launching of the Champion Community Initiative.

### Access to Safe Water.

Resolving the potable water issues at health posts is extremely complicated and fundamentally different at almost every site. Following the technical report commissioned by PECSE, the Project is working with USAID and the US Military to drill wells in some (six) health posts and to connect other sites to existing water supply systems in their villages.

# *ANNEXES*

# ANNEXE I

## PECSE PROJECT INDICATORS STATUS UPDATE JULY 2006

Indicators	Activities/ Mode of calculation of the indicator	Source of the data / Base line / Target	Timing	Annual Targets			Remarks
				Year 1	Year 2	Year 3	
<b>SPECIFIC OBJECTIVE (SO)</b> <b>To increase the expanded coverage of essential health services packages in Republic of Djibouti so that individuals have access to Health service that enable to reduce infant and maternal mortality and morbidity rate</b>							
Indicator 1 : DPT3 coverage	Numerator: number of children by 12 months having received DPT3 in a specified program year in PECSE areas Denominator: total population of child <12 months in PECSE areas	Routine Data Base line: 11 % target: 10% increasing from the second year	Annual	11%	13% <b>16%</b>	15% <b>16%</b>	In agreement with the definition of the cases worked out by the MOH The base line data in rural area was based on Djibouti Strategic framework against poverty 2004
Indicator 2: Number/ Percentage of Health Posts linked to community health committees with both male and female representation	Numerator :Number of Health Post in PECSE areas that are formally linked to a health committees with both male and female representation Denominator : Number of Health Posts in PECSE areas	Routine Data Base line : 0 Target: 61% of the 23 health posts ( 14 Health Posts) N= 23	Annual	5 22%	11 48% <b>15</b>	14 61% <b>100%</b>	- year 1: 5 - year 2: 6 - year 3: 3
Indicator 3: Number/Percentage of health posts rehabilitated , including a water system	Numerator: number of health posts rehabilitated with water system X 100 Denominator: Total health posts to be rehabilitated by PECSE	Rehabilitation report of PECSE Base line = 0 N= 16 Target = 100%	Quarter	3 17 %	10 63 % <b>10</b>	16 100% <b>10</b>	16 Health Posts will be rehabilitated by the project ( other partners will rehabilitate the remaining 6 ) - year 1: 3 HP - Year 2: 7 HP - Year 3: 6 HP
Indicator 4: Number of training modules implemented	Number of training Modules developed and implemented in all the project districts	PECSE report Base line data =0 Target = 1 8	Quarter	10	15 <b>15 (2 other written but not used)</b>	18 <b>15</b>	- year 1: 10 - year 2: 5 - year 3: 3

<b>IR 1. INCREASED SUPPLY OF ESSENTIAL HEALTH SERVICES</b>							
IR : 1.1 Population Coverage rates	Numerator: total consultations (New + old) X100 Denominator: Total population in the health post catchments areas	Routine Data Project Documents Base line: 10-15% Target: 40 %	Quarter	10 %	20 % <b>38%</b>	40 % <b>38%</b>	Given the difficulties to obtain data from each facility for this indicator because of the unavailability for the demographic data for each health facility, we made an estimation for rural areas in collaboration with the HMIS team
IR : 1.2 Number/ Percentage of Health posts rehabilitated and equipped, providing a basic package of essential health services in PECSE targeted areas	Numerator : number of rehabilitated health posts in PECSE targeted areas that have essential equipment and provide a basic package of essential health services X100 Denominator: Number of health posts in PECSE areas	Routine Data Project Documents Base line: 0  Target: 19  N= 19 health Posts	Annual	3	10 <b>0</b>	19 <b>0</b>	- Year 1: 3 - Year 2: 7 - Year 3: 9 <b>10 Health posts are rehabilitated but still not equipped</b>
<b>IR 2: IMPROVED QUALITY OF SERVICES</b>							
IR: 2.1: Number of trained health workers (including community health workers and community health committee members) in the Project Area	Numerator : number of health workers trained X 100  Denominator: total of health providers targeted in the Project area.	PECSE documents Base line = 0  Target = 300	Quarter	<b>150</b> <b>50 %</b>	<b>250</b> <b>83%</b> <b>259</b>	<b>300</b> <b>100%</b> <b>568</b>	At least 300 Health workers will be trained till the end of the Project
IR- 2.2 Number/Percentage of health posts supervised according to MOH guidelines for supervision and management	Numerator : Number of health post supervised at least once every quarter X 100  Denominator : total health posts in the project area	PECSE report Level of base=0 N = 23  Target = 100 %	Quarter	50 %	35% <b>20%</b>	45% <b>100%</b>	PECSE aims at ; Organizing the supervision of the teams of all health posts in rural areas (N=23) Developing a supervision guide
IR-2.3 Number/Percentage of women seen at least once during their pregnancy	Numerator: number of women seen at least once during their pregnancy X 100 Denominator: a number of expected pregnancies	Routine Data Base line: 24% Target: 10% of increase per annum	Annual	24%	26% <b>24%</b>	28% <b>24%</b>	N.B.: numbers expected pregnancies $\cong$ total expected birth The base line of this indicator was estimated based on MOH Documents 2003

IR-2.4: Number/Percentage of births attended in a health facility	Numerator: Number of deliveries in a health facilities X 100 Denominator : Total number of expected pregnancies	Routine Data Base line: 20% Target: 20% of increase per annum	Annual	20 %	22% <b>23%</b>	26% <b>23%</b>	The base line of this indicator was estimated based on PAPFAM 2002 page 146
<b>IR3. ENHANCED LOCAL CAPACITY TO SUSTAIN HEALTH SERVICES</b>							
IR-3.1 Number of radio spots developed and broadcasted	Number of radio spots developed and broadcasted	Project Document	Annual	2	5 <b>7</b>	7	Year 1: 2 Year 2 : 3 Year 3 : 2
IR-3.2: Number/percentage of communities with trained community health workers	Numerator : Number of community with at least one trained community health volunteer Denominator : Number of Community within Health Posts in PECSE areas	Routine Data Base line : 0 Target: 87% of the 23 health posts ( 20 Health Posts) N= 20	Annual	0	5 22 % <b>5</b>	20 87% <b>100%</b>	- year 1: 0 - year 2: 5 - year 3: 15

**In red: updated situation as of July 30<sup>th</sup>, 2006**

**ANNEXE II: SUMMARY TABLE OF PECSE TRAININGS (JULY 2006)**

<b>DISTRICTS</b>	<b>Number of trainers trained 19-24 Mars 2005</b>	<b>Number of health providers trained 1st round</b>	<b>Number of health providers trained 2<sup>nd</sup> round</b>	<b>Number District Health Management Team (DHMT) members trained</b>	<b>Number of DHMT members who trained the health providers</b>	<b>Number of the training centre members who supervised the DHMT training</b>	<b>Number of trainers trained in social mobilization and BCC</b>	<b>Number of health committee members and community volunteers trained</b>	<b>Number of health providers trained in HMIS</b>	<b>TOTAL</b>
<b>Ali-Sabieh</b>	4	10 24-27/04	17 13-15/10	6 18-21/11	4	4	11	32	23	70
<b>Dikhil</b>	4	14 17-19/05	13 12-14/10	3 18-21/11	6	4	6	68	20	98
<b>Arta et Périphérie</b>	4	16 05-07/07	14 01/02/06	3 18-21/11	1	4	3	38	13	58
<b>Obock</b>	4	11 11-13/07	15 20-22/10	4 12-15/11	6	4	9	55	18	86
<b>Tadjourah</b>	4	12 18-20/07	16 20-22/11	5 12-15/11	6	4	11	81	20	116
<b>Ville de Djibouti</b>	10 + 3	-	-	40	2	-	5+3	-	119	140
<b>TOTAL</b>	<b>33</b>	<b>63</b>	<b>61</b>	<b>61</b>	<b>23</b>	<b>18</b>	<b>48</b>	<b>274</b>	<b>213</b>	

*NB : The yellow columns were not included in the totals*

**In total, 568 persons were trained by PECSE, consisting of health providers (246) and community health workers (322).**

**ANNEXE IV: SUMMARY TABLE OF HEALTH FACILITIES REHABILITATIONS (July 2006)**

Region	Health Facility	Kind	Rehabilitation status
ALI-SABIEH	<b>ALI-SABIEH</b>	<b>CMH</b>	<b>NA</b>
	24. Holl Holl	Health Post	<b>Completed by PECSE</b>
	25. Dasbyo	Health Post	<b>Completed by PECSE</b>
	26. Ali-Addé	Health Post	<b>Ongoing by PECSE</b>
	27. Assamo	Health Post	<b>Ongoing by PECSE</b>
	28. Goubetto	Health Post	<b>Completed by PECSE</b>
ARTA	<b>29. Arta</b>	<b>Health Post</b>	Will be done with World Bank and Islamic Bank funds
	30. Wea	Health Post	Will be done with World Bank and Islamic Bank funds
	31. Damerjog	Health Post	Will be done with World Bank and Islamic Bank funds
	<b>PK 20</b>	<b>Health Post</b>	Will be done with World Bank and Islamic Bank funds
DIKHIL	<b>DIKHIL</b>	<b>CMH</b>	<b>Ongoing by PECSE</b>
	32. Gorabouss	Health Post	<b>Completed by PECSE</b>
	33. Gallamo	Health Post	<b>Ongoing by PECSE</b>
	34. As-Eyla	Health Post	Done by Partner US Army
	35. Yoboki	Health Post	Done by Partner US Army
	36. Mouloud	Health Post	<b>Ongoing by Partner US Army</b>
DJIBOUTI	<b>PK 12</b>	<b>Health Post</b>	<b>Partner French Coop (AFD)</b>
	<b>CSC Ambouli</b>	<b>Health Post</b>	<b>Completed by PECSE and World Bank</b>
OBOCK	<b>OBOCK</b>	<b>CMH</b>	<b>NA</b>
	37. Medeho	Health Post	<b>Completed by PECSE</b>
	38. Alaili-Dada	Health Post	<b>Completed by PECSE</b>
	39. Waddi	Health Post	<b>Completed by PECSE</b>
	40. Daley Aff	Health Post	<b>Completed by PECSE</b>
TADJOURAH	TADJOURAH	CMH	NA
	41. Adaylou	Health Post	<b>Completed by PECSE</b>
	42. Day	Health Post	<b>Ongoing by PECSE</b>
	43. Sagallou	Health Post	<b>Completed by PECSE</b>
	44. Randa	Health Post	<b>Done by Partners</b>
	45. Dorra	Health Post	<b>Ongoing by PECSE</b>
	46. Assagueyla	Health Post	<b>Ongoing by PECSE</b>
<b>Guirori</b>	<b>Health Post</b>	<b>Done by WHO and equipped by the PECSE Project</b>	

- *View of the 23 Health Posts targeted by the PECSE Project in Rural Areas*
- *The sites in green are not the PECSE Project sites*
- *The PECSE Project will also equip health posts in Ambouli (Djibouti), Guirori, Mouloud and 4 health posts in the Arta District which will be rehabilitated by other partners.*

**RUSSIA**

# The Maternal and Child Health Initiative Quarterly Report

**Contractor: John Snow, Inc.**

**Contract Number: HRN – I -00-98-00032-00. Delivery Order No.: 813**

**Reporting Period: October-December, 2005**

## SECTION 1: BACKGROUND

### 1.1. Description of Task Order Objectives

The purpose of the Maternal Child Health Initiative (MCHI) Task Order is to ensure the adoption of internationally recognized MCH standards and practices by the targeted health facilities in Russia.

MCHI contributes to USAID/Russia's Strategic Objective, SO 3.2: *Use of Improved Health and Child Welfare Practices Increased*. Indicators directly related include: Indicator 3.2.3: *Abortion rates*, the Intermediate Result 3.2, IR1: *Access to More Effective Primary Health Care (PHC) Services Increased*, and its indicator: *Number of health facilities implementing evidence-based maternal and child health (MCH) care practices*.

**1.2. Expected Results:** To address the mentioned objective, upon the completion of the project the following results will be achieved:

- A Russian organization with a strong MCH mandate empowered and strengthened to partner with MCHI in implementing the replication model.
- Internationally recognized standards and USAID promoted MCH and HIV/AIDS prevention practices adopted by targeted health facilities in at least fourteen regions of the Russian Federation, in addition to the two WIN Project's pilot regions.
- The abortion rate reduced in the targeted regions.
- Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.
- Access to reproductive health services and information for men increased in the targeted regions.
- Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated.
- A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions.
- Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation (VRF) in the Far East.
- Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI model.
- Family planning services with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions.
- Family Planning capacity strengthened in the regions and at the national level.
- Integration of family Planning into primary health care services piloted in selected rural areas in at least two regions with high abortion rates.
- Family Planning integrated into counseling services for HIV-positive women.
- Family Planning and prevention of mother-to-child transmission of HIV (PMTCT) capacity strengthened at HIV Centers.

- A collaborative model on PMTCT developed and implemented together with ARO in one of the pilot regions, for example, Irkutsk.
- Additional (non-intervention) regions oriented to MCHI model and up-dated replication package.
- New activities included and monitored in the overall monitoring and evaluation plan. Overall project results documented and disseminated in the pilot regions and nationwide.
- The maternal and perinatal health care system in the Moscow oblast will be reformed through the creation of a model state-of-the-art regional health care program at the Moscow Region Perinatal Center (MRPC).

## SECTION 2: CURRENT ACTIVITIES

### 2.1 Administrative Activities

- Presented MCHI financial reports and declarations for a 9 months period to the Social Insurance Fund, Statistics Department and Tax Inspection of the Russian Federation.
- Hired Oksana Berdnikova for a position of MCHI Administrative-Training Coordinator in October, 2005.
- Visited MCHI Project Coordinator, Crystal Ng, on October 17-26, 2005.
- Participated MCHI Financial Officer, Maria Nemchinova, in JSI Financial Meeting in Uganda on November 6-10, 2006.

### 2.2 Summary of the program activities

#### Replication Strategy Policy Development

- Conducted an **MCHI Workshop on the project dissemination strategy** on December 20-23, 2005.

#### Activities in the Far East regions

- Conducted **initial visits** to Sakhalinskaya oblast and Sakha Republic (Yakutia) on October 3-8, 2005.
- Conducted a training course on **Antenatal Care** in Khabarovsk on November 7-11, 2005.
- Conducted a **follow-up visit** to Khabarovsk and Komsomolsk-on-Amur on November 14-18, 2005.
- Conducted a **Breastfeeding** training course in Yakutia on November 7-11, 2005.
- Conducted a training course on **Newborn Resuscitation** in Yakutia on November 14-18, 2005.
- Conducted a training course on **Newborn Resuscitation** in Sakhalin on November 28-December 2, 2005.
- Conducted a **Breastfeeding** training course in Sakhalin on December 5-9, 2005.

#### PMTCT activities

- Participated in the **National HIV/AIDS Conference in Suzdal** on October 11-14, 2005
- Participated Project Coordinator, Anna Karpushkina, in the **Strategic Workshop on the Issues of Organization of Prevention, and Treatment of HIV in the frame of implementation of National Project in Health Care** in November 29-30, 2005.
- Approved **PMTCT Clinical Guidelines** by the Ministry of Health and Social Development and the Federal Service of the Russian Federation for Surveillance in Consumer Rights Protection and Human Welfare in December, 2005.
- Participated at the **UNICEF Annual Review** and presented MCHI PMTCT guidelines there in November, 2005.
- Collected data on **PMTCT+Family Planning Survey** on October 31, 2005.

- Participated at World HIV/AIDS Day activities on December 1, 2005.
- Initiated development of **Family Planning Guidelines for HIV positive women** in December, 2005.

### **Family Planning activities**

- Held a visit to Vologda on **the Family Planning Strategy Implementation** on October 11-13, 2005.
- Conducted a **workshop on development Family Planning strategic work-plan on dissemination of project activities** in Tumenskaya Oblast on October 25-28, 2005.
- Held a **study tour to JSI/Romania Family Health Initiative** on November 28-December 4, 2005.
- Held a **Family Planning conference for rural areas in Vologda** on December 5, 2005.

### **Youth Reproductive Health Program (YRHP)**

- Conducted a **workshop of MCHI YRHP working group** in Moscow on November 14-16, 2005.

### **Training activities**

- Conducted a training course on **Antenatal care** in Barnaul on October 10-14, 2005.
- Conducted a training course on Antenatal Care in Krasnoyarsk on October 24-28, 2005.
- Conducted a **Breastfeeding refresher training course** in Vologda on October 24-28, 2005.
- Conducted a training course on **Antenatal care** in Omsk on December 5-9, 2005.
- Conducted a training course on **Antenatal care** in Kaluga on December 12-16, 2005.

### **Monitoring and Evaluation**

- Initiated work on **Demographic Health Survey (DHS)** in Vologda in November, 2005.
- Developed a draft of M&E Guidelines in October, 2005.
- Visited MCHI M&E Consultant, Patricia David, on December 1-13, 2005.

### **Follow-up activities**

- Conducted **follow-up visits** to Barnaul on October 17-19, to Krasnoyarsk on November 1-3, to Omsk on November 28-30, to Kaluga on December 19-21, 2005.

### **Documentation and Dissemination Strategy**

- Prepared and sent for publication 2 articles in October, 2005.
- Gave 5 interviews and presented at a press conference in Tumenskaya Oblast in October, 2005.
- Finalized a design of an MCHI web site in October, 2005.

### **Russian Society of Obstetricians-Gynecologists (RSOG)**

- Participated RSOG representatives in the initial development of **Family Planning Guidelines for HIV positive women** in December, 2005.

### **Collaboration/Meetings:**

#### **Assistance to Russian Orphans (ARO)**

- Participated MCHI COP, Natalia Vartapetova, in an MCHI/ARO Coordination Meeting on November 8, 2005.
- Attended MCHI Information and Communication Coordinator, Yulia Boyarkina, the press-conference on issues related to children affected by HIV/AIDS on November 30, 2005.

## Other MCHI Activities

- Participated MCHI consultants in Joint Meeting of WHO and JSI on revision of neonatal and perinatal curricula on November 23-30, 2005.
- Attended and made a presentation at the APHA meeting in Philadelphia on December 10-14, 2005.

## 2.3 Performance

### Replication Strategy Policy Development

- An **MCHI Workshop on the project dissemination strategy** was conducted in Moscow Oblast on December 20-23, 2005. The purpose of this workshop was to discuss a plan of activities for 2006, and to discuss the final MCHI dissemination conference and procedures of the project close-out. As a part of the discussion of upcoming activities, a calendar was developed featuring concrete dates and human resources. MCHI discussed the final conference in detail: the venue, goals and objectives of the conference, possible guests and participants, materials needed. It was decided to create a steering committee on the conference organization. The initial meeting of the committee was planned to be held in February, 2006. Taking into account a busy plan of projected activities, MCHI staff discussed optimization of the office's workload, as well as methods of better communication and cooperation inside the team.



*Results of the discussion  
on optimization of the  
office work*

### Activities in the Far East regions

- The **initial needs assessment visits** were conducted to Sakhalinskaya oblast and Sakha Republic (Yakutia) on October 3-8, 2005. During these visits, the team of MCHI experts, including MCHI COP Natalia Vartapetova and Project Coordinator Anna Karpushkin visited 11 pilot facilities and conducted needs assessments, held three conferences on the project activities for health providers, met with the regional working groups, and provided feedback on the visits and discussed an action plan. During the visit to Sakhalin, Natalia Vartapetova gave 5 interviews to the local mass media.
- A training course on **Antenatal Care** was conducted in Khabarovsk on November 7-11, 2005. 30 people from pilot facilities of Khabarovsk and Komsomolsk-on-Amur city participated in the course, including heads of health departments. MCHI invited one new trainer from pilot facilities from Vologda to facilitate the course as a co-trainer. The conducting of the course was controlled by the chief obstetrician-gynecologist of Khabarovskiy region, and the heads of city maternity # 1 and the Oblast Perinatal center also took on active roles in the course. During the course the key trainers gave interviews about the Project implementation in Khabarovskiy region to the local TV-channel. During the practical sessions, the participants experienced the counseling of 12 pregnant women. (Attachments # 1, 2 - Agenda, List of Participants).
- A **follow-up visit** to Khabarovsk and Komsomolsk-on-Amur was conducted on November 14-18, 2005. During the visit to Khabarovsk Children Polyclinic, the team of MCHI experts concluded that the polyclinic had practically implemented 10 steps of successful breastfeeding; that personnel are being trained in a creative manner; that breastfeeding support is actively working; and that the polyclinic is ready to be assessed for the International Status of "Baby-Friendly Polyclinic." The team of experts also visited perinatal center and maternity # 1 in Khabarovsk and maternity of Komsomolsk-on-Amur. All the three maternities have MCHI implementation plans, orders, and statements on the Project's realization. After undergoing training courses on breastfeeding, antenatal care, and FCMC, the personnel started conducting



*The participants are  
discussing action plans*

their own training courses. After half a year of conducting training courses, all the three maternities have reorganized rooming-in wards. Health indicators are being improved, and the possibility of early discharge from the maternity emerged. During the visits, the experts gave recommendations on the conducting of the courses, using trainer's manuals and presentations. MCHI Clinical Coordinator Oleg Shvabskiy participated in the regional conference on HIV/AIDS/STIs and Hepatitis prevention. At this conference, Dr. Shvabskiy presented MCHI PMTCT guidelines.

- A **Breastfeeding** training course was conducted in Yakutia on November 7-11, 2005. The course was facilitated by MCHI experts, Dr. Elena Safronova and Dr. Marina Mamoshina. The number of participants was 37 people from pilot facilities, including representatives from the Ministry of Health of Sakha republic, department of pediatrics of Yakutsk medical college. All the participants expressed interest in the content of the course and the teaching techniques. (Attachments # 3, 4 - Agenda, List of Participants).
- A training course on **Newborn Resuscitation** was conducted in Yakutia on November 14-18, 2005. The objective of the course was to prepare medical providers (physicians, nurses and midwives) to provide newborn resuscitation at birth. The total number of participants was 13 specialists (neonatologists). (Attachment # 5, 6 - Agenda, List of Participants).
- A training course on **Newborn Resuscitation** was conducted in Sakhalin on November 28-December 2, 2005. The total number of participants was 12 specialists, among whom were 6 neonatologists, 3 resuscitators, 1 nurse, and 2 midwives. All of them were very active and interested in the course. The training course was highlighted in the local TV channel. The key trainer gave an interview to the local newspaper and at the "open air" in the morning TV program. (Attachment # 7 -List of participants).
- A **Breastfeeding** training course was conducted in Sakhalin on December 5-9, 2005. The total number of participants was 30 people, among which were representatives of the MCH department of Sakhalinskaya Oblast. During the course, much attention was paid to PMTCT. The course presented modern principles of breastfeeding. All the participants were satisfied with the course and evaluated the course as a highly useful and informative. (Attachments # 8, 9 - Agenda, List of Participant).

#### **PMTCT activities**

- Project COP Natalia Vartapetova and Project Coordinator Anna Karpushkina participated in **the National HIV/AIDS Conference in Suzdal** on October 11-14, 2005. At this conference, Natalia Vartapetova made a presentation of MCHI's PMTCT guidelines. The guidelines were disseminated among the participants of the conference. The guidelines generated great interest and after the conference, MCHI received requests from Smolensk Oblast and Chuvashskaya Republic for copies of the Guidelines. Chuvashskaya Republic would spend its funds to print 500 copies for health workers of the Republic.
- Project Coordinator Anna Karpushkina participated and presented at **the Strategic Workshop on the Issues of Organization of Prevention, and Treatment of HIV in the frame of implementation of National Project in Health Care (founded by the President of RF)** in Kemerovo in November 29-30, 2005. The workshop was organized for all Siberia and Far East regions by the Federal Service of the Russian Federation for Surveillance in Consumer Rights Protection and Human Welfare. At the workshop, Anna Karpushkina presented MCHI's PMTCT Guidelines and disseminated it for Far East and Siberia regions.

- MCHI COP Natalia Vartapetova participated at the **UNICEF Annual Review** and presented MCHI's PMTCT guidelines in November 2005. UNICEF wished to finance printing of 5000 copies of the Guidelines.
- **PMTCT Clinical Guidelines** were approved by the Ministry of Health and Social Development and the Federal Service of the Russian Federation for Surveillance in Consumer Rights Protection and Human Welfare in December 2005. MCHI received official welcoming letters from these organizations, which were included in the introduction to the Guidelines.
- Data on **PMTCT+Family Planning Survey** were collected on October 31, 2005. Final data checking and cleaning was conducted in November 2005.
- MCHI representatives participated at **World HIV/AIDS Day** activities on December 1, 2005. MCHI had a booth presentation of the MCHI materials in the U.S. Embassy in Russia for the Embassy representatives.
- MCHI initiated development of **Family Planning Guidelines for HIV positive women** in December 2005. A review of the international data and research on this topic was conducted. A general outline of the Guidelines was developed in December 2005.

### **Family Planning activities**

- A visit to Vologda on the **Family Planning Strategy Implementation** was held on October 11-12, 2005. During the visit, a workshop was held on the strategy implementation with representatives of medical prevention centers of Vologda Oblast. MCHI consultants also discussed opportunities of conducting Demographic Health Survey (DHS) in Vologda Oblast with participation of Vologda Research and Coordination Center of Russian Academy of Science. At the end of October, MCHI discussed and developed a draft of the questionnaire for the RHS.
- **A workshop on development Family Planning strategic work-plan on dissemination of project activities** was conducted in Tumenskaya Oblast on October 25-28, 2005 with participation of Vologda oblast representatives. The objectives of the workshop were to discuss the results of the project implementation in Tumenskaya Oblast, to get familiar with the existing situation on reproductive health and a system of FP service providing at the city and rural levels in the Oblast, to develop a plan of activities on the model implementation, discuss needed IEC materials, and to plan the budget. During this workshop, an MCHI FP Working Group also performed a field visit to the medical facilities of the rural areas of Tumenskaya Oblast, including Maternity and Women's Consultation of Tobolsk town, Area Hospital of Abalak village, Central Rayon Hospital of Yarkovo village, Feldsher's Unit of Borkovo village. During these visits to facilities, the team met with practical doctors, nurses, and midwives, and also spoke with clients. On October 27, a conference featured O.P Gorbunova, chief specialist of the Oblast Health Department, who presented the status of obstetric and gynecological service in the Oblast. Representatives of the pilot facilities spoke on the results on the project implementation in their facilities. As a result of the conference, a plan of implementation of the oblast model of FP services improvement was developed.
- **A study tour to JSI/Romania Family Health Initiative** was held on November 28-December 4, 2005. The objectives of the tour were to observe and study the process of broadening access and utilization of reproductive health/family planning services in Romania, including programmatic, technical, IEC, training and policy dimensions and to learn from Romania's experience and share Russia's experience in reproductive and maternal health care reform and to achieve greater equity



and better quality services, particularly for women and children. The Russian delegation consisted of representatives of Vologodskaya Oblast, including the Deputy Chief of Health Department of Vologda Region, Chief MCH Specialists, and Heads of Vologda Oblast three pilot rural areas; representatives from Tumenskaya Oblast included the Deputy Chief Doctor of Tumen Regional MCH Center, Head of Obstetric Department of the Oblast Hospital of Tobolsk city, and Chief Physicians of the Central Area Hospitals of Yarkovo, Tumenskiy rayon, and Ishim town. During the visit, the Russian delegation got acquainted with the objectives, activities, and results of the Romanian project and its sub-contractors - SECS (Society for Education on Contraception and Sexuality) and PSI (Population Service International). MCHI training coordinator Elena Stemkovskaya presented the MCH Initiative, its goals, objectives, and results.

*Discussing the Romanian experience in the sphere of Family Planning*

The Russian delegation visited family planning clinics and Feldsher's units in 2 rural districts, and had the opportunity to speak to family doctors. The Russian delegation also visited Institute for Mother and Child Care in Bucharest. Dr. Alien Stanescu, the Institute's Vice President, made a presentation on the organization of the Romanian health system, health system financing, and national programs for women's and child health.



*Tumen representatives, visiting one of the rural districts*

As a result of the visit, the Russian delegation had plenty of ideas on how to develop family planning services in the rural areas. The heads of rural administration got acquainted with the Romania project's activities and understood the importance of improving family planning services in their areas. Due to MCHI and the opportunity of sharing experience with other international projects, specialists learned more about the approach and mechanisms of providing rural populations with family planning services. Heads of local administration underlined the importance of such observation visits, which help to improve the quality of services (Attachment # 10 - List of Participants).

- MCHI FP Consultant Anna Samarina held a **Family Planning conference for rural areas in Vologda** on December 5, 2005. Representatives of pilot rayons of the Oblast participated in the conference, organized by the Vologda Center for Medical Prevention. Chief physicians of the rayon's central hospitals, obstetricians-gynecologists, midwives of feldsher's units, pediatricians, and general practitioners were among the participants of the conference. Anna Samarina made presentations on the MCHI implementation in the Oblast, demographic situation in the Russian Federation, advantages of Family Planning and counseling on Family Planning. The participants of the conference expressed significant interest in participating in the project with their facilities and rayons.

## **Youth Reproductive Health Program (YRHP)**

- **A workshop of the MCHI YRHP working group** was conducted in Moscow on November 14-16, 2005. The goal of the workshop was to review Russian and international experience in the field of adolescent and youth reproductive health care, to discuss development of MCHI YRH program Guidelines on the work implemented in the field of adolescent and youth reproductive health care, and to discuss future workplans and steps. Representatives from Tumen, Barnaul, Velikiy Novgorod, Khabarovsk, Orenburg, Vladivostok, Vologda, and Komi Republic participated in the workshop. During the workshop, it was decided to create MCHI Guidelines on developing policies and programs in the area of youth reproductive health, to conduct a training on youth-friendly services in Moscow on March, and to organize a conference in Barnaul on April. The goal of the conference will be to share with other MCHI regions Barnaul's experience providing local programs on youth reproductive health and its multi-sectoral approach. The Barnaul NGO "Siberian Initiative" will conduct a special training on volunteering work in Barnaul in January-February 2006. (Attachments # 11, 12 - agenda, list of participants).



*Discussing action plans and future steps*

## Training activities

- **A training course on Antenatal care** was conducted in Barnaul on October 10-14, 2005. The course was conducted with participation of MCHI master trainers in collaboration with two new co-trainers from Vologda and Tumen Oblasts. The course was conducted for representatives of Barnaul, among who were 2 representatives of Obstetrics and Gynecology department of Medical University of Barnaul and representatives from Orenburg. All the participants were very active and interested in changing antenatal care. During the course all the sessions were demonstrated not only by means of presentations, but also in case studies, psychological tests, role plays and small group discussions. All the participants showed a good level of knowledge and interest in obtaining new knowledge. During pre-tests, the participants had an accuracy rate of 30%, as opposed to post-tests, which participants showed an accuracy rate of 89%. (Attachments # 13, 14 - agenda, list of participants).
- **A training course on Antenatal Care** was conducted in Krasnoyarsk on October 24-28, 2005. Medical providers from Krasnoyarsk and Uchta (Komi Republic) participated in the course. All of them were very interested in the course and took active part in all the course activities. Heads of Health Department of Krasnoyarsk also showed great interest in the course. Chief obstetrician-gynecologist of Krasnoyarsk attended most of the sessions. During the practical sessions, participants had an opportunity to counsel 12 antenatal and postpartum clients. (Attachments # agenda, list of participants).



Practicing antenatal counseling

### Success story

*Valentina Torchakova has been working as a midwife in the City Maternity #5 of Krasnoyarsk for more than 10 years. During this period, she has helped to facilitate the happiness of becoming a mother, as her caressing arms helped birth thousands of new Krasnoyarsk citizens. Five years ago, Valentina herself became a mother. This experience helped her not only to better understand the dreams and expectations of her clients, but also to consider if she was using accurate and beneficial procedures in the maternity. Valentina asked herself and her colleagues: Why are no relatives permitted to be present in the delivery room? Why can't a father see his dearest baby before discharge? Why are so many drugs used during pregnancy and delivery? Are these drugs useful and safe?*

*A year and a half ago, Krasnoyarsk started to implement MCHI, which is implemented in Russia by John Snow, Inc. (JSI) under the financial support of USAID. Valentina was one of the pioneer midwives of her maternity to participate in MCHI's family-centered maternity care training course. To participate in this course, she needed to leave Krasnoyarsk for Kaluga. She was very happy to see the oldest Russian city of Kaluga and to get acquainted with the experience of maternities of other regions. Valentina was impressed by the new methodology of training, the large amount of modern, evidence-based materials, and the process of delivering a child without assistance-- all by herself. At the course's final conference, she said, "Now I have a feeling of being a midwife of the third century".*

*Six months later, a team of MCHI experts visited her maternity with a follow-up visit. The team was met by the enthusiastic midwives and obstetricians-gynecologists who were very proud to show the experts their maternity, delivery rooms, and postpartum wards. Valentina participates in the process of labor in a "new way," training her colleagues with the knowledge she gained from the FCMC course. Even more impressively, having understood that there remained much for her to learn, Valentina enrolled in the psychological faculty of Krasnoyarsk University. "Now I regret only one thing," says Valentina. "I could have worked this way much earlier in my life and I wouldn't have lost several years in finding truth: the most important people in a maternity are the family – a mother, a father, and a newborn!"*

- **A Breastfeeding refresher training course** was held in Vologda on October 24-28, 2005. The total number of participants was 44 people from Vologda, Cherepovetz, Velikiy Ustug, Sokol cities and village Sheksna. MCHI invited two master trainers and one new trainer, neonatologist from Cherepovetz maternity to facilitate the training course. All the participants were very thankful to the Project for the opportunity to participate in the course. (Attachments # agenda, list of participants).

- **A training course on Antenatal care** was conducted in Omsk on December 5-9, 2005. Representatives from pilot facilities of Omsk and Tara participated in the course. All the methods of interactive adults training were used during the course: presentations, work in small groups, role plays, discussions, video. Much time was spent on the participants' self-learning: they tried to use the provided literature, find the necessary information, and prepare reports. During the practical session, participants practiced in counseling pregnant women in women's consultation. In the maternity hospitals, participants counseled antenatal clients, got acquainted with their anamnesis, and came to the conclusion that practically 80% of pregnant women should stay at home rather than in a maternity hospital. Participants believed that they do not need such aggressive treatment. (Attachments # agenda, list of participants).
- **A training course on Antenatal care** was conducted in Kaluga on December 12-16, 2005. Representatives from medical facilities of Kaluzhskaya Oblast and Velikiy Novgorod participated in the course. Teachers from medical colleges were among the participants of the course. Chief obstetrician-gynecologist of Kaluzhskaya Oblast attended all the sessions of the course. One day of the course was devoted to visiting the obstetric department of the Oblast Maternity, where participants had a chance to counsel pregnant and postpartum women on the interested topics. Overall, 9 pregnant and 9 postpartum women were counseled. All the women were satisfied with the counseling and information provided. In general, the course was quite successful, and all the participants were satisfied and ready to implement new antenatal approaches in their facilities. The results of the pre-test showed the level of knowledge of the participants to be low, at – 35.9 % of the right answers, whereas after the course, the results of the post-test showed participants at 81.8% of the right answers. (Attachments # agenda, list of participants).

### **Monitoring and Evaluation**

- Work on **Demographic Health Survey (DHS)** to be conducted in Vologda was initiated November, 2005. Indicators and a second draft of the questionnaire for the Survey were discussed. The indicators in the questionnaire would provide supplementary information on family planning and youth activities in rural and urban areas that would participate in that survey.
- A draft of **MCHI M&E Guidelines** for MCH Programs was developed in October 2005. The outline of the draft version was discussed with MCHI M&E consultant, Patricia David in December 2005. As a result of this discussion, it was decided to re-organize the guide in the following way: Who is the Guide for, Introduction, Goals and Purpose of M&E, How is an MCH program monitored and evaluated: an example from MCHI, and Using the data to improve services.
- MCHI M&E Consultant Patricia David visited MCHI on December 1-13, 2005. The objectives of her visit were to review and revise as appropriate the design, methodology, questionnaires, and any other tools needed to conduct the end-line study; to review the draft of a new document called "M&E Guidelines for MCH Projects," and advise on content, approach, target audiences and next steps; to review data from the FP/HIV survey and advise on next steps (analysis, reporting, etc); to review plans for conducting a possible modified DHS in Vologda Region utilizing local resources to conduct the study; to review Family Planning indicators, especially related to a pilot rural model, and make recommendations in light of available resources (time and human) in order to provide adequate reporting on specific expected results; to review Youth indicators, especially related to a pilot model, and make recommendations in light of available resources (time and human) in order to provide adequate reporting on specific expected results; to review the overall M&E Implementation Plan and indicators in light of experience with Baseline survey, other data sources and recently expanded SOW; and to assist Project staff to identify lessons learned, address anticipated

challenges/concerns, and make revisions as appropriate to ensure the obtaining of essential, valid and reliable data over the LOP.

### **Follow-up activities**

- **Follow-up visits** were conducted to Barnaul on October 17-19, to Krasnoyarsk on November 1-3, to Omsk and Tara on November 28-30, to Kaluga on December 19-21, 2005.

**In Barnaul**, MCHI experts visited 3 children's polyclinics. During these visits, the experts found out that there great work had been done and polyclinics had moved forward in the Project implementation. The polyclinics have implemented breastfeeding support practices and family planning and implemented work with adolescents. Practically all of the personnel of the polyclinics are trained in HIV/AIDS prevention, and women are being counseled in PMTCT. As for maternities, the MCHI team visited the pilot maternity and discovered that this facility needs support from Municipal and Oblast Health Department. The experts recommended the maternity to regulate issues on FCMC, rooming-in and breastfeeding with SanEpi Service. The experts pointed out great motivation and wish of maternity administration and personnel to participate in the project. Most of the offered by the Project practices are already implemented in the maternity.

**Krasnoyarsk:** Visit to pilot maternities showed that all the delivery rooms are single-seated. Each delivery room in Maternity # 5 has its name and color. Each room has a shower. 70-75% of deliveries are partner-deliveries. The midwives obligatory visit a woman in postpartum room. All the pregnant women in pathology department have a possibility to take classes in childbirth.

All the pilot women's consultations are well-decorated. There is a lot of information for clients in the walls, stands, and in cabinets, a lot of IEC materials. During a reception at consultation, the clients are listening lectures on family planning, which are recorded. Pilot Women's consultations constantly participate in the competitions on the decoration of the halls, walls and stands.

Much attention is paid to promotion of breastfeeding in the pilot children's polyclinics of Krasnoyarsk. Children's polyclinics actively collaborate with maternities and develop informational materials on breastfeeding.

**Omsk and Tara:** MCHI experts stated out that the personnel of the pilot maternities had done great work in implementing the project recommendations. The experts were asked lots of questions from the personnel, and there was organized a mini-conference to answer all the questions. Experts noticed that all the delivery rooms were well-decorated, and women used balls in deliveries. Maternities practice rooming-in after vaginal deliveries and C-sections. Relatives are allowed to make visits to women and babies and partner-deliveries are allowed in maternities free of charge. In pilot women's consultations there are organized lectures on Family Planning, they practice individual FP counseling and counseling in schools and colleges. Personnel of the FP department of the Oblast Clinical Hospital annually hold seminars for feldsher's units in Reproductive health and FP issues.

**Kaluga:** The MCHI expert team visited children's polyclinics and stated that much attention is being paid to breastfeeding support. Pediatricians and nurses actively visit pregnant women and breastfeeding mothers and counsel them on breastfeeding techniques. A breastfeeding support group has been created and is actively working. The MCHI experts also visited the Oblast maternity and pointed to great changes that had occurred since the last follow-up visit. Most of the project recommendations are being implemented into practice. Delivery rooms are perfectly equipped. Non-medicated pain relief is actively used, including balls, massage and music. Women deliver with a partner. All the midwives actively apply alternative positions in the 2<sup>nd</sup> stage of labor. In the postpartum period, mothers have rooming-in.

### **Documentation and Dissemination Strategy**

- 2 articles for Siberia Scientific Medical Journal were prepared and sent for publication in October, 2005.

- 5 interviews and presentations on the project implementation were given at a press conference in Tumenskaya Oblast in October, 2005.
- A design of an MCHI web site was finalized in October, 2005.

#### **Russian Society of Obstetricians-Gynecologists (RSOG)**

- RSOG representatives, Irina Savelieva and Zhanna Gorodnicheva participated in the initial development of **Family Planning Guidelines for HIV positive women** in December, 2005. They wrote several sessions on Family Planning and Contraception among HIV-positive women.

#### **Collaboration/Meetings:**

##### **Assistance to Russian Orphans (ARO)**

- MCHI COP Natalia Vartapetova participated in an MCHI/ARO Coordination Meeting on November 8, 2005.
- MCHI Information and Communication Coordinator Yulia Boyarkina attended the press-conference on issues related to children affected by HIV/AIDS on November 30, 2005.

##### **Other MCHI Activities**

- MCHI consultants participated in a Joint Meeting of WHO and JSI on the revision of neonatal and perinatal curricula on November 23-30, 2005. The objectives of the meeting were to review updated modules in Essential Obstetric Care, to finalize the draft of Essential Care modules, to review modules in Essential Newborn Care and Breastfeeding, and to provide suggestions for improved training methodologies in both modules. MCHI experts on breastfeeding and neonatal care, Elena Safronova and MCHI Clinical Coordinator Oleg Shvabskiy, participated in the meeting.
- MCHI COP Natalia Vartapetova, Project Coordinator Anna Karpushkina, and Clinical Coordinator Oleg Shvabskiy, attended the APHA Annual Conference held in Philadelphia on December 10-14, 2005. Natalia Vartapetova made a well-received presentation on “Promoting breastfeeding in Russia: From WIN project to Maternal and Child Health Initiative.”

### **SECTION 3: SELECTED UP-COMING EVENTS**

- **Revision of the Family Planning Curriculum** in January-February, 2006.
- **Family Planning training course** to be held in Yakutia on February 27-March 2, 2006
- **Training courses on antenatal care** to be conducted in Vladivostok in February 6-10, 2005.
- **Follow-up visits** to Primorskiy region and Orenburg to be conducted February 2006.
- **FCMC training course** to be held in Vologda on March 13-24, 2006.
- **A Youth Friendly Reproductive Health Services training course** to be conducted in Moscow on March 13-17, 2006.

# The Maternal and Child Health Initiative Quarterly Report

**Contractor: John Snow, Inc.**

**Contract Number: HRN – I -00-98-00032-00. Delivery Order No.: 813**

**Reporting Period: January-March, 2006**

## **SECTION 1: BACKGROUND**

### **1.1. Description of Task Order Objectives**

The purpose of the Maternal Child Health Initiative (MCHI) Task Order is to ensure the adoption of internationally recognized MCH standards and practices by the targeted health facilities in Russia.

MCHI contributes to USAID/Russia's Strategic Objective, SO 3.2: *Use of Improved Health and Child Welfare Practices Increased*. Indicators directly related include: Indicator 3.2.3: *Abortion rates*, the Intermediate Result 3.2, IR1: *Access to More Effective Primary Health Care (PHC) Services Increased*, and its indicator: *Number of health facilities implementing evidence-based maternal and child health (MCH) care practices*.

**1.2. Expected Results:** To address the mentioned objective, upon the completion of the project the following results will be achieved:

- A Russian organization with a strong MCH mandate empowered and strengthened to partner with MCHI in implementing the replication model.
- Internationally recognized standards and USAID promoted MCH and HIV/AIDS prevention practices adopted by targeted health facilities in at least fourteen regions of the Russian Federation, in addition to the two WIN Project's pilot regions.
- The abortion rate reduced in the targeted regions.
- Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.
- Access to reproductive health services and information for men increased in the targeted regions.
- Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated.
- A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions.
- Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation (VRF) in the Far East.
- Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI model.
- Family planning services with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions.
- Family Planning capacity strengthened in the regions and at the national level.
- Integration of family Planning into primary health care services piloted in selected rural areas in at least two regions with high abortion rates.
- Family Planning integrated into counseling services for HIV-positive women.
- Family Planning and prevention of mother-to-child transmission of HIV (PMTCT) capacity strengthened at HIV Centers.
- A collaborative model on PMTCT developed and implemented together with ARO in one of the pilot regions, for example, Irkutsk.
- Additional (non-intervention) regions oriented to MCHI model and up-dated replication package.

- New activities included and monitored in the overall monitoring and evaluation plan. Overall project results documented and disseminated in the pilot regions and nationwide.
- The maternal and perinatal health care system in the Moscow oblast will be reformed through the creation of a model state-of-the-art regional health care program at the Moscow Region Perinatal Center (MRPC).

## SECTION 2: CURRENT ACTIVITIES

### 2.1 Administrative Activities

- Presented MCHI annual financial reports and declarations to the Social Insurance Fund, Statistics Department and Tax Inspection of the Russian Federation.
- Visited JSI International Division Director, Ken Olivola, on March 6-8, 2006.
- Visited MCHI Senior Adviser, Mary Lee Mantz, on March 6-18, 2006.

### 2.2 Summary of the program activities

#### Replication Strategy

- Completed a visit of Lisa Hare and Tatyana Makarova, MCHI Technical Consultants on Leveraging Achievements on January 9-20, 2006
- Conducted a **Meeting of Steering Committee on MCHI Final Dissemination Conference** on February 10, 2006.

#### Activities in the Far East regions

- Conducted a training course on **Antenatal care** in Vladivostok on February 6-10, 2006.
- Conducted a **follow-up visit** to Primorskiy region on February 13-17, 2006.
- Conducted a **Family Planning** training course in Yakutsk on February 27-March 2, 2006.

#### PMTCT activities

- Won the Priority National Health Project in HIV/AIDS in March, 2006.
- Finished a **PMTCT+FP survey data analysis** in March, 2006.
- Prepared first draft of **FP Guidelines for HIV+ women** by MCHI consultants in January, 2006.
- Participated Project Coordinator, Anna Karpushkina, in **Coordinating Committee on PMTCT**, held by the Russian Ministry of health and Social Development on March 21, 2006.

#### Family Planning activities

- Visited MCHI **Family Planning consultants** Laurie Cappa and Katherine Shields on January 23-February 5, 2006.
- Held a **pre-course workshop for Family Planning** master trainers on January 24-27, 2006.
- Held an updated **Family Planning Training of Trainers** in Moscow on January 30- February 3, 2006.

#### Youth Reproductive Health Program (YRHP)

- Visited **MCHI Youth Consultant**, Joanne Haffey on January 11-23, 2006.
- Conducted a **training on development of volunteering initiatives in youth reproductive health** in Barnaul on January 30-February 1, 2006 by NGO "Siberian Initiative".
- Conducted a **Youth Friendly Reproductive Health Services training course** in Moscow on March 13-17, 2006.

### **Training activities**

- Conducted a **refresher training course on FCMC** in Barnaul on January 23-28, 2006.
- Conducted an **FCMC training course** in Vologda on March 13-24, 2006.

### **Monitoring and Evaluation**

- Conducted a **Refresher training on End-line Facility-based Survey** in Moscow on January 16-18, 2006.
- Conducted **End-line Facility-based Survey** in 14 regions on February 1, 2006.
- Finalized design and signed agreement on conducting of **Reproductive Health Survey** in Vologda in March, 2006.

### **Follow-up activities**

- Conducted **follow-up visits** to Vologodskaya Oblast on January 19-20, 2006, to Orenburg on February 20-21, 2006.

### **Documentation and Dissemination Strategy**

- Started working MCHI web-site on January 24, 2006.
- Signed a contract with a film company to produce an FCMC training film in February, 2006.

### **Russian Society of Obstetricians-Gynecologists (RSOG)**

- Participated RSOG representatives in a **Meeting of Steering Committee on MCHI Final Dissemination Conference** on February 10, 2006.

### **Collaboration/Meetings:**

#### **UNICEF**

- Participated at a **UNICEF meeting on PMTCT Monitoring Issues** on February 28, 2006.

#### **URC**

- Participated and presented at a URC workshop in Saratov on March 1-3, 2006.

### **Other MCHI Activities**

- Prepared abstracts to be submitted to Toronto HIV/AIDS Conference in February, 2006.

## **2.3 Performance**

### **Replication Strategy**

- MCHI Technical Consultants on Leveraging Achievements, Lisa Hare and Tatyana Makarova visited MCHI on January 9-20, 2006. The goal of the visit was to document MCHI's leveraging processes and achievements with the data available. The leveraging team interviewed each member of the program staff on the project activities and achievements and about the regions' feedback. During the visit the leveraging team visited one of the Project's sites- Vologodskaya Oblast, where they tried to assess the benefits, if any, of participating in the Project. In Vologda the leveraging team met with the Regional Coordinator, Chief Physicians of Maternity Hospitals and Head of MCH Department. The interviewed specialists stated their appreciation of the evidence-based approaches and practices, introduced by the Project. The detailed report on the leveraging study will be available in April, 2006.
- **A Meeting of Steering Committee on MCHI Final Dissemination Conference** was conducted on February 10, 2006. The goal of the meeting was to define the system of presentations, possible participants, topics of presentations and demonstration materials. Representatives from MCHI pilot regions, such as Altaiskiy kray, Primorskiy kray, Vologodskaya Oblast, Tumenskaya Oblast, Perm and Kaluzhskaya Oblast participated in the

meeting. During the meeting participants identified the title of the Final MCHI conference, possible non-pilot regions to be invited at the Conference, the form of the conference was also discussed at the meeting. It was decided to hold the second meeting of the Steering Committee in April, 2006.

### Activities in the Far East regions

- A training course on **Antenatal care** was conducted in Vladivostok on February 6-10, 2006. The course was conducted by two MCHI master trainers and one regional trainer from Irkutskaya Oblast. Representatives from pilot facilities of Nakhodka and Vladivostok cities participated in the course. It is worth to mention that representatives of Vladivostok Medical Academy were among the participants of the course. All the participants showed great interest in the content of the course and were very active discussing new evidence-based approaches to antenatal care. (Attachments # 1, 2 - Agenda, List of Participants)



- A **follow-up visit** to Primorskiy region was conducted on February 13-17, 2006. During the visit MCHI experts visited pilot facilities of Vladivostok and Nakhodka cities. The MCHI experts noticed that great work on implementing exclusive breastfeeding and family-centered maternity care was performed in all the pilot facilities of Primorskiy Krai. For example, all the children are discharged with dry cord from maternity in Nakhodka. Rooming-in after C-section is organized in maternity #3 of Vladivostok. Individual delivery rooms are created in all delivery departments and number of partner-deliveries has increased up to 30-40%. All the women noticed friendly atmosphere and high-qualified personnel in pilot maternities. Findings and recommendations of the follow-up visit were reported to and discussed with regional working group and facilities' staff. Also MCHI experts discussed future steps in collaboration with Primorskiy Krai health care department.



- A revised and updated **Family Planning** training course was conducted in Yakutsk on February 27-March 2, 2006. The course was conducted by three MCHI trainers in Family Planning from Vladivostok and Vologda, who were trained at a FP TOT course, held in Moscow in February, 2006. The course was intended to train health providers in international evidence-based practices and standards for family planning services, with an emphasis on counseling. The course was designed to strengthen providers' knowledge and counseling skills in order to provide quality family planning services, integrating family planning into the broader spectrum of reproductive health care services. Participants included 30 representatives from pilot medical facilities among who were heads of women's consultations, adolescents' gynecologists, midwives, representatives of Obstetrics and Gynecology department of Medical Institute of Yakutia State University. During the course the participants had an opportunity to practice different role-plays in family planning counseling, and got acquainted with modern methods of family planning. (Attachments # 3, 4 - Agenda, List of Participants).



### PMTCT activities

- MCHI won the **Priority National Health Project in HIV/AIDS in Russian regions** in March, 2006. The Federal Service on Supervision in the Sphere of Consumer Rights and Human Wellbeing organized an Open national Competition to implement a National health Project in HIV/AIDS and PMTCT. MCHI was invited to participate in the tender for 20

million rubles' National Grant. For the project MCHI identified a partner organization, the oldest and the largest national medical higher educational institution of Russia, a major center for training, certification and updating the medical personnel and pharmacists - the Sechenov Moscow Medical Academy (MMA). Together with MMA MCHI prepared a proposal including numerous activities to improve PMTCT and FP practices among HIV-positive women in 15 regions of Russia. On March 7, 2006 the Federal Service on Supervision in the Sphere of Protection of Consumer Rights and Human Wellbeing announced that MCHI had won the tender and there was signed a contract.

- A **PMTCT+FP survey data analysis** was finished in March, 2006. A working draft of the report was developed in the end of March, 2006 and will be forwarded for the agreement to Boston in April, 2006.
- First draft of **FP Guidelines for HIV+ women** was prepared by MCHI consultants in January, 2006. The draft will be edited and added by MCHI staff in April and will be sent to MCHI regions for discussion. The whole Guidelines will be published in June, 2006.
- Project Coordinator, Anna Karpushkina, participated in **Coordinating Committee on PMTCT**, held by the Russian Ministry of Health and Social Development on March 21, 2006. During the meeting there were discussed issues of PMTCT monitoring and PMTCT strategy development in Russia.

### Family Planning activities

- **MCHI Family Planning consultants** Laurie Cappa and Katherine Shields visited MCHI on January 23-February 5, 2006. According to the MCHI family Planning Strategy, MCHI was supposed to revised and update the FP training curriculum and then offer the new FP course. With support of World Education and MCHI FP consultants a new FP curriculum was developed. The goal of Katherine Shields' and Laurie Cappa's visit was to assist the MCHI team to pilot the new curriculum.
- A **pre-course workshop for Family Planning** master trainers was held on January 24-27, 2006. The purpose of this workshop was to orient the small group of MCHI FP master trainers to the new curriculum. The Master Trainers included two with long-standing experience with the MCHI project and two new trainers representing Barnaul and Khabarovsk regions. During the four days Katherine Shields, Laurie Cappa and a group of master trainers reviewed selected sessions of the FP curriculum, edited cue cards, discussed the schedule and methodology of the TOT, practiced conducting sessions and made materials and flip charts.
- An updated **Family Planning Training of Trainers** was held in Moscow on January 30-February 3, 2006. The event was facilitated by 4 MCHI master trainers, who were oriented to the new curriculum a week before the TOT. Most TOT participants came from the two MCHI pilot regions of Vologda and Tumen. In addition, five current MCHI regions sent 1-2 participants each. All the participants were highly engaged throughout the TOT and seemed ready and willing to conduct this kind of training in their regions. The TOT began with a demonstration by the master trainers sessions, introducing participants to family planning and giving them a short orientation to the adult learning methodology. For the remaining four days, participants were divided into pairs and taught sessions from the curriculum, immediately received feedback from their peers and the master trainers. So, the participants spent lots of time outside class preparing their sessions, and showed improved understanding of the content and training methods of the family planning curriculum over the course. So, as an outcome of the TOT, the course achieved



*Writing up regional action plans....*

its objective of developing a strong cohort of trainers who could be counted on to move the FP component forward in their regions. Most TOT participants demonstrated that they are capable of conducting the FP training effectively. By the end of the course all the participants wrote their regional action plans of how and when they are going to initiate FP training courses and what kind of support from the MCHI they would need. Three of the trained participants from Vladivostok and Vologda were used by the MCHI as master trainers to conduct a FP course in Yakutia. (Attachments # 5,6 - Agenda, List of Participants).

### **Youth Reproductive Health Program (YRHP)**

- **MCHI Youth Consultant**, Joanne Haffey visited MCHI on January 11-23, 2006. The goal of her visit was to assist in developing MCHI Youth Guidelines. A working draft of the MCHI **Youth Guidelines** was discussed in January-March 2006.

- **A training on development of volunteering initiatives in youth reproductive health** was conducted in Barnaul on January 30-February 1, 2006 by Barnaul NGO "Siberian Initiative". Representatives from Altai Krai, Tumenskaya, Vologodskaya Oblasts, Komi Republic, Vladivostok, Khabarovsk and Orenburg participated in the training. The purpose of the training was to learn how to prepare specialists for development and implementation of volunteering initiatives in the field of youth reproductive health at the regional level. During the training the participants developed regional programs on volunteering work considering the current situation in the regions. Due to the final evaluation of the course the participants expressed the opinion that the training was well-organized and gave them an opportunity to obtain the Barnaul regional program on youth reproductive health and features of the volunteering work in the frame of the program.



*Participants after the training became friends and likely-minded specialists*

- **A Youth Friendly Reproductive Health Services training course** was conducted in Moscow on March 13-17, 2006. Twenty-three service providers from Barnaul, Velikiy Novgorod and Orenburg cities, Vologodskaya, Irkutskaya and Tyumenskaya oblasts, Komi Republic and Primorskiy and Khabarovskiy REgions participated in the training. All participants were directly involved in providing reproductive health services for adolescents. By the end of the training participants learned about the importance of working with youth, definition of quality services, components of model reproductive health services for adolescents, approaches to reproductive health services for adolescents, adolescent social-psychological development, physical changes and common concerns during puberty, definition of sexually healthy adolescent, basic principles of working with adolescents, contraception for adolescents, emergency contraception, counseling for adolescents, elements of effective outreach. By the end of the course, participants developed their own action plans on how to establish youth-friendly reproductive health services in their regions and transfer knowledge and skills that they acquired during the course to their colleagues in the regions. (Attachments # 7, 8- Agenda, List of Participants).



*Learning basic principles of working with adolescents...*

## Training activities

- A **refresher training course on FCMC** was conducted in Barnaul on January 23-28, 2006. The goal of the refresher training course implementation of modern approaches to maternity care, observe practices and analyze clinical cases of pregnant women and newborns, to practically work in the MCH departments of maternities and to conduct theoretical sessions to strengthen knowledge and skills, obtained in the previous courses. (Attachments # 9 - List of participants).



*Preparing for clinical sessions.....*

- An **FCMC training course** was conducted in Vologda on March 13-24, 2006. The goals of the course were to implement modern methods of normal and pathology delivery management into practice of maternities, to introduce a notion of evidence-based medicine, to teach specialists principles of searching information, and to train new trainers in FCMC. In fact this training course was an integration of two courses – TOT in FCMC and FCMC training course. This TOT was conducted in the frame of the usual FCMC course for new trainers from Krasnoyarsk, Omsk, Orenburg, Cherepovetz, Vologda and Kaluga. Dr.I.Kostin, associate professor of Moscow State University of People's Friendship, representative of RSOG, participated in the FCMC training course, as a co-trainer. All the sessions were distributed among the pairs of trainers, so as one of them was a responsible master trainer and the second was a new one. All the principles of adult learning were used during the course, such as role-plays, small group discussions, brain-storm, video-films were also used. At the end of each day during the Steering Committee meeting each presentation was discussed, trainers' work was evaluated. All the trainers showed excellent knowledge of information they provided, even if there were some minimal problems among the new trainers, the team of master trainers was always ready to assist. Such a team work appeared to be very successful as to the end of the training course new trainers mentioned that they became more sure in their knowledge and mentoring skills and are ready to conduct trainings by themselves. The course was highlighted in the local TV channel-REN TV of Vologda. (Attachments # 10, 11 - Agenda, List of Participants).



*Discussing evidence-based clinical practices during the clinical week*

## Monitoring and Evaluation

- A **Refresher training on End-line Facility-based Survey** was conducted in Moscow on January 16-18, 2006. Regional coordinators on Survey conducting and technical staff, responsible for data entry were among the participants. They were trained in organizational principles and standard procedures for conducting a Facility-based Survey. (Attachments # - Agenda, List of Participants).
- **End-line Facility-based Survey** in 14 regions started on February 1, 2006. Data collection and data entry in the regions were finished on March 20, 2006. Since that time MCHI started data checking and cleaning.
- A Design of the **Reproductive Health Survey** in Vologda was finalized and an agreement between MCHI and Vologda Scientific-Coordination Center of the Academy of Science on conducting this Survey was signed in March, 2006. Piloting of questionnaires for the Survey and results of piloting were analyzed in March, 2006. Sample size was also discussed and agreed. The RHS will be started in April, 2006.

## Follow-up activities

- **Follow-up visits** to Vologodskaya Oblast was conducted on January 19-20, 2006, to Orenburg was conducted on February 20-21, 2006. During the visit to Vologodskaya Oblast MCHI experts visited the city of Cherepovetz. In the maternity they found out that all the delivery rooms are single, there are soup dispensers and absorbent paper towels. The maternity uses WHO partograph, which is filled in by midwives. Most of the practices, suggested by the Project are implemented. In women's consultations there is much educational information for the clients, there a lot of handouts. Family Planning is a key topic in work. The room for childbirth education is very well decorated. In the children's policlinic breastfeeding prevalence has raised twice till the time the Project is being implemented. During the visit the experts conducted a refresher training for providers of maternity and women's consultation. They highlighted the following topics: postpartum hemorrhage, active management of the third period of labour, pre-eclampsia, partograph, neonatal care. During the visit to Orenburg MCHI experts visited Women's consultation, delivery department and children's policlinic. In the women's consultation the experts stated that this facility actively collaborates with the maternity in childbirth education. There are lots of IEC materials in the halls and in physician's cabinets. As for the delivery department of the perinatal center all the personnel is trained in FCMC, breastfeeding and antenatal care. Most of the practices have been implemented, for example the number of episiotomy has decreased two times, partner deliveries have been increased 3 times - up to 22 %. All the newborns after C-section are roomed-in with their mothers. In the children's policlinic all the personnel is trained in 40-hour Breastfeeding course, trainings in essential antenatal care have started. Young families are educated in Breastfeeding.

## Documentation and Dissemination Strategy

- An MCHI web-site started working on January 24, 2006. The address of the site is [www.jsi.ru](http://www.jsi.ru).
- A contract with a film company to produce an FCMC training film was signed in February, 2006. The film is going to be a visual aid for physicians and midwives in maternity care. At the present time the scenario has been written, and animated slides for cue are being prepared . The film-shooting will take place in the pilot maternity of Vologda in the beginning of June, 2006.

## Russian Society of Obstetricians-Gynecologists (RSOG)

- RSOG representatives participated in a **Meeting of Steering Committee on MCHI Final Dissemination Conference** on February 10, 2006 and in FCMC training course, held in Vologda on March 13-24, 2006. During this meeting Professor V.Radzinskiy proposed MCHI to develop clinical protocols on normal birth management, pre-eclampsia, vaginal birth after C-section, preterm pre-labor, postpartum hemorrhage. These protocols will be presented at the national level during May Conference.

## Collaboration/Meetings:

### UNICEF

- Natalia Vartapetova, MCHI COP, and Anna Karpushkina, Project Coordinator, participated at a **UNICEF meeting on PMTCT Monitoring Issues** on February 28, 2006. During the meeting the actual issues on HIV monitoring improvement among pregnant women and newborns.

### URC

- Anna Karpushkina, Project Coordinator, participated at a URC workshop in Saratov on March 1-3, 2006. At the workshop she made an hour - presentation on the data, obtained in the result of conducting a PMTCT+FP survey.

**Other MCHI Activities**

- Natalia Vartapetova, MCHI COP, and Anna Karpushkina, Project Coordinator prepared abstracts on the results of PMTCT+FP survey and on the implementation of MCHI PMTCT guidelines, to be submitted to Toronto HIV/AIDS Conference to be held in August, in February, 2006.

### **SECTION 3: SELECTED UP-COMING EVENTS**

- An **FCCM training course** to be held in Sakhalin on March 27-April 7, 2006.
- An **Antenatal Care training course** to be conducted in Yakutia on April 10-14, 2006.
- A **Conference on multisectoral approach to youth reproductive health programs** to be conducted in Barnaul on April 10-12, 2006.
- A **Family Planning training course** to be held in Sakhalin on April 17-20, 2006.
- A **meeting of Steering Committee** to be conducted in Moscow on April 18-19, 2006.
- An **MCHI Final Conference** to be conducted in Moscow on May 15-17, 2006.
- A **JSI Eastern European and Eurasia Meeting** to be held in Moscow on May 18-19, 2006.

# The Maternal and Child Health Initiative Quarterly Report

**Contractor: John Snow, Inc.**

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## **SECTION 1: BACKGROUND**

### **1.1. Description of Task Order Objectives**

The purpose of the Maternal Child Health Initiative (MCHI) Task Order is to ensure the adoption of internationally recognized MCH standards and practices by the targeted health facilities in Russia.

MCHI contributes to USAID/Russia's Strategic Objective, SO 3.2: *Use of Improved Health and Child Welfare Practices Increased*. Indicators directly related include: Indicator 3.2.3: *Abortion rates*, the Intermediate Result 3.2, IR1: *Access to More Effective Primary Health Care (PHC) Services Increased*, and its indicator: *Number of health facilities implementing evidence-based maternal and child health (MCH) care practices*.

**1.2. Expected Results:** To address the mentioned objective, upon the completion of the project the following results will be achieved:

- A Russian organization with a strong MCH mandate empowered and strengthened to partner with MCHI in implementing the replication model.
- Internationally recognized standards and USAID promoted MCH and HIV/AIDS prevention practices adopted by targeted health facilities in at least fourteen regions of the Russian Federation, in addition to the two WIN Project's pilot regions.
- The abortion rate reduced in the targeted regions.
- Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.
- Access to reproductive health services and information for men increased in the targeted regions.
- Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated.
- A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions.
- Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation (VRF) in the Far East.
- Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI model.
- Family planning services with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions.
- Family Planning capacity strengthened in the regions and at the national level.
- Integration of family Planning into primary health care services piloted in selected rural areas in at least two regions with high abortion rates.
- Family Planning integrated into counseling services for HIV-positive women.
- Family Planning and prevention of mother-to-child transmission of HIV (PMTCT) capacity strengthened at HIV Centers.
- Additional (non-intervention) regions oriented to MCHI model and up-dated replication package.
- New activities included and monitored in the overall monitoring and evaluation plan. Overall project results documented and disseminated in the pilot regions and nationwide.

- The maternal and perinatal health care system in the Moscow oblast will be reformed through the creation of a model state-of-the-art regional health care program at the Moscow Region Perinatal Center (MRPC).

## SECTION 2: CURRENT ACTIVITIES

### 2.1 Administrative Activities

- Presented MCHI quarterly financial reports and declarations to the Social Insurance Fund, Statistics Department and Tax Inspection of the Russian Federation.
- Submitted a request for MCHI no-cost extension to the USAID in April, 2006, which was approved in May.
- Applied for registration of the Institute for Family Health (IFH) as a NGO – envisioned to be the legacy Russian organization to carry on the work of MCHI.

### 2.2 Summary of the program activities

#### Replication Strategy

- Held an MCHI Final Dissemination Conference on “**Improving quality of medical care of women and infants: the MCHI experience**” in Moscow on May 15-17, 2006.
- Held **JSI Eastern Europe and Eurasia (EE/EA) Regional Meeting** in Moscow on May 18-19, 2006.

#### Activities in the Far East regions

- Conducted a training course on **FCMC** in Uzhno-Sakhalinsk on March 27-April 7, 2006.
- Conducted a training course on **Antenatal Care** in Yakutsk on April 10-14, 2006.
- Conducted a **Family Planning** training course in Uzhno-Sakhalinsk on April 17-20, 2006.
- Conducted a training course on **FCMC** in Yakutsk on May 22-June 2, 2006.
- Conducted a training course on **Antenatal Care** in Uzhno-Sakhalinsk on May 22-26, 2006.

#### PMTCT activities

- Participated MCHI COP, Natalia Vartapetova, and MCHI Project Coordinator, Anna Karpushkina in the **regional PMTCT workshop**, held in Saint-Petersburg on April 5-7, 2006
- Led the session on PMTCT at the EE/CAR Conference on HIV/AIDS on May 16, 2006.
- Prepared a set of presentations on PMTCT guidelines in May, 2006.
- Prepared a draft of the report on the **PMTCT+FP Survey** in June, 2006.
- Prepared a first draft of **FP Guidelines for HIV+ Women** in June, 2006.
- Presented MCHI COP, Natalia Vartapetova at the meeting, entitled “HIV, Women, Children”, held by the Ministry of Health and Social Development of Russia in Moscow on June 27, 2006

#### Family Planning activities

- Revised and edited MCHI **Family Planning Training Curriculum and Family Planning Training of Trainers Curriculum** for primary health care providers in April-May, 2006.

#### Youth Reproductive Health Program (YRHP)

- **MCHI Youth Consultant**, Joanne Haffey, provided TA on April 3-15, 2006.
- Conducted a **Conference on Multi-Sectoral Approach for Youth Reproductive Health Programs** on April 10-12, 2006 in Barnaul.
- Published and disseminated MCHI **Youth Guidelines** in May, 2006.

## Monitoring and Evaluation

- Completed MCHI Endline Facility-Based Survey in April, 2006.
- Conducted **Reproductive Health Survey** in Vologda in April, 2006.

## Documentation and Dissemination Strategy

- Held a meeting on **Development of Obstetric Clinical Protocols** in Moscow on April, 17-18 2006.
- Started shooting an educational film on FCMC practices in Vologda on June 5, 2006.

## Russian Society of Obstetricians-Gynecologists (RSOG)

- Participated RSOG representatives in **development of Obstetric Clinical Protocols**.

## Collaboration/Meetings:

### URC

- Shared MCHI Family Planning resources in May, 2006.

### Other MCHI Activities

- Natalia Vartapetova, MCHI COP, participated in the JSI International Division Meeting on June 5, 2006 in Washington DC.
- Natalia Vartapetova, MCHI COP, presented the key findings and accomplishments of MCHI to USAID/W and met with the team leader for the USAID/W EE Bureau (Harriett Destler) on June 6, 2006 in Washington DC.
- Natalia Vartapetova, MCHI COP, participated in working meetings with JSI Senior Management on June 8-9, 2006 in Boston.
- Conducted an **MCHI Staff Retreat** in Moscow Oblast on June 21-23, 2006.

## 2.3 Performance

### Replication Strategy

- MCHI Final Dissemination Conference, titled **“Improving Quality of Medical Care of Women and Infants: The MCHI Experience”** was held in Moscow on May 15-17, 2006. The Conference presented the main MCHI results and lessons learned in improving women’s and infants’ health in 16 regions across Russia. The Conference featured sessions and master classes demonstrating MCHI activities in Russian regions in: Perinatal and Antenatal Care, Newborn Care, Reproductive Health, and PMTCT. Approximately 300 participants attended, from more than 30 Russian regions, among who were heads of regional health departments, MCH departments, chief specialists, medical school representatives, and leading Russian specialists. In addition, guests included Eastern European and Eurasian countries, USAID and other international organizations, and representatives from the JSI home office in Boston.

The Conference was opened by the greetings of key stake-holders. Dr. Valentina Sadovnikova, deputy director of the MCH department of the Russia Ministry of Health and Social Development, greeted participants on behalf of the Ministry of Health and Director of the MCH department, Dr. Olga Sharapova and expressed deep gratitude to the MCHI COP, Dr. Natalia Vartapetova, for the fruitful collaborative work, being implemented in the field of maternal and child health. The Director of the USAID/Russia health office, Betsy Brown, expressed deep appreciation to JSI for the excellent work implemented in the field of reproductive health in Russia for the past ten years. Theo Lippeveld, JSI Vice President, greeted participants on behalf of JSI and stated that MCHI has



*“Owing to the MCHI, implemented in 16 Russian regions, the abortion rate decreased, the number of normal deliveries increased, maternal and child health improved”, -stated Betsy Brown*

successfully achieved the expected results.

The first day of the Conference was devoted to such issues as modern perinatal care in MCHI, clinical protocols in maternity care developed by MCHI and newborn health. Representatives from MCHI intervention regions presented their achievements and results in these areas. During lunch time and coffee-breaks there was organized an exhibition, which was on display for 3 days, where MCHI regional representatives showed films, IEC materials and pictures of the project implementation.

The second day was devoted to reproductive health issues, decrease of abortion rate and promotion of family planning services. The Chief Obstetrician-Gynecologist of Barnaul presented a multidisciplinary approach to family planning services provision, which has resulted in increased use of modern methods of contraception, leading to decrease in abortion rate. During this session the participants of the Conference had an opportunity to get acquainted and compare the international experience of Family Planning programs, which was presented by Laurie Cappa, JSI Senior Technical Advisor, and Dr. Merce Gasco, COP of the Romanian Family Health Initiative.



*"The Project breathed in new strength into health managers and specialists. It pushed to integration. And now not only medical workers are engaged in the family planning and reproductive health issues"-says N.Brynza, 1<sup>st</sup> deputy director of Tumen Oblast health department*

The second part of the day was devoted to PMTCT session, which was held as part of the Eastern European and Central Asian AIDS Conference. The session was led by Professor Eugeniy Voronin, the head of the National Centre for Assistance to Women and Children living with HIV/AIDS. JSI leading experts on HIV/AIDS - Andrew Fullem and Ruslan Maluta, were among key speakers at this session. Dr. Alexander Golusov, the head of the department for HIV/AIDS surveillance at the Federal Service on Supervision in the sphere of protection of consumer rights and human wellbeing announced that JSI together with Moscow State Medical Academy won the Priority National Health Project in HIV/AIDS to be implemented in 15 regions of Russia. He also stated that JSI appeared to be an organization, which implements an extremely effective, competent, and useful work for Russia.

The evening of the second day of the Conference highlighted a gala reception, where participants had an opportunity to talk informally with each other and with the project representatives. All the participants seemed to be active, sharing opinion on the information they received and presented during the Conference.

The third day of the Conference was devoted to master-classes of MCHI experts on FCMC, Antenatal Care, Breastfeeding, Family Planning and Youth reproductive health policy and programs. During these classes MCHI experts told participants of the Conference about the content of the courses, goals and objectives, training format and briefly conducted some interactive sessions like they usually do during MCHI training courses. The Conference concluded by discussing future plans for the project dissemination and all regions expressed great interest and wished to implement MCHI in their territories.



*Master-class on Family Planning*

The minutes of the Conference were highlighted in the Federal "Medical Newspaper". (Attachments # 1, 2 - Agenda and the List of Participants).

- JSI Eastern Europe and Eurasia (EE/EA) Regional Meeting** was held in Moscow on May 18-19, 2006. The objectives of the meeting were to share and learn about the strategies of successful implementation of Reproductive and Maternal/Infant Health and HIV/AIDS programs in the region, to agree on standards of excellence in key program areas: Family Planning, Perinatal Care, and HIV/AIDS activities and to clarify JSI's areas of expertise/capacity in Europe/EE/Eurasia. The Meeting was attended by representatives from JSI's projects from Russia, CAR, Ukraine, Georgia, Romania, and Albania. During the Meeting there were organized several open session discussions, devoted to HIV/AIDS, Family Planning, Perinatal Care, Institutionalization of Evidence-based medicine, Policy reform and health financing. At these sessions participants discussed strengths and capabilities in the technical area, identified resources including experts, model sites, informational materials, and identified potential opportunities for future programming. As an outcome of these open session discussions there were formed two working groups on - New Business Development and Perinatal/Maternal Health. Each member of the group got its assignment, there were determined how these working groups can be sustained and effective and stay in touch.



*Representatives from JSI's projects from Russia, CAR, Ukraine, Georgia, Romania, attended the Meeting*

### Activities in the Far East regions

- A training course on **FCMC** was conducted in Uzhno-Sakhalinsk on March 27-April 7, 2006. Representatives from pilot facilities of the city participated in the course. Participants were represented by Heads of Health department of Sakhalinskaya Oblast, heads of Women's consultations, leading specialists of San-Epi service, obstetricians-gynecologists, neonatologists, midwives. All the participants showed great interest in the course. All of them took active part in various interactive discussions and presentations. Some specialists were already familiar with the FCMC practices and have already been implementing some of them in their maternities. At the beginning of the course the team of trainers conducted a pre-test and the percent of basic knowledge was quite low – 52 %. They knew little about evidence-based medicine, WHO partograph, alternative positions during labor, active management of third stage of labor, counseling, new approaches in antenatal care. During the course MCHI trainers tried to pay more attention to these issues. At the end of the course the results of the post-test were quite better – 82%. The participants of the course expressed deep gratitude to MCHI and its trainers and developed real action plans and assured the team of experts that they would start implementing the project ideas in their facilities. (Attachments # 3, 4 - Agenda, List of Participants).
- A training course on **Antenatal Care** was conducted in Yakutsk on April 10-14, 2006. Obstetricians-gynecologists, midwives, professor's associates of obstetrics and gynecology department of Yakutsk Medical Academy were among the participants of the course. All of them showed good basic knowledge of the discussed issues. As a result of pre and post-tests the level of knowledge after the course was 4 times higher than it was at the beginning of the course. At the end of the course the participants developed action plans, where they mentioned that they were going to share knowledge they got in the training course with their colleagues, to conduct training course in the facilities, to decorate stands in women's consultations according to new information. Representatives of obstetrics and gynecology department were going to conduct the same kind of training in Perinatal Center and invite Mass Media. (Attachments # 5, 6 - Agenda, List of Participants).

- A **Family Planning** training course was conducted in Uzhno-Sakhalinsk on April 17-20, 2006. Participants included 22 representatives from medical facilities among who were health care authorities, obstetricians-gynecologists, midwives and pediatricians. The course was conducted by two master-trainers – dr. Larissa Berezina (Vologda) and dr. Marina Maneshina (Orenburg), who were trained at the TOT, conducted in February in Moscow. During the course new approaches to family planning counseling, and how to inform clients about modern methods of contraception and STI/HIV/AIDS prevention were discussed. All the participants valued the handouts, especially FP training manual and WHO Medical Eligibility Criteria for the use of contraceptives. Trainers marked a huge interest and high level of knowledge among participants. By the end of the course all the participants realized positive aspects of counseling on family planning. (Attachments # 7, 8 - Agenda, List of Participants).



- A training course on **FMC** was conducted in Yakutsk on May 22-June 2, 2006. 30 medical providers from delivery departments of City hospital and Republic Perinatal Centre, specialists from medical academy of Yakutia State University and specialists of the local branch of the RF Federal Service for Surveillance in Consumer Rights Protection and Human Welfare actively participated in the training course. Eight couples took part at the final conference of the FMC training course and supported MCHI activities in the site. In the end of the course members of Yakutia Regional working group were sure in successful implementation of new delivery technologies in pilot medical facilities. They also wished to implement suggested MCH evidence-based practices into health care facilities of the whole Republic (Attachments # 9, 10- Agenda, List of Participants).
- A training course on **Antenatal Care** was conducted in Uzhno-Sakhalinsk on May 22-26, 2006. Representatives from the pilot medical facilities participated in the course, among who were obstetricians-gynecologists, pediatricians, midwives and nurses. Practically all the participants were very active, asked questions, expressed interest in the suggested approached to antenatal care. During the course there was organized a meeting with representatives of the local Mass Media and MCHI experts gave interview about the MCHI implementation in the region, goals and objectives of the course. During the visit to the City Maternity Hospital MCHI experts met with the personnel of the maternity, asked about the FMC practices implementation and answered the questions. The results of the pre-test – 35 % of right answers, after the course the percent of right question raised up to 70,4%. In the end of the course participants composed a poem, expressing gratitude to the project and its experts. (Attachments # 11, 12 - Agenda, List of Participants).

### **PMTCT activities**

- MCHI COP, Natalia Vartapetova, and MCHI Project Coordinator, Anna Karpushkina, participated in the **regional workshop on Experience Sharing and Consensus Building in PMTCT for Russia, Ukraine and Belarus**, held in Saint-Petersburg on April 5-7, 2006. At this meeting Natalia Vartapetova presented MCHI PMTCT guidelines.
- MCHI led the session on **PMTCT of the EE/CAR Conference on HIV/AIDS** on May 16, 2006. The Chairman of the session was Professor Eugeniy Voronin, the head of the National Centre for Assistance to Women and Children living with HIV/AIDS. JSI leading experts on HIV/AIDS - Andrew Fullem and Ruslan Maluta were among key speakers at this session. Dr. Alexander Goliusov, the head of the department for HIV/AIDS surveillance at the Federal

Service on Supervision in the sphere of protection of consumer rights and human wellbeing announced that JSI together with Moscow State Medical Academy won the Priority National Health Project in HIV/AIDS to be implemented in 15 regions of Russia. He also stated that JSI appeared to be an organization, which implements an extremely effective, competent, and useful work for Russia. During the Session Anna Karpushkina, project coordinator, presented results, obtained from the PMTCT+FP survey and MCHI PMTCT guidelines, which caused great interest and demand of representatives from international projects, working in Ukraine and CAR.

- A set of presentations on PMTCT guidelines to be disseminated in the regions was prepared in May, 2006.
- A draft of the report on the **PMTCT+FP survey** was prepared and sent for feedback from JSI HIV/AIDS consultants in June, 2006. Completion of the final report is targeted for the end of July.
- A first draft of **FP Guidelines for HIV+ women** was prepared and sent to MCHI consultants for revision in June, 2006.
- MCHI COP, Natalia Vartapetova, participated in the meeting, titled “HIV, women, children”, held in the context of Coordinating Committee on PMTCT and annual meeting of MCH service by the Ministry of Health and Social Development of Russia in Moscow on June 27, 2006. During the meeting she made a presentation on “Collaboration of MCH service and HIV/AIDS Centers on PMTCT in the frame of international project implementation”.

#### **Family Planning activities**

- **MCHI Family Planning Training Curriculum and Family Planning Training of Trainers Curriculum** for primary health care providers was revised and edited in April-May, 2006. The final version responds to technical and methodological suggestions from MCHI Master Trainers and participants of TOT, held in February, 2006. The sessions in HIV/AIDS and evidence-based medicine were strengthened. Counseling skills and the importance of effective counseling are emphasized throughout the Curriculum. The FP curriculum includes a Trainer’s Guide, which is very “user-friendly” and guides the trainers throughout the training sessions and standardizes every training session. In addition, there is a Manual for Participants. The final version was completed in English by the US-based team in April and then sent to Russia for translation. MCHI master trainers reviewed the translated version for translation errors. A set of materials for Family Planning training was placed in the MCHI web-site in June, 2006.

#### **Youth Reproductive Health Program (YRHP)**

- **Youth Technical Advisor and Communications Specialist**, Joanne Haffey, visited MCHI on April 3-15, 2006. The purpose of her visit was to assist the MCHI project staff to strengthen approaches and activities for youth to better ensure meeting related contractual results. The specific scope of work for this visit included assisting the MCHI project team and Youth Technical Working Group to assess progress on implementing the Youth Strategy and make revisions in the strategy based on progress to date toward meeting the youth indicators; conduct a multi-sectoral youth workshop in collaboration with Barnaul Region; identify how key activities, outcomes, and lessons learned related to the youth interventions by MCHI would be documented (including for final report).

- **A Conference on Multi-Sectoral Approach for Youth Reproductive Health Programs** was conducted on April 10-12, 2006 in Barnaul. Representatives from health sector, education, social support, youth agencies from 8 MCHI regions: Barnaul and Orenburg cities, Vologodskaya, Irkutskaya, Tyumenskaya oblasts, Komi Republic, Primorskiy and Khabarovskiy Krai participated in this conference. During the conference the regional experience in conducting youth programs and Barnaul city program for adolescents and youth reproductive health protection were presented. The first day of the conference was opened by Altai krai and Barnaul city Government officials. The Barnaul government actively supports adolescent sexual and reproductive health programs. The city has at least eight intersectoral youth-related committees and councils that meet regularly to plan and share information. Many examples were given for how all sectors interact and support one another. On the second day of the conference, participants visited the facilities participated in Barnaul city program on youth reproductive health. All these facilities prepared detailed presentations of their great work. On the third day of the conference representatives from each MCHI site conveyed their team's impressions of the Barnaul program as well as their own plans for the future. Participants were uniformly impressed with the Barnaul program. Also MCHI gave a detailed review of the draft MCHI youth guidelines, soliciting comments and programming examples along the way from the participants. (Attachments # 13, 14 - Agenda, List of Participants).
- **MCHI Youth Guidelines**, the key project product related to youth was published and presented during the master-class on Youth reproductive health policy and programs at the MCHI Final conference in May 2006.



### Monitoring and Evaluation

- **MCHI Endline Facility-Based Survey** was completed in April, 2006. The results of the survey in summary tables, including data from baseline and endline surveys were presented at the MCHI Final Conference in May, 2006.
- **Reproductive Health Survey** was completed in Vologda in April, 2006. The survey report and database were received and checked in June 2006.

### Documentation and Dissemination Strategy

- A meeting on **development of obstetric clinical protocols** was held in Moscow on April, 17-18 2006. Representatives from Krasnoyarsk, Kaluga, Orenburg, Vologda, Barnaul, Vladivostok, perm Tumen and Moscow took part in the meeting. During the meeting participants discussed and agreed on the following clinical protocols: Normal birth, Pre-eclampsia and eclampsia, Postpartum hemorrhage, Vaginal birth after previous C-Section, Pre-labour rupture of membranes. These clinical protocols were published and presented at the MCHI Final Conference in May, 2006.
- MCHI started shooting **an educational film on FCMC practices** in Vologda on June 5, 2006. MCHI Clinical Coordinator, Oleg Shvabskiy, together with the film-shooting team visited Vologda pilot maternity and collected material for a film production: labor, delivery, couples interviews.

### **Russian Society of Obstetricians-Gynecologists (RSOG)**

- RSOG representative – Dr. Igor Kostin participated in the **development of Obstetric Clinical Protocols** and presented at the MCHI Final Conference in May, 2006.

### **Collaboration/Meetings:**

#### **URC**

- MCHI shared Family Planning materials and the team of MCHI master trainers with URC in May, 2006.

#### **Other MCHI Activities**

- MCHI COP, Natalia Vartapetova, participated in the **JSI International Division Meeting**, held on June 5, 2006 in Washington DC. During this meeting she presented the outcomes of the EE/EA meeting, held in Moscow in May, 2006. In addition, Dr. Vartapetova is the elected representative for the JSI projects' COPs, and presented an update on selected highlights from the various projects.
- MCHI COP, Natalia Vartapetova, presented the key findings and selected accomplishments of MCHI to USAID/W. The presentation was well attended by several high level people from USAID/W and her presentation generated some excellent discussion about the future direction of RH in Russia and the EE region. One highly placed official, who recently visited USAID/R and the MCHI Project, complimented Dr. Vartapetova and her team for their outstanding work and said that the way such a relatively small team had leveraged the support and commitment of their Russian partners to have such a "reach and impact" was truly remarkable. Dr. Vartapetova also met with Harriett Destler to discuss future programming strategy, especially in the area of family planning.
- MCHI COP, Natalia Vartapetova, participated in working meetings with JSI Senior Management on June 8-9, 2006 held in Boston. During these meetings she met with Boston-based MCHI team to discuss implementation plans for the final phase of the Project and met with the JSI Senior Management team (including Joel Lamstein) to discuss issues and strategy in relation to the development of the Institute for Family Health (IFH).
- An **MCHI Staff Retreat** was conducted in Moscow Oblast on June 21-23, 2006. The purpose of the internal meeting was to discuss the formation of the new organization "Institute for Family Health" and to discuss the activities, to be implemented during the extension period. During the retreat MCHI team discussed the development of the new organization, its vision, mission and expectations. Strengths, weaknesses, opportunities and threats of the current office were identified. The scope of work for the extension period was determined. MCHI COP, Natalia Vartapetova, introduced work plans for a year and three –year period of time.

### **SECTION 3: SELECTED UP-COMING EVENTS**

- Presentation at Toronto **HIV/AIDS Conference** in August 13-18, 2006
- **ANC training course** in Vladivostok - beginning or mid September, 2006
- **Joint Meeting of MCHI and MOH** on realization of MCH services in Far East Federal district (Vladivostok) - mid or end of September, 2006.

- TDY by Penelope Riseborough, JSI Communications Advisor, to assist the MCHI team in assessing progress in implementing the Documentation and Dissemination Plan, and assist where appropriate in order to meet goals. Her visit is tentatively scheduled for September.
- Finalize the HIV/FP study report by end of July 2006.
- Finalize the close-out plan and submit to USAID; begin the close-out steps for the final six months of the Project.

**ANNUAL REPORT**

**MATERNAL AND CHILD HEALTH INITIATIVE (MCHI)  
PROJECT - RUSSIA  
HRN-I-00-98-00032-00 Delivery Order No. 813**

**IMPLEMENTED BY  
JOHN SNOW, INCORPORATED**

**OCTOBER 2006**



John Snow, Inc. 44 Farnsworth Street Boston, MA 02210 USA

## I. Executive Summary

In September 2006, the Russian mission of the United States Agency for International Development (USAID/Russia) approved a four-month no-cost extension, under the Maternal and Child Health Technical Assistance and Support Contract (TASC I), for the Maternal and Child Health Initiative (MCHI), implemented by John Snow, Inc. (JSI). The extension allows MCHI to complete the implementation of activities leading to achieving the contractual expected results, which were modified in June 2005 along with expanded scope of work and increased funding ceiling of \$9.94 million. MCHI is now in its close-out phase and will end in January 2007.

The project's stated objective is to ensure the adoption of internationally recognized maternal and child health (MCH) standards and practices by the targeted health facilities in Russia. MCHI contributes to USAID/Russia's Strategic Objective, SO 3.2: *Use of Improved Health and Child Welfare Practices Increased*. Indicators directly related include: Indicator 3.2.3: *Abortion rates*, the Intermediate Result 3.2, IR1: *Access to More Effective Primary Health Care (PHC) Services Increased*, and its indicator: *Number of health facilities implementing evidence-based maternal and child health (MCH) care practices*.

### MCHI's Expected Results:

- A Russian organization with a strong MCH mandate empowered and strengthened to partner with MCHI in implementing the replication model.
- Internationally recognized standards and USAID promoted MCH and HIV/AIDS prevention practices adopted by targeted health facilities in at least fourteen regions of the Russian Federation, in addition to the two WIN Project's pilot regions.
- The abortion rate reduced in the targeted regions.
- Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.
- Access to reproductive health services and information for men increased in the targeted regions.
- Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated.
- A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions.
- Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation (VRF) in the Far East.
- Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI model.
- Family planning services with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions.
- Family Planning capacity strengthened in the regions and at the national level.
- Integration of family Planning into primary health care services piloted in selected rural areas in at least two regions with high abortion rates.
- Family Planning integrated into counseling services for HIV-positive women.
- Family Planning and prevention of mother-to-child transmission of HIV (PMTCT) capacity strengthened at HIV Centers.
- Additional (non-intervention) regions oriented to MCHI model and up-dated replication package.
- New activities included and monitored in the overall monitoring and evaluation plan. Overall project results documented and disseminated in the pilot regions and nationwide.
- The maternal and perinatal health care system in the Moscow oblast will be reformed through the creation of a model state-of-the-art regional health care program at the Moscow Region Perinatal Center (MRPC).

Selected achieved results include:

- Developed a successful replication model that resulted in rapid scale-up from two regions (during WIN 1999-2003) to 16 regions, including four regions in the Russian Far East (RFE). Keys to this success include:
  - a. Using a competitive selection process based on specific and transparent criteria;
  - b. Revising or developing and disseminating “user-friendly” materials such as: the WIN Guide, *How to Implement Effective Health Care for Women and Infants*; training curricula; evidence-based protocols and guidelines, etc.;
  - c. Engaging participating regions in developing workplans that reflect the specific needs and priorities of each individual region; and
  - d. Combining the essential components of teamwork, training, follow-up, monitoring and evaluation, and client feedback.
- Reached over ten million clients at 180 health facilities, including clients at over 73,000 deliveries.
- Increased beneficial evidence-based practices from 50% to 76% at targeted facilities, while reducing non-beneficial non-evidence-based practices from 65% to 36% in less than two years.
- Reduced the perinatal mortality rate (between 2003 and 2006) from 12.2% to 9.9% in selected regions and from 9.3% to 7.1% in targeted cities.
- Reduced the abortion rate (between 2003 and 2006; per 1,000 women of reproductive age) from 47 to 45 in the selected regions and from 46 to 41 in targeted cities. This represents a more rapid reduction in MCHI intervention regions than the overall national downward trend.
- Reduced unplanned pregnancies by 13% and increased use of modern contraceptives by 31% in MCHI regions.
- Developed national guidelines for the prevention of mother-to-child transmission (PMTCT) of the human immunodeficiency virus (HIV) in response to the worsening HIV/AIDS situation in Russia and conducted the first study in Russia on the family planning practices of HIV+ women with subsequent development of family planning guidelines for HIV+ women/couples.
- Increased client satisfaction with the services provided at health facilities.
- Changed the way providers relate to clients and to each other. The majority of providers are now enthusiastic and committed to evidence-based practices and the client-centered approach.
- Garnered support from administrators at facility and regional levels, who now demonstrate a commitment to the model through growing policy reform and allocation of resources to support the innovations. Data showing the positive impact of the program and evidence of cost savings were keys to this change. Developed capacity for sustainability through the formation and development of national training-of-trainers, regional and local trainers, technical working groups; a cadre of technical experts; IEC materials and curricula; monitoring and evaluation tools; a network of interregional representatives/coordinators; a website to disseminate materials and updates; and other methods.
- Verified and documented that over USD \$22 million in funding and in-kind resources and allocations had been leveraged from the public and private sectors in just five of the Project’s regions and municipalities. Overall, MCHI leveraged approximately USD \$12 for every one dollar invested by USAID.
- Assisted USAID-funded programs in other countries (e.g. Ukraine, Albania, Georgia, Romania, Central Asian Republics [CAR]) to accelerate their start-up process and learn from the experience in Russia.
- Registered the Institute for Family Health (IFH), a Russian-based NGO with a strong MCH and reproductive health mandate.

The quarterly reports for the current TASC reporting period are available for more detail on Project activities and accomplishments over the past year (October 2005 – September 2006).

Selected programmatic highlights include:

- Conducted a three-day dissemination conference on “Improving Quality of Medical Care of Women and Infants: The MCHI Experience.” The Conference presented Project results and lessons learned in improving women’s and infants’ health in 16 regions across Russia. Approximately 300 participants attended from more than 30 Russian regions, Eastern European and Eurasian countries, USAID and other international organizations, and the JSI home office in Boston – May 2006.
- Hosted a two-day JSI Eastern Europe and Eurasia (EE/EA) Regional Meeting – May 2006.
- Completed the MCHI Endline Facility-Based Survey – April 2006.
- Presented to USAID/W the key Project findings and accomplishments – June 2006.
- Formed and led the 1<sup>st</sup> national working group on evidence-based protocols development – September 2006.
- Developed a website for dissemination of technical materials throughout Russia and the EE/EA region.

Overall, the **capacity building** at the regional level has been impressive, and the potential is great for continued achievement and further expansion. The design and implementation process of the MCHI Project is an **excellent model** for similar work in other countries and for the incorporation of evidence-based, internationally-recognized standards of care into the Russian health care system. The Project has reached a substantial part of the 16 MCHI target regions, which together constitute more than one-sixth of Russia’s total population. Both **replicability** and **sustainability** are key MCHI successes. Choosing facilities that are interrelated sets of MCH clinics, family planning centers, and HIV/AIDS centers has helped to horizontalize previously vertical institutions and to standardize content and continuity of care.

It is highly likely that the evidence-based interventions introduced by MCHI will be sustained in target facilities beyond the life of the Project and that adoption of those interventions will be rolled out or expanded to most, if not all, of the other health facilities in the intervention regions. The adoption and integration of **internationally-recognized, evidence-based standards** has occurred at an impressive pace across a broad range of political and health institutions, and has actively involved people over a vast geographic area. Interlinking components and a multi-level focus gave the project and its activities strength, breadth, adaptability, and flexibility. By identifying and supporting “catalyst” institutions and individuals, MCHI has helped multi-level leadership implement bold, rapid, and substantive changes.

# TANZANIA

TASC II has been in operation in Tanzania since May 1, 2006. The main objective of the task order is to provide malaria technical support to USAID – Tanzania and participate in the planning, management and implementation of the President’s Malaria Initiative (PMI). Dr. René Salgado has been assigned to provide this support full time. His title is Technical Advisor to the President’s Malaria Initiative.

From the start, TASC II activities have been key to the success of PMI in Tanzania. Dr. Salgado lead the Tanzania and Zanzibar PMI teams in preparing the Malaria Operational Plan (MOP) for fiscal year 2007. This endeavor involved convening consultative meetings with the National Malaria Control Programme of mainland Tanzania and the Zanzibar Malaria Control Programme in Zanzibar. More than 100 participants from the public and private sectors, bilateral and multilateral agencies (e.g. WHO, UNICEF, etc.), non-governmental and faith-based organizations as well as educational and research institutions attended the consultative meetings. These extensive consultations have been hailed by participants as an excellent opportunity to provide input into PMI-funded malaria activities. Dr. Salgado prepared and facilitated all meetings and was the main writer and editor of the final product, the MOP. Based on the MOP, PMI – Tanzania received \$27 million for FY 2007—the largest share of the PMI pie.

Once the MOP was approved, Dr. Salgado started the preparation of the terms of reference for Requests for Applications (RFAs) for technical services. These RFAs are procurement instruments for PMI activities. A recently completed RFA was for securing indoor residual spraying (IRS) and other malaria actions. On occasion, Dr. Salgado reviews RFA applications and provides input to USAID – Tanzania on the technical soundness of what is proposed.

USAID – Tanzania relies on Dr. Salgado’s services for day-to-day management of all PMI activities. In addition to those mentioned above, duties include attending technical meetings, collecting and providing data and information to USAID – Tanzania and USAID – Global, helping manage PMI contractors, liaising with NMCP, ZMCP and other malaria stakeholders, providing technical advice on evaluation instruments (DHS, Health Facility Survey, etc.), conducting field visits in the mainland and Zanzibar, organizing support for visiting USAID personnel, providing technical review and input to consultant reports and a myriad of other activities that facilitate the smooth running of PMI in Tanzania.

Dr. Salgado sits at the National Malaria Control Programme in mainland Tanzania and is considered one more member of the NMCP team. His duties at NMCP include providing technical advice, clarifying USAID rules and regulations for national staff, reviewing and providing input to technical materials, writing speeches and technical reports, convening and managing PMI meetings and responding to ad hoc requests from national authorities.

# **UKRAINE**

**JSI/TASC UKRAINE  
MATERNAL AND INFANT HEALTH PROJECT  
END OF PROJECT TECHNICAL REPORT  
USAID CONTRACT NO.: HRN-I-00-98-00032-00,  
GSH-I-801-03-00026**

**DRAFT  
END OF PROJECT REPORT  
SUBMITTED 31 OCTOBER 2006**



## EXECUTIVE SUMMARY

From October 2002 until the end September 2006, the Mother and Infant Health Project implemented by John Snow Inc. with the technical support of AED, worked intensively in Ukraine to improve mother and infant health. MIHP cooperated with health authorities and facilities in 9 oblasts of the country (Donetsk, Dnipropetrovsk, Lugansk, Volyn, Rivne, Lviv, Kirvograd, Poltava, and Zhytomir) in Kiev city and in the Autonomous Republic of Crimea, and was able to demonstrate important improvements in maternal and infant health. MIHP's impressive results presented during the National Dissemination Conference held in Kiev in September 2006. The main result of the Project is the change in attitudes of health professionals working in MIHP sites regarding perinatal care. They accepted and endorsed a new family-centered approach based on scientific evidence.

As a result of the implementation of effective perinatal care, the level of "over-medicalization" based on out-of-date protocols and obsolete habits decreased both in antenatal clinics and in maternity departments, leading to a better surveillance of pregnant women and to an improvement of mother and newborn health in maternities. For example, MIHP implementation decreased maternal postpartum complications such as postpartum hemorrhage and the improved newborn health, as demonstrated by the elimination of newborn hypothermia. In MIHP sites, the neonatal mortality decreased significantly from 2002 to 2006.

MIHP worked at three levels:

1. Supported MoH to revise, develop and disseminate more than 40 national, evidence-based obstetrical and neonatal protocols. These new standards and protocols are the legal basis for the implementation of effective perinatal care nationwide, and these new protocols are in-line with international standards recommended by WHO.

2. Implemented effective perinatal care in MIHP sites in eleven regions of Ukraine. The Project worked in twenty maternities and forty-two women's clinics, implementing on a daily basis effective perinatal care. The Project has worked with some sites since 2003. In addition to these health facilities, which are directly in charge of perinatal care and in order to create a link between early neonatal care to pediatric care, two pediatric polyclinics implemented an integrated and evidence-based approach to infant health.

The implementation of these evidence-based technologies was monitored carefully through a comprehensive and detailed monitoring and evaluation system. The regular data analysis helped the project and each site to identify problems and weak points and to propose appropriate solutions.

In addition, the Project evaluated the cost impact associated with the implementation of effective perinatal technologies in maternity departments, and was able to demonstrate that in addition to mother and infant health improvement, the implementation of these simple and evidence-based technologies saved money both for families and the health system.

- More than 1600 health professionals were trained; training courses were conducted on 15 topics, and more than 120 Ukrainian health professionals became expert trainers, some of them becoming international trainers who are now teaching Effective Perinatal Care in NIS countries.

- Due to a fruitful collaboration with WHO/EURO and Eastern European JSI sister projects, MIHP leads the preparation of an updated training package for Effective Perinatal Care. This training package was especially developed for countries with a post-Soviet health system. This material could be used to train medical staff in all NIS and CIS countries, and will certainly contribute to improving the health of mothers and infants in this region of the world.

- New evidence-based training material for antenatal care was developed with the support of the JSI Russian project, and this material is used in the 2 countries with good results.

- A new training package was also developed to improve the quality of pediatric care. This training material, developed for pediatricians and family doctors, is focused on an integrated approach to infant health.

MIHP provided to each of the project sites basic medical equipment according to their specific needs. MIHP procured lifesaving equipment for newborns and mothers, and also insisted on the procurement of a chain of items to implement fully the concept of "warm chain" in maternities. One other driving concept was to help each site to become "friendly and client-oriented" and to encourage family support, privacy and confidentiality.

Schools for Parenthood were created or improved in each antenatal clinic; each of them received simple media systems to improve knowledge of the clients and their family.

After two years of activity, USAID requested the addition of Prevention of Mother to Child Transmission to the project activities in at least three regions. Therefore, the Project decided to totally integrate PMTCT in each activity in order to avoid the consolidation of a "vertical program". Despite health personnel fears, fears due partially to poor

knowledge, the project succeeded in decreasing the level of stigmatization and improved medical care for HIV+ mothers and their newborns in all MIHP maternities.

3. MIHP worked at the education level and supported the revision of University curricula to include evidence-based perinatal care in the pre-service curricula for medical students. This point is crucial because the students will learn effective perinatal technologies from university, and implement them, which will sustain the improvement of perinatal care in Ukraine.

MIHP worked also actively the Kiev Institute of Post graduate education which has included Effective Perinatal care training material in their post graduate curriculum for obstetrician /gynecologists since 2005.

All MIHP activities were supported by comprehensive activities to advocate and sustain the important behavior changes of the community and health professionals. A special effort made to promote the role and the importance of the family in perinatal care by inviting partners and family to support pregnant women attending antenatal consultations and parenthood classes with them, supporting them during labor and delivery, and visiting and helping new mother and baby after birth.

Several IEC materials were developed and disseminated to MIHP sites to support project activities. A didactic video summarizing MIHP work in women's clinic and maternities was shot on the premises of Lutsk and Zhytomir sites, which made it possible to disseminate the information about effective perinatal technologies to the national level. In addition to this video, USAID prepared and showed the other movie named "Delivering in Kindness" on the 5<sup>th</sup> TV Channel of the Ukrainian TV network, which attracted the attention of the general public to the project and to effective perinatal care implemented in Ukraine. Radio talk shows complemented Project presence in mass media. The MIHP informational booklet was printed out and started being widely distributed to support the project's good results.

## I. CLINICAL ACTIVITIES

In order to have a clear understanding of the situation, MIHP decided to start its activities by assessing the level of care provided to women and infants and the global situation of selected MIHP facilities (maternities, women's clinics and pediatric polyclinics). Therefore, the first task of the Project was to develop appropriate tools to conduct these different assessments; this was done during early 2003 and based on the WHO/Euro developed "follow up format".

The main findings of the needs assessments were similar for maternities, women's clinics and pediatric polyclinics and identical all over the different oblasts assessed during the project life

(See Annex 1: Detailed results of different needs assessments):

- Out-of-date, non-evidence-based clinical protocols or missing protocols;
- Over – medicalization of perinatal care and infant care;
- No involvement of mother/family in care and decision making;
- Poor infrastructure of health facilities, especially regarding heating and water systems leading to a high level (90%) of newborn hypothermia and improper infection control;
- Non evidence-based and conservative protocol ruling infection control in maternity;
- Scarcity of basic lifesaving medical equipment;
- Scarcity of available IEC materials for the community;
- Poor medical staff counseling skill, counseling for postpartum women was very poor, especially regarding postpartum contraception;
- Staff conservatism and fear.

The MIHP strategy was developed after a detailed analysis of these needs assessments.

MIHP clinical activities were conducted at three levels, each of them were linked and implemented more or less in parallel.

**A. Policy level:** The project decided to work actively with the MoH in order to improve national perinatal protocols, allowing for the legal implementation of evidence-based perinatal protocols implemented internationally and recommended by WHO.

**B. Oblast, facility-pilot site level:** The Project implemented Effective perinatal technologies in the four first pilot oblasts (Donetsk, Lviv, Lutsk Oblasts and Autonomous Republic Crimea) and develop some facilities into "Centre of Excellence" implementing and demonstrating good practices and which were used as training centres.

**C. Education level:** It was clear that on job training will not be sufficient to sustain the introduction and implementation of effective perinatal care at national level. In consequence MIHP worked with the main Universities and the academic society on the revision of pre service curriculum for medical students as well as the introduction of effective perinatal technologies in the curriculum of post graduate education for ob/gyn (cooperation with Kiev National Academy for Post graduate education).

**A. Policy level: Cooperation with the Ministry of Health (MOH) on the development of clinical standards/protocols creating a legal base for effective perinatal care implementation.**

Due to obsolete protocols inherited from USSR and a limited access to international evidence-based literature, perinatal care in Ukraine was regulated by a majority of non-evidence-based clinical standards and protocols. In many cases, the protocols did not exist at all. Therefore, one of the priorities for the Project became the active support of the MoH in a first phase to help them to recognize that the country was ruled by out-of-date standards that needed revision. The second phase of support for the MoH consisted of the revision and the development of new standards and protocols based on scientific evidence. These new standards and protocols followed WHO's recommendation and created the legal basis for the implementation of effective perinatal technologies in Ukraine.

Throughout the life of the Project, four "Technical Advisory Groups" (TAG) were created by the Ministry of Health of Ukraine to work on the revision and development of perinatal care standards and protocols. MIHP worked closely with MoH to support TAG activities.

At the initial phase, three "TAGs" were created: a group revising obstetrical and gynecological protocols; a second group revising neonatology protocols; and a third one working on the revision of pediatric protocols.

Each "TAG" included medical university teachers and practicing specialists. All participants were selected by the MoH, and the work of "TAG" was organized according to a standard plan:

- Organization of a first sensitization meeting to allow the "TAG" members to review the existing protocols and to prioritize the development of the most needed protocols in their own specialty;
- Then members of each "TAG" were invited to attend an advanced course on evidence-based medicine;
- In a third phase, detailed research activities were conducted mainly by MIHP staff to collect on each clinical issue existing evidence and/or existing protocols. These scientific documents were then translated and provided to the "TAG" member to allow each of them to analyze international publications, to compare them to existing Ukrainian documents, and to decide what could be used to develop appropriate national protocols;
- Protocols were difficult to develop, and TAG members were not really trained for it. The development of each protocol was long, and in some case more than 18 months were necessary to develop a protocol and to have it endorsed by the MoH.
- Some protocols were more difficult to develop most likely because of the TAG consisted of too many members and/or because of the participation of very conservative members. Several times, MIHP supported the expertise of international consultants.

With MIHP's support, the MoH of Ukraine developed and endorsed 41 national standards/protocols on perinatal topics, some protocols to be implemented by obstetricians and midwives, some others to be implemented by neonatologists, pediatric nurses and pediatricians.

MIHP provided additional support to the MoH in printing more than 13,000 copies of these newly developed standards/protocols, thereby allowing the national dissemination of effective perinatal care to maternity, pediatric polyclinics and family doctors. (See Annex 2: List of developed standards/protocols supported by MIHP).

Unfortunately, several newly developed and important national perinatal standards/protocols could not be implemented in maternities due to the fact that they were in contradiction with the extremely conservative protocol on "Infection Control in the Maternity". Therefore the MoH requested the Project to also support the revision of this protocol. During the last year of the project, MIHP supported a fourth MoH' "TAG" in charge of the revision of the protocol "Infection Control in Maternity", and this group included medical specialists and epidemiologists. Russian experts supported the development of this protocol, conducting training for TAG members on evidence-based infection control, and sharing their experiences on infection control in maternities. Nevertheless, by the end of the Project, no consensus had been reached on this issue.

**B. Oblast, facility-pilot site level: Implementation of Effective Perinatal care in daily activity in the maternity, women's clinic and pediatric polyclinic.**

According to MIHP's contract, one of the project's responsibilities was to implement effective perinatal care in health facilities- maternities and women clinics- to demonstrate that effective perinatal technologies were safe and really effective.

The Project decided to start working in maternity departments to introduce effective perinatal care during delivery and the postpartum period. This decision was taken first because the majority of mortality and morbidity problems, both for mother and infant, are connected to the quality of care provided at birth and during the postpartum period. Therefore the improvement of the quality of delivery care was probably the most effective way to decrease maternal and neonatal morbidity and mortality; the second reason was the availability in the Russian language of an already-prepared training material for maternity staff on effective perinatal care. This training material was developed by WHO/EURO, and has been used successfully in different countries, including Russia (JSI WIN Project).

The Project conducted several trainings courses to inform, convince and provide technical skills and update knowledge of maternity staff. Each of these training courses followed adult learning technologies, and were interactive, focused on team work, reinforcing staff counseling skills and included important clinical component.

MIHP implemented a chain of training activities to reinforce skills and knowledge. The results of each training course were assessed by regular follow-up visits. If during follow-up visits some special difficulties or problems were identified, reinforcement trainings courses were organized to solve them.

## **I. Training courses organized for maternity staff**

### ***1.0 "Promoting Effective Perinatal Care" (PEPC)***

The training material developed by WHO/EURO is a comprehensive, interactive, 2-week didactic package including important clinical activities and insisting on the team approach to care in the maternity. The recommended technologies are evidence-based, family-oriented, low cost, and do not require expensive medical equipment to implement. The purpose of this course is to train together obstetricians, midwives, neonatologists and pediatric nurses. The first week of the training is mainly "theoretical" and the second week is much more practical, working in routine situations and allowing newly trained staff to implement their new knowledge and skills to concrete cases.

MIHP organized the first training course in the obstetrical department of Donetsk City Hospital #3 in August 2003. This first training was conducted in Russian by international WHO consultants, and one consultant was not a Russian speaker. Due to this negative experience, MIHP decided not to use non-Russian speaking trainers again. A total of 18 Effective Perinatal courses were organized during the project's life for 643 health professional working in the 20 MIHP maternities.

In order to ensure adequate MIHP training activities in Ukraine independently of international trainers, 2 trainings of trainers were conducted for 27 potential trainers. Four Ukrainian trainers were invited by WHO to facilitate EPC courses in the Central Asia Republics (Uzbekistan, Tajikistan, and Kyrgyzstan) and Russia (Vladivostok).

The active involvement of the university was recognized as crucial for the acceptance of the new technologies and for sustainability at the national level. Thus, MIHP trained 51 professors and assistant professors from all the obstetric and gynecology chairs of Ukrainian medical universities.

MIHP responded to the request of the MoH and UNICEF to train in effective perinatal technologies the experts of "Baby Friendly Initiative Hospitals". Sixty nine of experts were trained in effective perinatal care in order to create a link between "BFIH" and the effective perinatal technologies recommended by the MoH. As a result of this training, the group decided to add 2 new conditions for a maternity to obtain the "BFIH" certification: to allow the companion presence during labor and delivery and to allow the mother and the newborn to receive visits in their room during the postpartum hospitalization. These two new steps will have an important effect on the family involvement and on their satisfaction.

Training activities results were assessed by regular data collection and by follow-up visits.

### ***1.1 Follow up visits***

Follow-up tools were developed and local experts were trained to conduct them. Follow up visits were planned to be supportive and problem solving-oriented rather than ex-Soviet "inspection" visits.

Follow-up visits in maternities were conducted by an expert team (midwife, ob/gyns and neonatologist). During these visits, the team assessed the real implementation of effective perinatal care, identified problems and proposed supportive and appropriate solutions to the health facility and to MIHP.

These visits were extremely helpful for the Project and for the sites, helping both of us to identify problems and propose appropriate solutions.

### 1.2 Re-enforcement of effective perinatal care training courses

In some cases, both follow-up visit results and the data analysis identified maternities facing important problems in implementing effective perinatal care. Therefore, the Project organized “on-the-job”, 9-day clinical re-enforcement trainings. Re-enforcement training courses helped the staff to identify their problems and to agree on solutions.

Table 1. Training activity on Effective Perinatal Care in maternity

Category of training	Number of trainings conducted	Number of trained staff	Number of trained trainers	Ukrainian become international experts
EPC training courses	18	643	27	4
EPC Follow-up visits	46	-	13	
EPC Tutorial training courses	12	1800	10	

## 2.0 “Specific training courses” to improve Effective Perinatal Care in maternities

Changing medical practices is difficult, long and painful. Medical professional faced problems with understanding and implementing some difficult components of the Effective Perinatal Care course.

MIHP understood this difficulty and saw the need to conduct short training courses on specific and difficult topics. Therefore, additional training materials were developed by MIHP.

### 2.1 Evidence –based medicine

The concept of evidence-based medicine was completely new in Ukraine. In this regard, the necessity of introducing it to medical society was clear after a few months of Project implementation since it was obvious that the medical staff would accept and adhere to the changes if they could understand the benefit of these proposed changes.

This introduction was difficult due to the scarcity of evidence-based material in Russian language as well as small number of Russian speaking evidence-based medicine specialists. Nevertheless, MIHP with the support of WHO and other international expertise, developed a 3–day training course on evidence-based medicine (EBM):

- to explain the main principles and approaches of EBM;
- to train medical staff on the necessity of assessing their practices critically and how to do it;
- to propose available sources of modern evidences to medical doctors.

A special 1-day training course was developed for midwives and nurses based on role play and case study allowing them to understand, and therefore agree to evidence-based principles. An advanced evidence–based medicine course was developed for the MoH, oblast health authorities and universities professors. Throughout the Project’s life, these evidence-based training courses became the cornerstone of effective perinatal care implementation.

Table 2. Training course on Evidence-based Medicine

Category of training	Number of trainings conducted	Number of trained staff	Number of trained trainers
EBM courses	31	476	5

### 2.2 Warm chain implementation

One of the serious problems found during the Project’s needs assessment was the high level of newborn hypothermia. Baseline data showed that more than 70% (and in some maternity more than 90%) of the newborns were hypothermic 30 minutes after birth. The “warm chain” concept was totally unknown and not implemented. MIHP conducted five special 1-day training courses on the prevention of newborn hypothermia in the biggest maternities to boost the knowledge of the staff. Ninety-two medical specialists attended these sessions. As a result of routine “warm chain” implementation and baby temperature monitoring, the level of hypothermia in Project’s sites dramatically decreased from 85% in average to 1%.

### 2.3 Breastfeeding practical course

Despite UNICEF and the MoH’s repeated efforts to promote breastfeeding in Ukraine, the knowledge of maternity staff on this issue was really insufficient. Special breastfeeding courses focusing on practical issues and good counseling skills were conducted for 156 healthcare providers. These training courses developed the capacity of healthcare providers to understand the 10 principles of breastfeeding and raised their confidence in breastfeeding initiation and maintenance.

After these trainings, counseling on breastfeeding issues and practical support proposed to mothers became a routine practice in all MIHP maternities where breastfeeding is initiated in practically 95% of all cases.

#### **2.4 Improvement of organisation of newborn resuscitation**

The MIHP needs assessment found a high level of neonatal resuscitation and a surprising level of babies dying of newborn asphyxia despite the fact that all neonatologists of Ukraine are officially “certified” by the MoH to be fully qualified to conduct adequate neonatal resuscitation. During MIHP assessment, the resuscitation skills of these specialists were found to be very poor. The organization of newborn resuscitation was also unsatisfactory in the majority of the maternities. MIHP organized interactive seminars to help each maternity to assess and improve the quality of neonatal resuscitation. All level of staff, from senior management to midwives and nurses, were invited to attend these seminars.

In 17 maternities out of 20, local prikaz supported the creation and the activity of a group responsible for the improvement of the quality of the organization of newborn resuscitation. Each group prepared an “internal work plan” including mandatory qualitative assessment of newborn resuscitation skills of each staff, practical training on newborn resuscitation, internal certification of each staff, and monitoring of resuscitation issues. This process was initiated in Year III of the project, and unfortunately it was not possible by the end of the project to observe clear, positive results.

*Table 3. Training course on Quality Improvement (QI) of organisation of newborn resuscitation*

Category of training	Number of trainings conducted	Number of trained staff	Number of trained trainers
Training on QI of newborn resuscitation organisation	19	455	10
QI follow-up visits	10	5	5

#### **2.5 Management of Low birth Weight Babies**

The needs assessment showed that low birth weight baby were poorly treated. They were separated from their mothers, artificially fed and over-treated. Thus, to improve the quality of care to low birth weight babies, MIHP developed a 2-day training course focusing on maternal involvement, appropriate feeding and evidence-based treatment. Two training courses were conducted in Donetsk and Lutsk for 26 medical staff. The main result of such training courses was the organization of rooming-in, allowing better breastfeeding practices and the initiation of “Kangaroo method”.

#### **2.6 Postpartum counseling on Family planning**

According to the needs assessment and the repeat follow-up visits, women after giving birth were not receiving adequate postpartum family planning counseling. MIHP organized five 2-day training courses on this topic for 122 maternity staff members to improve medical staff knowledge and effective counseling skills. As training results indicate, an increased number of women and couples received professional counseling on postpartum family planning.

#### **2.7 Improvement of Infection control in maternity**

In Ukraine, the existing regulation of infection control in maternity is not-evidence-based and prevents medical staff to implement effective perinatal technologies. In addition to the support given to MoH in the revision of this protocol, MIHP provided to the maternity staff and local epidemiologists modern evidence-based information on infection prevention through training courses conducted by MIHP.

A training material was developed in Ukraine by MIHP and epidemiologists after the visits of Russian experts whom conducted several seminars, sharing their experience on modern ways of infection control in maternity

##### **2.7.1 Theoretical courses on Infection Control**

A 4-day theoretical training course was developed, and competent trainers from Sanitary-Epidemiological Departments were identified. This theoretical training course was conducted 8 times for 268 participants from all 20 MIHP maternities.

During these training participants received information on evidence-based infection control systems. Participants also had the opportunity to evaluate the effectiveness of “their own in-used” measures regarding prevention of nosocomial infection compared to evidence-based recommendations.

After these trainings, evidence-based infection control systems were developed in each maternity.

### 2.7.2 Tutorial trainings on Infection Control

The Project understood that the improvement of the practical skills of medical staff was the most important issue for the effective implementation of infection control system. Therefore, the Project developed and organized 2-day infection control tutorial trainings courses. These “hand-to-hand” tutorial training sessions helped the staff to identify their problems and find appropriate solutions. Participants learned that hand washing is the simplest and most effective method to prevent infection in health facilities, and they practiced thoroughly hand washing techniques. They also discussed in detail glove use, disinfection of instruments, and waste management. With facilitators, they developed for their own facilities “infection prevention algorithms” for different invasive manipulations.

Table 4. Training courses on Infection Control (IC)

Category of training	Number of trainings conducted	Number of trained staff	Number of trained trainers
Training courses on IC	12	268	11
Tutorial trainings on IC	16	336	

## II. Training courses for other health facilities

Considering the importance of creating and maintaining the continuity of evidence base care for mother and baby, MIHP organized trainings courses for the staff of women consultations and Pediatric Polyclinics, inviting family doctors.

### 1. Improvement of Antenatal Care

The Project started antenatal training courses in March 2005. A training package was especially developed to train the staff of women’s clinics-obstetricians and midwives. This 6-day antenatal training course was developed in cooperation with international experts and the JSI Russia project.

Family doctors were invited to attend these training courses since they are responsible, according to the job description, for following the normal pregnancy.

The goal of this training was to improve participants’ knowledge on modern evidence-based approaches to pregnant women and birth preparation. Special attention was paid to improving participants’ counseling skills. As in all training courses organised by MIHP, participants were trained as a team: midwives, ob/gyns and family doctors together, and were trained by a team of experts midwife and ob/gyn.

Follow-up visits organized found that these trainings raised medical staff counseling skills, and that in each women clinic, a class for birth preparation was organized and equipped. Pregnant women received better quality of care, the development of the fetus received more attention, and they were encouraged to attend antenatal visit with their partner.

Table 5. Training course on Antenatal Care

Category of training	Number of trainings conducted	Number of trained staff	Number of trained trainers
Antenatal Care training courses	11	271	15
Antenatal follow-up visits	15	-	

### 2. Improvement of Infant Care

In order to close the circle between women’s clinic, maternities and pediatric polyclinics, the Project developed and conducted training courses on infant care for pediatricians, nurses, and family doctors.

The objectives of this 6-day training course were to teach participants to implement in daily practice the assessment of child development, growth monitoring, mother counseling on key feeding practices, danger signs, and care for development. This course was the first one in Ukraine teaching an integrated approach of management of infant care. Two pediatric training courses were conducted for 50 participants. However, because these training courses were conducted late in project life their clear impact could not be evaluated.

### 3. Training course on BABIES Matrix

A training course on the “BABIES Matrix”, which is a tool to analyze perinatal and neonatal mortality and to guide managers to make informed decisions, was conducted by WHO experts. From 22 oblasts, responsible managers

from MCH departments attended this event. As a possible result of this training course, in 2005, the MoH for the first time used the BABIES matrix to report and analyze perinatal mortality. This report included statistical data on maternal and infant morbidity and mortality, as well as prognosis of these indicators for the next year, and recommended measures for their reduction.

#### **4. Study Tour in Lithuania**

MIHP conducted a five-day study tour for MoH and MIHP sites managers in Lithuania in 2005 in order to allow Ukrainian specialists to observe how good effective perinatal practices could be implemented with successful results from a country having inherited the same post-Soviet health system. This experience was extremely positive, and Ukrainians participants came back with a new understanding and practical ideas for implementing effective perinatal technologies.

#### **5. PMTCT- Integration of PMTCT in all MIHP activities**

A need assessment conducted in Year III of the project indicated the poor knowledge of HIV/AIDS/PMTCT issues of the staff in charge of HIV+ women both in women's clinics and in maternity departments. The assessment also identified the important fear of the medical staff being contaminated by HIV patient. The poor knowledge and the fear led to improper care and significant stigmatization and discrimination for HIV + mother and their babies.

The main task of the Project was to convince Ob/Gyns, neonatologists, midwives, and nurses that the Prevention of HIV from Mother to child Transmission has to be fully integrated in effective perinatal care and to help women's clinics and maternity staff to fight against discrimination and stigmatization.

The WHO PMTCT training material was adapted to the Ukrainian situation, and a 3-day training course was conducted in each project maternity for the maternity staff. These training courses involved the participation of People Living With HIV/AIDS. Initially, the MIHP PMTCT program was implemented in two oblasts: Donetsk and Crimea. All MIHP sites were later covered by PMTCT activities. Training courses were conducted in 19 out of 20 maternities, and 251 maternity staff were trained to integrate PMTCT into their daily practice. Medical care provided to HIV+ mother and their newborn (elective C-section, appropriate feeding) were improved in accordance with WHO recommendations.

During follow up visits, it was observed that the staff was less afraid, more empathetic to HIV+ patients and provided better care. Some impressive results were achieved such as the demolition of a wall segregating HIV+ mother and newborns in Simferopol maternity .

MIHP answered to the request of Kiev city Network of People Living with HIV and conducted four informational sessions on PMTCT for 15 social workers of this NGO. After these courses, elective C-section for HIV+ mothers became routinely implemented, ARV treatment for mother and baby was adequate, and newborns received correct feeding recommendations. The quality of postpartum counseling was much better, especially regarding postpartum family planning and baby care. Follow up visits indicated decreases of personal fear, increases in empathy, understanding and respect, and reductions in stigmatization (*No "isolation" for HIV+ mother/baby in maternity, Free visits of relative to HIV+ mother/baby, "Skin-to-skin" contact and rooming-in for HIV+ mother/baby*). See Annex 3: Table of MIHP trainings courses, trained staff, trained trainers

#### **C. Education level: Introduction of Effective Perinatal Technologies in the curriculum of pre-service and post-graduate education for ob/gyns.**

The third component of the MIHP strategy was to work with universities and academic society to introduce evidence-based concepts and effective perinatal technologies into the curriculum for medical student at the pre-service level and post graduate level.

Late in Year III, the Project actively supported medical universities and postgraduate education institutes in the revision of different curricula. To achieve this ambitious goal, a fifth "TAG" was established. The Project trained its members in principles of evidence-based medicine. MIHP shared with "TAG" members the new WHO, JSI and USAID training document "Effective perinatal care".

MIHP representatives met with the management of Kiev National Academy of post-graduate education. An agreement on future collaboration for integrating effective perinatal technologies into post-graduate training curriculum was reached.

## II. EQUIPMENT SUPPLY

MIHP provided basic medical equipment to pilot sites in order to implement effective perinatal care. A baseline inventory was conducted, and a list of basic equipment needed was developed. This was challenging as sites were requesting expensive and unnecessary complex and very sophisticated medical equipment, not realizing that they were missing simple, lifesaving medical equipment.

The first priority that MIHP outlined after the initial needs assessment was to agree with the sites on their needs and to provide to them basic equipment medical equipment, which included the following:

- Basic lifesaving equipment for both mothers and newborns (e.g. Ambu masks, laryngoscopes, blood pressure gauge);
- Equipment for newborn care (jaundice trans-coetaneous -meter, phototherapy lamp, thermometers etc.);
- Newborn Intensive Care Unit equipment (e.g. heated changing tables, heated cradles, radiant heater for newborns, Incubators, pulsoxymeter, lung ventilation machine)
- Equipment for delivery rooms in order to make them safe and family oriented but also to allow the implementation of effective perinatal technologies such as free delivery position (e.g. beds, balls, gym-ladders, carpets, etc);
- Operation theater equipment (e.g. operation tables, suction apparatus, anesthesia intubation's system)

The second priority was to provide to the health facilities few but important items to support them to make their sites family oriented, respecting privacy of the mother and family. The project supported or equipped all women's clinic in order to create a school of parenthood in each of them and a room for birth preparation.

MIHP provided basic medical equipment to 20 maternities, 42 women's clinics and 2 pediatric polyclinics for a total of more than \$ 600,000 USD. The Project very carefully selected the equipment providers so that if any equipment were to be out of order, the provider could repair it in a very short time and efficient manner. The equipment supplied was guaranteed for 12-24 months. The sites were very satisfied with the equipment provided, which allowed them to implement effective perinatal technologies and to provide more safety in the health facilities.

It is important to report that nearly all facilities were able to identify additional funding to improve their medical equipment. For example, Zhytomir maternity was able to refurbish and equip with a complete set of new medical equipment its new NICU department.

## III. MONITORING AND EVALUATION

### I. MIHP maternities

Among all 20 maternities, 4 most representative facilities were selected for the MIHP I final report tables: Lutsk city maternity, Lviv Oblast maternity, Simferopol city maternity #2, and Donetsk maternity #3 (referred to simply as "Lutsk", "Lviv", "Simferopol" and "Donetsk #3" throughout the report). The main criteria for selection was how representative the facility was with regard to the number of deliveries per year (more than 1000) and implementation of the MIHP project since 2003. Of the MIHP facilities that met those criteria, these 4 were selected deliberately—Lutsk is an exemplary facility where MIHP interventions have been most accurately and fully implemented; Donetsk #3 has implemented MIHP interventions since the beginning, but is more 'average'. Therefore, experiences there can be generalized to other facilities; Simferopol and Lviv were not implementing so successfully as Lutsk and Donetsk #3 did due to complex reasons. The selected maternities are also geographically dispersed—Lutsk and Lviv in the West, Donetsk in the East and Simferopol in South of Ukraine. Nevertheless, their geographic situation does not seem to have influenced their results.



**Figure 1: Map of Ukraine, MIHP Facilities**  
Donetsk Maternity #3 is one of eight maternities in the city of Donetsk (population 1,026,000). It is a busy maternity, in charge of nearly 1,500 deliveries per year, specialized in pre-term delivery which accounts for 15% of the deliveries. No maternal deaths were registered from 2002 until Sept 2006. The maternity has 108 staff providing perinatal care, one 1/3 of them have been trained directly by MIHP in evidence-based perinatal technologies. The maternity was certified as "BFHI" in 2004 since 2003 all

delivery rooms are individual.

Lutsk maternity is the only one in this city of 220,000 people. It sees nearly 3,500 deliveries per year, up to 4% of which are pre-term. One maternal death was registered in 2002, none were reported in 2004 and 2005, and one death occurred in 2006 (records were maintained through September 2006). The maternity has 171 staff providing perinatal care, 16% of whom have been directly trained by MIHP in evidence-based perinatal technologies. The maternity was certified as “BFHI” in 2005. Since 2003 all delivery rooms are individual.

Lviv Oblast maternity is one of five maternities in the city. The maternity receives patients from the city and the oblast (population 750,000 and 2.754, 000 accordingly). It sees nearly 3,000 deliveries per year. During the years 2002-2006, one maternal death was registered in 2003, two in 2004, and two through September 2006. The maternity has 90 staff providing perinatal care, 27.8% of whom have been trained directly by MIHP in evidence-based perinatal technologies. Excluding one delivery room where women deliver stillborns, all delivery rooms have been individual since 2005. The maternity was certified as “BFHI” in 2005.

Simferopol maternity #2 is one of two maternities in the city of Simferopol (population 350,000). It sees nearly 2,800 deliveries per year. The maternity receives patients either from the city or from all Republic of Crimea; this maternity is the only one to deliver for the region HIV+ women. Only one maternal death in 2003 was registered during the period of 2002 - September 2006. The maternity has 130 staff that provide perinatal care, 21% of whom have been trained directly by MIHP in evidence-based perinatal technologies. Since 2005 all delivery rooms are individual. The maternity was certified as “BFHI” in 2003.

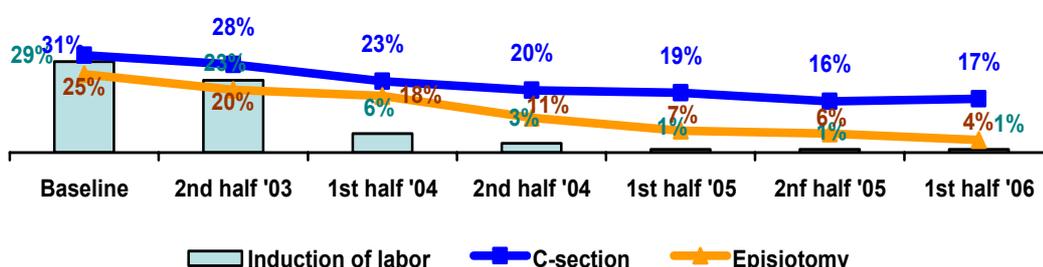
### 1. Decrease Over-Medicalization

One of the first challenges the project faced was the over medicalization of delivery. Before the project, amniotomy, episiotomy, pain medication and labor stimulation were performed routinely. Implementing evidence-based management of delivery made these procedures in each case rarer and justifiable. Promoted by MIHP, effective perinatal technologies led to decreased levels of C-section by up to 55%. The main contributing factors of the decrease of over -medicalization were the usage of the partogram and evidence-based indications for C-section as stipulated in Ukrainian national protocols.

**Table 1: Labor Medicalization**

	LVIV		DONETSK #3		LUTSK		SIMFEROPOL	
	BASELINE	ENDLINE	BASELINE	ENDLINE	BASELINE	ENDLINE	BASELINE	ENDLINE
Amniotomy	12%	0%	31%	0%	40%	3%	40%	9%
Episiotomy	22%	7%	37%	3%	21%	3%	22%	3%
Labor induction	15%	0%	40%	0%	7%	1%	17%	1%
Pain medication use	26%	0%	60%	0%	17%	0%	27%	8%
Oxytocin stimulation	27%	3%	21%	2%	26%	1%	31%	1%

**Graph A: Decreasing % of C-section, episiotomy and labour induction**



### 2. Effective Delivery Practices

The aim of the project was to explain and implement effective perinatal technologies in the pilot sites such as partner presence, usage of partogram, free delivery position. Before the project, practically none of these EPC technologies were known and implemented.

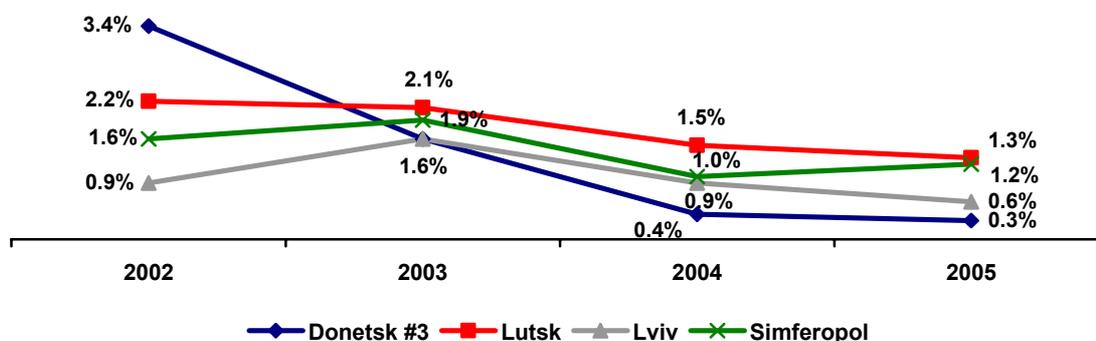
Similarly, the issue of preventing newborn hypothermia was unknown, and the air temperature (25+°C) in delivery room/C-section room was not maintained appropriately. After 4 years of project implementation, listed technologies have become an integral part of delivery care.

**Table 2: Effective Delivery Practices**

	LVIV		DONETSK #3		LUTSK		SIMFEROPOL	
	BASELINE	ENDLINE	BASELINE	ENDLINE	BASELINE	ENDLINE	BASELINE	ENDLINE
Partner presence	0%	75%	0%	87%	2%	79%	14%	54%
Use of partogram	0%	77%	0%	86%	0%	90%	0%	78%
Free position at time of giving birth (back position excluded)	0%	90%	0%	81%	0%	96%	0%	46%
Adequate DR temperature (25+°C)	5%	100%	41%	100%	54%	100%	48%	100%

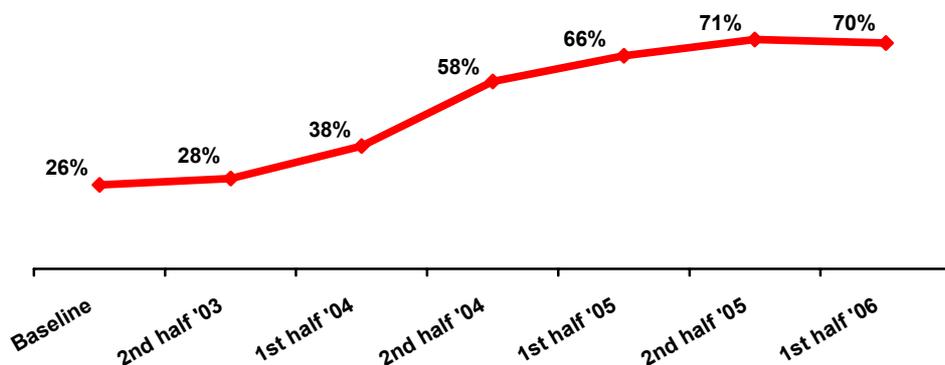
Implementation of AMTSL (Active Management of Third Stage of Labor) has also helped to decrease dramatically the level of postpartum hemorrhage. For example, in Donetsk maternity it dropped down from 3.4% in 2002 to 0.3% in 2005.

**Graph B: Decreasing level of postpartum hemorrhage**



**Graph C: Increasing level of “normal” deliveries**

All efforts made in the improvement of perinatal care in MIHP sites resulted in a growing level of “normal”<sup>4</sup> deliveries and client satisfaction (according to many anecdotal reports).



<sup>4</sup> According to WHO a “normal” delivery is a delivery that starts spontaneously at 37-42 weeks of gestational age, ending vaginally with cephalic presentation of the fetus, and with good state of health of both mother and newborn.

**Table 3: Self-administered postpartum questionnaire for mothers**

	LVIV		DONETSK #3		LUTSK		SIMFEROPOL	
	BASELINE	ENDLINE	BASELINE	END LINE	BASELINE	ENDLINE	BASELINE	ENDLINE
% of women having pubis shaving and/or enema upon admission in maternity	63%	0%	20%	1%	20%	1%	10%	5%
% of rooming in	5%	100%	91%	89%	100%	97%	85%	98%
% of free visits in the postpartum room	21%	100%	91%	99%	0%	100%	95%	100%

The analysis of the self-administered questionnaire filled out by mothers during postpartum hospitalization confirmed positive changes in maternity care. Negative practices such as pubis shaving and enema became extremely rare. Alternatively, rooming in and free visits in the postpartum room became common practices.

**3. Improvement of the Newborn Health**

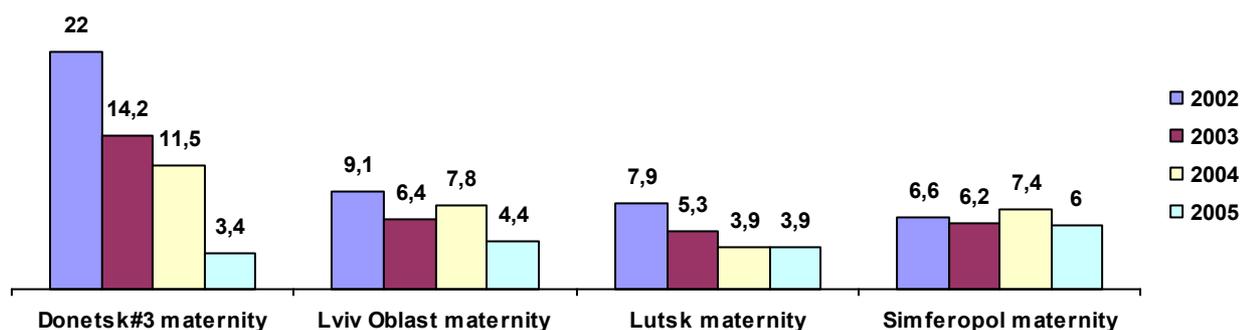
The partner presence, supporting free delivery position, important reduction of drugs, no unjustifiable labor lexicalization, wide usage of partogram and a better understanding of the importance of newborn hypothermia prevention have contributed to decreasing the need of newborn resuscitation and, as a direct effect, the number of newborn needing Intensive Care (NICU).

**Table 4: Newborn Care**

	LVIV		DONETSK #3		LUTSK		SIMFEROPOL	
	BASELINE	ENDLINE	BASELINE	END LINE	BASELINE	ENDLINE	BASELINE	ENDLINE
Hypothermic	76 %	0%	59%	1%	90%	0%	69%	1%
Resuscitation	9%	1%	13%	8%	5%	1%	5%	3%
NICU admission	6%	1%	16%	9%	7%	4%	18%	6%

**Graph D: Decreasing level of Neonatal Mortality**

One of the most representative indicators of effectiveness of evidence-based perinatal technologies is the level of neonatal mortality, which shows a decreasing trend.



**II. MIHP antenatal clinics**

The implementation of effective perinatal technologies in maternities would not be so successful without close cooperation with antenatal clinics. To insure consistency in management of pregnancy the project has trained health care providers on effective perinatal technologies from 41 antenatal clinics.

**Table 5: Antenatal Care (data extracted from woman’s individual file)**

<p style="text-align: center;"><b>PREVALENCE OF SELECTED PRACTICES</b></p>	<p><b>M I H P  A N T E N A T A L  C L I N I C S</b></p>	
<p style="text-align: center;">% of mother who had 13 and more antenatal visits</p>		
<p style="text-align: center;">% of antenatal visits with partner</p>		
<p style="text-align: center;">% of fundal –symphysis height chart filled</p>		
<p style="text-align: center;">% of mothers who have been hospitalized during pregnancy (including both “day care”<sup>5</sup> and maternity hospitalization)</p>		

WHO recommends a minimum of 4 antenatal visits to ensure adequate antenatal care. In Ukraine, the recommended number of antenatal visits is 10-12. In 2002, 50% of pregnant women had an excessive number of visits (13 and more antenatal visits); in 2006 only 20 % of pregnant women had an excessive number of antenatal visits. MIHP, advocating for active partner involvement in perinatal care, has raised the level of partner attending antenatal visit with the women from 0.6% in 2002 to 17% in 2006, which is still not very satisfactory.

Filling out, for each pregnant woman, the fundal-symphysis height chart is a proven effective tool to monitor the Intra Uterine Fetal Growth, moreover, to inspect the intra uterine growth retardation. In 2002, only 3% of pregnancies were followed using this tool. However, in 2006, 86% of pregnancies were followed using this tool.

Unfortunately, MIHP didn’t reduce significantly the % of antenatal hospitalization - 60 % in 2002 and still 52% in 2006. This is due to administrative constraints and to the fear of the staff. It is clear that the improvements observed in antenatal clinics are not as good as those observed in maternity. This is probably due to the delay in starting

<sup>5</sup> “Day care” – Day care is provided in women clinic where some beds are existing allowing some short time treatment.

antenatal training courses compared to maternity courses and also due to the fact that the follow-up visits to antenatal clinics were systematic enough, leading to problem identification and appropriate solutions.

The implementation of integrated infant care in pediatric polyclinics was implemented too late in the project life to be really evaluated.

## Conclusion

From 2002 to 2006 the improvement of the quality of care was impressive, as indicated by the figures regarding the prevalence of postpartum hemorrhage and newborn resuscitation. In each of four maternities, a chain of effective perinatal principles was implemented. The creation of individual delivery rooms allowed companions/partners to attend births and support mothers. Women are now encouraged to choose their delivery position and move or walk during delivery.

Allowing women to have a partner present during delivery and to choose their delivery position while strictly monitoring labor with the partogram, the number of “medical interventions” was reduced- i.e.- labor induction, artificial rupture of membranes, episiotomy, and C-sections (see Table 1 and Graph A).

Better delivery conditions have supported the implementation of the “warm chain” strategy. According to MIHP facility monitoring data, the proper implementation of the “warm chain” has practically eradicated newborn hypothermia in MIHP sites (see Table 4).

After 3 years of implementation, MIHP maternities have experienced dramatic reductions in neonatal mortality. In the Donetsk #3 facility, which specialized in pre-term deliveries, the prevalence of neonatal death declined from 22% in 2002 to 3.4% in 2005. During the same time period, the prevalence of neonatal death declined from 7.9% to 3.9% in Lutsk. Considering the achievements in quality, evidence-based perinatal care practices in these MIHP facilities, we would propose that some (if not all) of this reduction in neonatal mortality is a result of MIHP and the chain of effective perinatal interventions.

## IV BCC OVERVIEW and ACCOMPLISHMENTS

A variety of BCC activities aimed at raising the general population’s awareness of maternal and infant health issues and increasing the knowledge and skills of health providers were conducted during the project’s life. These activities included trainings, conferences, workshops, media tours and the development and distribution of IEC materials. Technical assistance was provided by AED/Washington staff members and international consultants. The activity details are described below.

### 1) IEC Materials

MIHP with the technical support of AED developed 23 different IEC print materials on breastfeeding, family delivery, baby care, postpartum contraception, hypothermia prevention, SIDS and antenatal care. Close to one million materials were printed and distributed to maternities and health centers. The following is a list of the materials and the number of copies of each:

Name of IEC Material	Number of Copies
1. Booklet “You should know about it - HIV/AIDS”	100,000
2. Booklet “Breastfeeding”	100,000
3. Booklet “STIs”	100,000
4. Brochure “Role of fathers-to-be”	85,000
5. Brochure “Role of mothers-to-be”	85,000
6. Leaflet “Danger sings during pregnancy”	100,000
7. Leaflet “Warm Clothes – Hypothermia Prevention”	100,000
8. Booklet “Postpartum Contraception”	30,000
9. Booklet “Baby Health Card”	30,000
10. Booklet “Mother Format”	24,000
11. Poster ”Breastfeeding – 1”	5,000
12. Poster “Breastfeeding – 2”	10,540

13. Poster “Free positions during delivery”	15,000
14. Poster “Happy Newborn”	1,000
15. Poster “Sudden Infant Death Syndrome Prevention”	17,000
16. Poster “ Baby Clothes-Hypothermia Prevention”	17,000
17. Booklet “Breastfeeding - FAQs”	80,000
18. Booklet on MIHP achievements	5,000
19. Poster “Family Delivery”	5,000
20. Booklet on HIV (general information)	3,000
21. Poster about home clothes for babies	3,000
22. Little poster on family delivery	1,000
23. Booklet on HIV pre- and post-test counseling	80,000
<b>TOTAL</b>	<b>996,540</b>

MIHP was also supported by AED which oversaw the production of an educational video on perinatal care in 2006. This video, which was produced by CURE, documents the experience of actual Ukrainian couples as they attend prenatal visits and parenting classes and give birth in MIHP maternity hospitals. Educational messages about healthy pregnancy and childbirth practices are interwoven with the visual segments. The video was distributed to key partners and MIHP sites during the final MIHP dissemination meeting in September 2006, and it will be distributed more widely under MIHP II.

## **2) Training Activities**

### ***IEC counseling trainings***

Eight (8) IEC counseling trainings were conducted in four oblasts during the life of the project. The purpose of the trainings was to improve the ability of health providers (ob/gyns, neonatologists and midwives) to effectively use IEC materials to counsel patients during antenatal and postpartum visits. More than 200 providers were trained.

Follow-up visits to MIHP sites showed that trained health providers spent more time with women and their companions during antenatal and postpartum visits and encouraged them to read IEC materials. Questionnaires filled out by postpartum women indicated an improvement in their knowledge about baby care and postpartum family planning methods. Fathers-to-be reportedly read IEC materials especially designed for them and became more involved in antenatal visits and deliveries.

### ***Breastfeeding counseling trainings***

MIHP’ BCC expert collaborated with local experts to conduct six (6) trainings on breastfeeding counseling within the context of larger perinatal workshops. A total of 156 health providers were trained. Mr. Golubov also co-facilitated a one-week training of trainers (TOT) on breastfeeding counseling, together with AED consultant Maryanne Stone-Jimenez. Seventeen (17) trainers from nine oblasts were trained. As a result of these trainings, 95% of mothers are exclusively breastfeeding their babies upon discharge from MIHP maternities.

### ***Postpartum Contraception Trainings***

Five (5) trainings on post-partum contraception were conducted over the life of the project, with a total of 122 health providers trained. The providers learned how to effectively communicate postpartum contraception messages to women and their husbands using especially designed booklets.

### ***HIV counseling trainings***

The BCC Specialist and the MIHP PMTCT assistant facilitated two TOTs on HIV counseling in Kiev and Dnipropetrovsk. The trainings aimed to improve basic HIV pre- and post-test counseling skills of health providers and to teach them how to use the MIHP booklet on HIV and pregnancy entitled “Since you’re pregnant – this is for you”. A total of 24 health providers were trained. The TOT participants had trained 860 other health providers by the end of August 2006.

## **3) Research**

### ***Research on breastfeeding in Crimea***

AED conducted formative research on breastfeeding knowledge, attitudes and practices in the Republic of Crimea in December 2003. The research, which was conducted by Mr. Golubov and AED/Washington staff member Bérengère de Negri, consisted of focus group discussions and individual interviews with mothers and health

providers in health centers, maternities and polyclinics in Simferopol. The findings were used to develop MIHP trainings and IEC materials on breastfeeding.

#### ***Research on antenatal practices in Simferopol***

AED consultant Fatima Djatdoeva conducted an assessment of the Simferopol perinatal counseling center in December 2003. The objective was to assess the antenatal practices of health providers in order to inform the creation of training and IEC materials for future interventions.

#### ***Research on SIDS in Lugansk***

The MIHP BCC Specialist and AED oversaw the design and implementation of formative research on SIDS in Lugansk in June 2006. The objective of the research was to identify current infant care practices that could put babies at risk of SIDS and assess knowledge of SIDS among mothers and health providers. A consultant from the SIDS Center of New Jersey designed the moderation guides. A total of six focus groups were conducted: four with mothers, two with pediatric patronage nurses and one with pediatricians. The groups were moderated by local focus group consultants. The findings will be used to design a SIDS awareness campaign in Lugansk under MIHP II.

#### ***Women's Satisfaction Survey***

In the final year of the project, a women's satisfaction survey was conducted among postpartum women in Donetsk maternity N 3 and Lugansk-city maternity N 3 in order to assess differences in women's perceptions of perinatal practices in MIHP and non-MIHP sites. Self-administered questionnaires were distributed to postpartum women by the MIHP site coordinators. A total of 160 women completed them. The survey results indicated clear differences in perinatal practices between the MIHP site (Donetsk) and the non-MIHP site (Lugansk), but there were few differences in satisfaction indicators. This may have been due to the fact that the women in Lugansk were not aware that better practices existed. An improved version of the survey will be conducted under MIHP II.

#### **4) Media Tours**

In collaboration with CURE, the Project organized five (5) press tours in MIHP maternities in order to raise awareness of effective perinatal care among journalists and the general public. The tours took place in Donetsk, Lutsk, Simferopol, Dnepropetrovsk and Zhitomir oblasts. Local health authorities and mass-media representatives participated in the maternity tours, which were followed by a presentation of MIHP objectives and achievements. Media representatives were given the opportunity to interview postpartum mothers and their relatives. More than 150 journalists attended the press tours in the five oblasts. As a result, stories on effective perinatal practices were published in local newspapers and aired on local TV and radio programs. Evaluation data demonstrated an increase in deliveries in maternities where press tours were conducted.

#### **5) Cooperation with UNICEF**

##### ***Baby Friendly Hospital Initiative***

UNICEF was a major MIHP partner for advocating effective evidence-based perinatal technologies in Ukraine. In order to improve baby friendly hospital initiative (BFHI) in Ukraine, MIHP and UNICEF conducted two trainings on effective perinatal practices for experts who conduct baby-friendly assessments. Sixty-nine (69) people were trained during the two trainings. The BCC Specialist and other MIHP clinical expert collaborated with UNICEF to facilitate the trainings.

MIHP also worked with the Ministry of Health and UNICEF to introduce two additional BFHI criteria into the assessment tools: 1) companion support in individual delivery rooms; and 2) visits in postpartum period.

This collaboration resulted in the dissemination of effective perinatal practices in many oblasts. UNICEF reported that five non-MIHP maternities in western Ukraine created individual delivery rooms and started allowing family deliveries as a result of these efforts.

##### ***Breastfeeding Policy and Practice Workshop***

MIHP and UNICEF conducted a joint one-day workshop on breastfeeding policies and practices in June 2004. The 35 participants included head neonatologists of four MIHP oblasts and representatives of oblast Departments of Health. The aim of the workshop was to identify barriers to breastfeeding practices and possible solutions. Participants agreed on the following measures to improve breastfeeding practices:

- Provide breastfeeding training for medical personnel in MCH facilities
- Introduce a breastfeeding curriculum into medical schools

- Advocate for the Ukrainian government to adopt the International Code of Marketing of Breast Milk Substitutes

### ***Development of a guidebook for mothers and their relatives***

In 2005, MIHP worked with UNICEF to develop and distribute a comprehensive guidebook for mothers and their relatives on antenatal care, perinatal care, child and nutrition, baby care, danger signs for mothers and babies, information for fathers-to-be, and immunization.

### **6) MIHP Website**

In 2004 MIHP developed its website to disseminate various information on effective mother and infant care practices among both health care providers and mothers and their families. The website included the following sections: Protocols and prikazes developed by MIHP together with MoH, IEC materials, information on effective perinatal care including evidence-based articles etc. Please visit the website for details: [www.mihp.com.ua](http://www.mihp.com.ua)

During the operation of the web-site more than 3000 visits were registered. The web-site will continue to operate in MIHP-II as a link on a new website to be developed in 2007 so that all the information can be easily accessed.

## **V. STAFFING**

During the Project life MIHP worked with 30 Ukrainian staff in Kiev office. The main office in Kiev was supported by the important work in the field of the oblast and maternity coordinator who were responsible for the daily implementation of MIHP activities and for the collection of accurate data. The role of the oblast coordinator was crucial for the real implementation of the Project and for its future sustainability.

Several international consultants supported the project, sharing their experience mainly from the Baltic and from NIS countries. MIHP had the opportunity to work with several WHO consultants and often shared their expertise with JSI EE projects.

## **VI. CONCLUSIONS**

During the project life MIHP learned important lessons from the different level of implementation. These lessons learned will be incorporated as MIHP II is implemented.

### **Policy level:**

- The close collaboration with MoH was crucial to creating a strong base for nationwide dissemination and successful implementation of effective perinatal technologies.
- The newly developed evidence-based clinical protocols endorsed by national Prikazes gave a legal ground to the implementation of effective perinatal technologies nationwide.
- Development of national evidence-based protocols is a long and difficult process.
- Chair representatives, as well as influential members of professional associations, need to be involved as soon as possible in the development of standards and protocols.
- The early involvement of local authorities (City/Rayon/Oblast) to improve the quality of care is crucial. For example, the Governor of Zhytomir Oblast understood the need of warm chain technologies to eliminate newborn hypothermia; therefore he immediately issued a prikaz ordering the implementation of the warm chain in all oblast 'maternities.
- The support of the chief physician from health facility is crucial to help the staff to accept more easily the changes. For example, Dr. Viktor Moroz, Chief Physician of Novovolynsk Rayon Hospital, which implemented very successfully effective perinatal care, said: *"When we tried to join the Project, my only wish was to receive new modern equipment, while training of the staff seemed not important to me. Having joined the Project, I realized that the most important need was the training."*

### **Health facilities level:**

- The Project supported the development of the three Centres of Excellence: in Lutsk City Maternity, in Zhytomir Oblast Centre and in the Obstetrical Department of Donetsk City Hospital #3. In these three centres effective perinatal technologies are fully implemented, attracting the attention of health professionals by their excellent results. Representatives from all Ukrainian oblasts and from some rayons visited MIHP Centres of Excellence to observe effective perinatal care really implemented and to learn from these sites.
- The changes of perinatal practices satisfy medical professionals, families, health and civil authorities.
- Routine implementation of effective perinatal technologies in MIHP sites changed the practices and the mentality of health professionals, which decreased the number of delivery complication, perinatal losses and infant morbidity.
- Family is actively involved in care, which improve pregnancy and delivery outcomes.

- The introduction of effective perinatal care in daily practice in woman's clinics, maternities and pediatric polyclinics facilitates the establishment of a comprehensive linked system of effective medical care.
- To ensure "family oriented care" in Women's clinics, companions must be encouraged to attend birth preparation classes to be informed about existing perinatal practices.
- The improvement of pediatricians', and especially family doctors', clinical skills in growth monitoring, assessment of nutritional status, danger signs, and breastfeeding practices will be extremely important to improve the quality of infant care. Certainly, decreased infant morbidity could have an impact on infant mortality.

Despite the fact that the Ministry of Health fully supported the Project and the fact that effective perinatal technologies were well received in the country, MIHP faced several challenges:

- The slow and incomplete dissemination and implementation of the newly developed clinical protocols due to the limited capacity of the MoH in training of medical staff had shorted the impact of MIHP work.
- The conservatism of the leading specialists and university teachers was an important barrier to the changing the mentality, education and attitude towards patients.
- The fact that health managers are not well informed and preferred to receive expensive and unnecessary equipment rather than implementing cost-effective technologies was also an impediment to project implementation.
- Though MIHP interventions have reduced intra partum and postpartum lexicalization, antenatal care still remains excessively medicalized, as 52% of pregnant women are still hospitalized during their pregnancy in Departments of Pregnancy Pathology for non evidence-based reasons.

### **Recommendations**

To successfully disseminate and implement effective perinatal technologies all over Ukraine, it will be important for MIHPII:

- To continue working with MoH in the development of the necessary clinical protocols and to support more actively MOH in effective dissemination of the new standards/ protocols including proper monitoring of their implementation.
- To encourage an informed choice of oblast/city authorities and policymakers to implement effective perinatal care for their citizens.
- From the initial stage, to involve healthcare authorities, including the Sanitary-Epidemiological Departments in making decisions related to implementing effective perinatal technologies, supporting such implementation and monitoring actively the results.
- To organize at least one "Centre of Excellence" in each oblast to be used as the base for oblast training activities. Each oblast will build its own group of trainers responsible for teaching activities, as well as monitoring implementation.
- It will be necessary that these "oblast centres of excellence" will be recognised and certified by MoH as official teaching centres.
- Study tours to the Centres of Excellence organized for health managers and professionals will show to new oblasts' real implementation and encourage them to implement effective perinatal technologies.
- To involve the faculty of medical universities and postgraduate educational establishments in Project trainings.
- To include effective perinatal technologies in pre-service, post graduate and medical college curricula. It will be the most effective way to disseminate and sustain the implementation of effective perinatal technologies nationwide.
- To inform the community about new perinatal technologies in order to create a demand for positive changes.

# MMIS

**Making Medical Injections Safer  
John Snow, Inc.**

**Annual  
Performance Monitoring Report  
for Activities from  
October 1, 2005 – September 30, 2006**

**Submitted to USAID on October 23, 2006**





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## **I. Background**

With funds from the President's Emergency Plan for AIDS Relief (PEPFAR), the United States Agency for International Development (USAID) contracted John Snow Inc. (JSI) to implement *Preventing the Medical Transmission of HIV: Reducing Unsafe and Unnecessary Injections in Selected Countries of Africa and the Caribbean* in Ethiopia, Mozambique, Nigeria, and Uganda. The original 11-month USAID project began officially in early March 2004. A no-cost extension was granted from the original end date of January 2005 to March 31, 2005 while the project negotiated for additional funding with USAID. On March 21, 2005, a contract cost extension was granted that continues the project to September 30, 2009, under the new title: *Immediate Relief to Decrease Unsafe Injections Under the President's Emergency Plan for AIDS Relief: Uganda, Ethiopia, Mozambique, and Nigeria*. The project is still commonly known by the abbreviated name: Making Medical Injections Safer (MMIS).

In addition to these countries, JSI continues to work on a five-year Cooperative Agreement with the US Centers for Disease Control and Prevention (CDC) in seven countries in Africa and the Caribbean and is a subcontractor to Initiatives, Inc. for a project in Guyana. Therefore, the project provides direct programming or technical assistance to 12 PEPFAR-supported countries.

This annual performance report for the MMIS Project covers the period October 2005-September 2006. It summarizes the accomplishments of global and country activities in Ethiopia, Mozambique, Nigeria, and Uganda in the following technical areas: commodity management and procurement, capacity-building and training, behavior change communication, waste management, as well as monitoring and evaluation.

## **II. Project Management and Partnerships**

### ***MMIS Arlington office***

As of September 30, 2006, at the JSI/MMIS headquarters in Arlington, VA, the combined USAID and CDC projects have seventeen full-time and one part-time staff members. This includes a project director, a project manager, a monitoring and evaluation advisor, three monitoring and evaluation technical officers, four technical officers, a communications strategist, an administrator, two project coordinators, three financial program coordinators, and one part-time technical officer.

JSI partners with the following subcontractors known for their expertise in key technical areas: Program for Appropriate Technology in Health (PATH) for procurement and waste management, the Academy for Educational Development (AED) for Behavior Change Communication (BCC), and the Manoff Group for BCC in Mozambique.

In addition to these full-time and part-time staff, MMIS continues to work in close collaboration with other JSI projects (DELIVER, MEASURE, and SCMS) and other bilateral projects to ensure consistency and coherence across its interventions in the field.

### ***MMIS Field offices***

The MMIS project assures a constant presence in its program countries through its field offices and host country national staffs. Field staffs' familiarity with their respective countries and ability to influence change within the health system have been a key factor in the project's success to date. In all four USAID countries, MMIS has field offices staffed with a country director, a logistics advisor, a waste management advisor, a BCC advisor, and an administrative/finance officer (a few countries have additional administrative support).

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### ***Partnerships***

MMIS country teams serve as key Ministry of Health (MOH) technical advisors in the areas of injection safety and health care waste management. In all countries, the Minister of Health or other high-level official chairs a National Injection Safety Task Force, made up of key MOH departments, the Ministry of Environment, key development partners, and other stakeholders in injection safety and health care waste management. In most countries, MMIS staff also play the role of secretariat of the National Injection Safety Task Forces.

At the international level, MMIS continues to have strong working relationships with the WHO Africa Regional Office (WHO/AFRO), WHO headquarters in Geneva, and the Safe Injection Global Network (SIGN). JSI/MMIS has been an active participant in the Geneva-based Immunization Safety Steering Committee and has contributed to WHO's global efforts to develop guidelines for health care waste management. The Immunization Safety Steering Committee has been dissolved at the end of 2005 and its activities streamlined in other departments of WHO/Geneva. MMIS continues to work with the relevant departments of this organization on injection safety issues. Additionally, MMIS is an active participant in the quarterly PEPFAR Partners meetings chaired by USAID.

### **III. MMIS Staff Update**

#### ***MMIS Arlington***

In FY 2006, MMIS hired a total of 8 new staff members to fill both existing positions as well as newly created positions at the MMIS Arlington, VA, USA office. The new positions are in areas (i.e. monitoring and evaluation) where the project has experienced significant growth. The additional staff will improve MMIS's ability to effectively manage the existing M&E workload and, as a result, be more responsive to the project's funders.

Since the last semi-annual performance monitoring report in April 2006, MMIS has added 2 new staff members:

Ms. Deepa Bhat joined MMIS in July 2006 as Associate Technical Officer in M&E. Ms. Bhat has a B.A. in Biology, a Master's in Public Health with a concentration on Epidemiology and Biostatistics, and a M.S. in Food Policy and Applied Nutrition. Her M&E experience includes 2 years as an Evaluation Specialist at the National Alliance of State and Territorial AIDS Directors and 6 months as an epidemiologist for the Health Department in New York. She has had a variety of overseas internships and consulting assignments in evaluation.

Ms. Megan Noel also joined MMIS in July as an Associate Technical Officer in M&E. Ms. Noel has a bachelor's degree in International Affairs and a Master's in Public Health. Prior to joining MMIS, Megan worked as a consultant on the MEASURE Evaluation Project (with the Futures Group) and as an M&E Specialist for the Community REACH Project.

#### ***Transfer to MMIS Arlington office***

Senior Logistics Advisor Dr. Ousmane Dia, who is currently based in South Africa, will be transferring to the MMIS Arlington Office. Since the last report, U.S. immigration approval has been received and his transfer is planned for December 2006. It was always the design and intention of the project to have this position be based out of Arlington. MMIS is entering a phase where the strategic thinking about the

sustainability and long term vision of the project needs are being refined. Therefore, Dr. Dia is needed in these central level discussions and his transfer will facilitate his participation.

During the first two years of the project, most country teams did not have full-time logistics advisors (logistics duties were also handled by the waste management advisor). To provide appropriate support, the Senior Logistics Advisor was based in South Africa to allow for timely and frequent supervision with short distance travels to the program countries. At this stage of the project, Dr. Dia has recruited, trained, and supervised a logistics advisor in all four USAID countries. Over the past several months, Dr. Dia has systematically visited every country to supervise the utilization of the logistics and supply chain management tools that he helped to develop or revise. While project management is confident that country teams are well trained and need less frequent visits, MMIS will assure that the field offices continue to receive the appropriate level of technical support from Dr. Dia.

#### ***New Regional BCC Adviser***

In an effort to augment the support for behavior change, communication, and advocacy activities to country teams, MMIS has hired a Regional BCC advisor to be based in Nairobi to support MMIS activities in the region. Mr. Jones Mpakateni, who started in September 2006, had previously been working as a WHO/AFRO regional information, education and communication (IEC) advisor for immunization in Southern Africa and as a social mobilization advisor for polio eradication in Nigeria. He has particular expertise in community participation and training/capacity-building, both of which are highly pertinent to MMIS at this stage of the project.

#### ***Intern***

In addition to the above staff update, Angela Ratkowski joins the MMIS team as an intern for the time period of September 2006 through April 2007. She is completing a Masters Degree in Social Work from the University of Maryland-Baltimore College and also has a Bachelor of Arts degree in photojournalism from Columbia College in Chicago. She served as a Peace Corps Volunteer in West Africa and recently completed an internship at USAID/Africa Bureau.

## **IV. Technical Approach**

### **A. Global Project Activities: October 2005–September 2006**

#### ***Task 1: Commodity Management and Procurement***

##### ***Tender and procurement process***

The commodity schedule follows behind the budget cycle due to the timing issues relative to the initially established tender schedule in the project. The final deliveries from the previous commodity period were released, and a new tender was launched.

Under the overall procurement strategy, the MMIS process involves high levels of participation at country level to ensure that relevant issues are accounted for, such as country policy issues, refinements of product categories (not brand-specific) or changes related to lessons learned, expansion plans, etc. A brief overview of the current tender process is included below. Tables including estimated quantities for the recent tender are also included in this section.

- *Country Verification*

Each tender cycle begins with a verification of the appropriate mix across countries. As mentioned above, country teams confirm local contextual issues related to the mix across the three categories: standard disposable, re-use prevention (RUP), and RUP + anti-needlestick devices. This activity accounts for new or changed facilities, as well as information emerging from their recent experience.

The process in-country includes two levels of activity. First, the country director works with the MOH to determine, and in some cases re-confirm, which facilities or districts will be included in MMIS coverage and other activities. These discussions go beyond procurement and include training, the possibility of contributions or activities of other partners. In Ethiopia, for example, the MOH made a decision to change the facilities in which MMIS was working in order to leverage and focus the training resources of another program. While these discussions and agreements are not part of the tender process, it is the place where decisions are made regarding where and how commodity coverage is focused.

The second level of in-country activity is to confirm what categories of commodities the district or facility personnel feel is appropriate to introduce. MMIS does not promote a specific mix or attempt to influence their decisions unless they appear inappropriate (such as requesting all fixed needles or no safety boxes). Unlike EPI, since safety syringes for curative services have only been available in the market since 2004, there is not a sufficient evidence base to suggest or recommend specific percentages or a realistic option to bundle with drugs.

Districts and/or facilities need to consider how goods will be timed with training resources, usage issues related to medical procedures, cost sustainability issues, and any other issue specific to their situation as they decide what is appropriate. They rely on general guidance regarding appropriateness for procedures and settings, as well as factors unique to their situation. As an example of a contextual decision, while Ethiopia opted for a large supply of standard disposables, Uganda is not including any in the MMIS mix because the National Medical Stores needs their support in reducing their inventory of standard disposables. Discussions and negotiations of this nature are made with the country director and/or the logistics manager, targeting the district- or facility-level procurement stakeholder (typically the Chief Pharmacist, either of a district or referral hospital, where applicable) and are followed by planning and discussions with the CMS management.

For the tender, PATH uses the preliminary mix information with percentages from the previous year to launch the tender while countries move into forecasting activities. The estimates in the tender are based on budget availability, but are qualified in all documentation as being subject to change to accommodate the flexibility that countries need.

- *Proposal Review and Award*

The tender is distributed to interested parties via the International Association of Safe Injection Technologies (IASIT) and posted on PATH's web site. When proposals are available, non-responsive bids are eliminated in a first-round cut, and remaining samples and summary information are sent to the technical review teams. Examples of non-responsive proposals are those that fail to include substantial required information, those who clearly lack capacity to fulfill orders, etc.

- *Technical Review and Final Estimations*

The technical review team includes clinical, public health, field implementation, injection device design, and procurement experts. Across the disciplines, the reviewers work in three teams. After

final reviews are compiled and the tenders are awarded, country teams finalize the actual quantities based on final costs from the selected suppliers.

The current tender was based on the following mix and quantities in Tables 1 and 2. Note that quantities are subject to change throughout the production and shipping phases. As in the past, space availability and adjustments for patterns emerging in new facilities require some degree of flexibility.

**Table 1: Mix of Syringe Type by Country**

	<b>Standard Disposable</b>	<b>RUP Detachable Needle</b>	<b>RUP Fixed Needle</b>	<b>RUP + Anti-Needlestick</b>
Mozambique	0%	80%	20%	0%
Nigeria	25%	25%	25%	25%
Ethiopia	40%	0%	50%	10%
Uganda	0%	55%	40%	5%

**Table 2: 2006 Quantities of Injection Safety Equipment by Country**

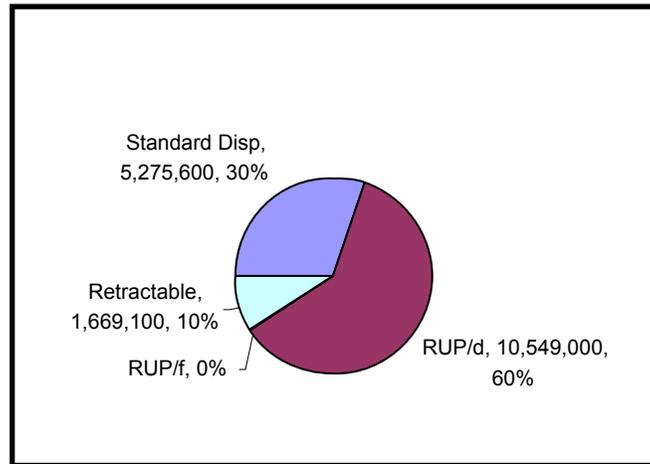
	<b>Standard Disposable</b>	<b>RUP Detachable Needle</b>	<b>RUP Fixed Needle</b>	<b>RUP + Anti-Needlestick</b>	<b>Needle Removers</b>	<b>Safety Boxes</b>
Ethiopia	5,275,600	10,549,000		1,669,100	326	158925
Mozambique		5,822,693	1,940,898	0	100	63400
Nigeria	3,804,200	5,633,600	2,406,500	5,311,600		200575
Uganda	0	10,761,600	5,134,400		1812	155,000
<b>Total</b>	<b>9,079,800</b>	<b>32,766,893</b>	<b>9,481,798</b>	<b>6,980,700</b>	<b>2,238</b>	<b>577,900</b>

\* RUP/d and RUP/f: Syringe equipped with Reuse Prevention features with detached or fixed needle.

### **Monitoring Overall Mix**

As part of the overall commodity strategy, MMIS continues to monitor the mix of supplies provided through the project procurement mechanism. This monitoring is useful in identifying use issues that emerge as safety syringes are integrated into curative practices. The chart in Figure 1 shows the mix among the USAID countries, now with RUP syringes separated into two categories: fixed needles and detachable needles. Table 1 provides the mix by country. Please note that the mix does not intend to represent a recommendation for national planning, but rather is included as an illustration of changes and developments. The notable change is that need and flexibility of detachable needles has changed the overall mix, as well as created a drop in average cost.

**Figure 1: Overall Mix of MMIS Syringe Types in USAID countries**



### ***Industry Relations***

MMIS continues with its efforts to support a productive and transparent relationship with industry, primarily through IASIT. MMIS met with IASIT representatives to request that IASIT consider stimulating industry working groups at country level to sensitize and support private sector distributors who are transitioning to safe injection equipment. IASIT has agreed to consider this. IASIT is undertaking initiatives to emphasize quality standards, which is consistent with the MMIS procurement strategy. They have requested collaboration from MMIS, WHO, and others. MMIS has tentatively agreed to participate.

MMIS has developed the concept for a procurement issue brief to share relevant information with industry stakeholders at international and country levels. Staff in Central Medical Store (CMS) entities have requested to be included on distribution list of this issues brief.

As expected in a highly competitive industry, MMIS is aware of sensitivities among members of industry. MMIS has continued with the pooled tender strategy, in part to manage the impact of such issues at a global project level and to avoid unnecessary disruption at the country level. Independent from MMIS, manufacturers are engaged in market development either directly or via local representatives. Overall, this is a highly positive development, as a willing market is a step forward towards sustainability. While this is generally a positive sign, it is important to note that MMIS has sensitized industry that any private marketing initiatives must be clearly separated from MMIS activities. Because private marketing efforts are not required to operate under principles of public sector procurement, maintaining this activity as separate is important. Cooperation from industry has been strong to date.

### ***Technical Assistance***

Technical assistance and situation assessment continued throughout the reporting period. The technical assistance during the current period focused on supporting advocacy issues related supporting procurement and logistics among local and international partners. Trips were made to Mozambique, Nigeria, and Uganda.

### ***Policy Environment***

While advocacy work typically is performed by Country Directors, technical assistance in procurement and logistics supports their efforts by identifying potential areas of advocacy. For example, in Mozambique the follow-on outcome of a technical assistance visit was acceptance of a policy to adopt single-use syringes in place of glass syringes. Efforts to include safe injection equipment on national tenders and supply lists also continued during the period. The Uganda Ministry of Health publicly announced their national policy to shift to RUP syringes as the national standards, and MMIS is supporting the transition by facilitating a workshop on specification development for key stakeholders.

### ***Collaborations***

MMIS participated as the injection safety expert in the Inter-Country Mid-Level Management Course sponsored by the WHO and UNICEF in Pretoria. Seventy participants from 21 African countries participated. MMIS facilitated the half-day session on injection safety.

In addition to the CMS entities recognized and authorized by Ministries of Health, faith-based organizations often manage significant supply chains of medical supplies. MMIS is informally collaborating with Joint Medical Stores (JMS) in Uganda and reviewed their concerns about transition and phase-in plans. JMS received updated specifications and other technical advice regarding introduction issues.

### ***Customs and Regulatory Issues***

Processes for customs, exonerations from import taxes, and other import regulations are an expected and ongoing management activity in each of the countries. Requirements change frequently, and MMIS supports country staff and their local counterparts in interpreting specific details, providing reports, and other assistance. Space planning is becoming an important issue within port processes. With the increase of commodities from donor-funded programs, CMS entities in all of the USAID countries are reporting space problems from unexpected shipments and programs that do not provide or facilitate distribution plans. Since the beginning of the project, MMIS has invested in pre-planning activities with CMS entities and has continued to provide reports and plans. Uganda National Medical Stores will be changing their system to require other programs similar to what MMIS has been providing. In Ethiopia, a partnership model with Pharmid is underway to support warehousing and distribution needs there, especially in consideration of significant recent changes to the districts and facilities included in the MMIS scope.

### ***Consumption Monitoring***

#### ***National Import Information***

In the past reporting period, countries have continued to gather information through local customs authorities or local regulatory agencies on total importations into project countries to compare with emerging LMIS data. While existing information sources appear to be incomplete, the information gathered in Ethiopia and Nigeria reconfirms that the private sector plays a significant role in in-country supply of syringes and that some private importers have started importing safety syringes.

#### ***Progress with LMIS***

Compared to the previous reporting period, use of the LMIS tool has improved, and support to logistics advisors has continued. The number of countries reporting overall has increased, as has completeness and timeliness of the reporting. Country logisticians are analyzing their own data and are taking appropriate corrective decisions, such as bundling and re-distribution of commodities when necessary. Stock outs have reduced in the intervention districts.

The project originally used the only available data for planning, which was the statistic from WHO of 1.5 injections per person per year used. However, because syringes are consumed for non-injection purposes and because consumption reports indicate that this figure is not likely to be accurate for planning purposes, MMIS introduced a concentrated survey of consumption patterns in selected districts. The survey is being conducted in Kenya, Botswana, Uganda, Rwanda, and Ethiopia because their operation context best supports the activity. This activity will continue through February. Achieving completeness of at least 80% will give the project more reliable data to consider for future forecasting.

The recommended structure was to select preferably 2 districts without a referral hospital and one with a referral hospital to facilitate the impact of referral hospitals on the overall consumption in a district. While it will be extremely difficult to monitor quantity sold by private pharmacies to patients, the logisticians will attempt to request relevant information where possible without accessing patient records (the design of the study does not include access to patient information). The survey has been launched with the full cooperation of the MOH, especially the cooperation and involvement of district-level management.

The consumption data collected from March to June 2006 in Uganda, using a corrected Number of Syringes per Person per Year (NSPY), shows a range that varies from 0.61 to 3.58 during the period in reporting districts. The NSPY is 1.44, 1.55 and 1.31 respectively for April and May which can be found in Annex B of this report.

These figures do not include data from private health facilities or syringes purchased by patients outside the facility. Consumption from private facilities and syringes purchased by patients are not currently documented, and are expected to increase the corrected NSPY. Tables 3 and 4 are examples of data collected in Uganda.

**Table 3: Injection Safety Indicators from Uganda**

<b>DISTRICTS</b>	<b>Mpigi</b>	<b>Isingiro</b>	<b>Ibanda</b>	<b>Nebbi</b>	<b>Hoima</b>	<b>ALL DISTRICTS</b>
<b>INDICATORS</b>						
Total number of syringes used	12,498	2,322	13,438	13,170	13,194	<b>54,622</b>
Number of syringes per person per year	0.35	0.08	0.75	0.34	0.39	<b>0.35</b>
EPI syringes VS total	0.02	0.09	0.21	0.06	0.15	
Number of HF that reported	6	3	18	13	25	<b>65</b>
Number of HF in the district	62	44	34	58	44	<b>242</b>
Completeness	10%	7%	53%	22%	57%	<b>27%</b>
Corrected NSPY	3.58	1.18	1.41	1.50	0.69	<b>1.31</b>

**Table 4: Mix of Sizes and Bundling for Syringes in Uganda**

Mix of Sizes & Bundling							Number of syringes per safety box
1 ml	2 and 3 ml	5ml	10 ml	20 ml	0,05 ml	0,5 ml	
1%	33%	43%	11%	0%	3%	8%	99

**Task 2: Capacity-Building and Training**

The MMIS project seeks to establish training and capacity building strategies that support the institutionalization of safe injection and waste management practices so that safety becomes a professional norm for all health workers and health facility staff. The in-service training portion of MMIS program activities serves a critical catalytic purpose, appropriate for a project of limited duration, of both defining the appropriate training content required by different cadres of personnel and quickly increasing the capacity of a substantial number of health workers currently on the job.

Table 5 shows global training numbers to date for the four USAID-funded MMIS countries by training category. Please see the country section for country-specific breakdowns.

**Table 5: Number of Persons Trained in USAID Countries to Date (since September 2004)**

Training Category	Persons Trained by MMIS to Date
Training-of-Trainers	1,073
Injection safety	23,725
Interpersonal communications	395
Logistics	522
Waste management	6,882
<b>TOTAL</b>	<b>32,597</b>

Because formal training alone will not change behaviors, a combination of approaches is necessary for health workers to incorporate safety into their daily activities. Continuing medical education, supportive supervision visits, job aides, on-the-job training and other supports to performance improvement are a part of this comprehensive strategy, which differs from country to country. The challenge of staff turnover throughout health centers in MMIS countries has led the program to reinforce these other capacity building strategies, particularly on-the-job training by supervisory staff.

**Training Materials and Approaches**

Over the past year, each MMIS country has developed training materials and approaches that reflect the local context and are based on technical references such as the *Facilitators' Guide* and national policies and guidelines. Stakeholders, including training institutions, participated in these adaptation workshops in each country. Materials and training activities specific to each cadre of health worker and ancillary staff have been implemented, reflecting the different competencies required to ensure a safe environment for staff as well as patients. The concept of focused, competency-based training was further promoted through work in Uganda, in which existing training materials were revised to highlight the specific skill areas and learning activities appropriate to different cadres of personnel. These modules are being shared with other countries for their consideration and possible adaptation.

Training tools developed earlier in the project have been revised to reflect the experiences of in-country implementation, share lessons and adapt tools and approaches across countries where appropriate. Based on these country experiences and feedback received from country teams and Ministries of Health, MMIS developed a set of training tools and job aides as a companion to the *Facilitators' Guide* and to complement existing materials. While this was originally envisioned as a "participants' guide," feedback from MMIS field staff in early 2006 indicated the need for practical tools for trainers to help them transform the technical reference material in the *Facilitators' Guide* into appropriate lesson plans, learning activities and job aides for participants. This document is in final production and will be available in by the end of 2006, supporting project efforts to continuously improve the quality of training interventions.

### ***Pre-Service Training***

A key strategy in ensuring the reach of MMIS training efforts and the ultimate sustainability of safe health worker practices is to integrate injection safety into existing curricula, notably for pre-service training institutions. MMIS is working with nursing schools and medical schools to ensure that graduates have achieved competency in safe injection practice. In addition, MMIS has been successful in adding injection safety modules when partners conduct training in related areas, such as WHO training prior to nationwide measles immunization campaigns or as other PEPFAR partners recognize the need for safe health care waste management as part of their programs. This allows the project to maximize resources and reach a much broader audience, helping to foster a professional norm of safe injection and proper waste disposal practice.

### ***Review of Training and Capacity Building Strategy***

MMIS has been working to review the training and capacity building strategy for each country and for the project as a whole based on country implementation experience and feedback from country teams. A matrix has been compiled to document the various capacity building interventions currently in place in each country, in an effort to identify gaps and share experiences and approaches among countries as appropriate. The July 2006 MMIS Country Directors' Meeting provided an opportunity to analyze the challenges faced in implementation of training activities and identify potential strategies for maximizing coverage while ensuring quality in training. The recommendations from that meeting included maintaining an emphasis on shorter, focused trainings and reinforcing other capacity building interventions such as on-the-job training and peer exchanges. The past year has yielded valuable lessons learned, which will continue to inform program planning in training and capacity building throughout the life of the project.

### ***Follow-on to Regional Workshops on Logistics Management and Procurement***

Following the two regional workshops on logistics management and procurement conducted in Cape Town in November 2005 and in Mombassa in February 2006, the national logisticians were assigned to conduct similar workshops. Examples of resulting national-level efforts include:

- Nigeria and Côte d'Ivoire: Trainings for district managers were conducted.
- Ethiopia: MMIS collaborated with DELIVER to provide on-the-job training. Together the team worked with stock managers to re-arrange deficient warehouses, add shelving, and put essential stock management systems in place.

### ***Task 3: Behavior Change and Advocacy***

Current thinking about behavior change holds that behavior, attitudes, and practices are changed by the employment of a complementary set of mutually-reinforcing activities. In the area of injection safety, MMIS views these activities as ranging from the adoption of supportive policies and guidelines, to the assurance of adequate supplies of equipment, to the use of participatory training methods plus follow-up reinforcement, to the design and implementation of effective communication efforts, including those involving advocacy. For that reason, descriptions of some of the project's work in behavior change during this timeframe are found in different sections of this report, including under capacity-building and training (Task 2); proper sharps disposal (Task 4); private providers and the informal health sector (Task 5); and monitoring and evaluation (Task 7).

#### ***Multi-year Strategy Development***

During the period of October 2005 to September 2006, a key area of activity for MMIS at global level has been the provision of support to countries to develop multi-year strategies for behavior change communication and advocacy. These strategies are organized around three main behavioral goals: promoting rational injection use (reducing unnecessary injections); ensuring the safety of those injections that are necessary; and assuring safe management of sharps waste. Strategy development has deliberately entailed the use of group processes involving several in-country partners in order to solicit their viewpoints, broaden the base of support for injection safety, and increase the likelihood that the strategy will actually be implemented.

At this point of the project, the multi-year strategies reflect increased emphasis on communication directed toward the community, while still maintaining a focus on the critical communication between health care provider and patient. This is in line with the project's overall strategy of working first within the health system (given that health workers are viewed by patients and communities as a key and trusted source of information) prior to expanding to channels that reach a broader portion of the population. The latter channels, including mass media, are generally viewed by communities as an important means of reinforcing information that has first been introduced via interpersonal communication.

#### ***BCC Materials Development***

A second key area of activity during this timeframe has been the provision of technical support to help assure the effectiveness and quality of BCC materials being developed by country teams. Toward that end, MMIS has developed and disseminated a number of tools and has provided guidance in their use. These include the creative brief, which provides a set of specifications and justification for each proposed material; tools and guidance on effective pre-testing of materials; and a checklist to use when an MMIS country team is considering adapting a BCC material from another country for its own use. These tools have been introduced to country-level BCC advisors and also to MMIS country directors at the Country Directors Meeting in Arlington, VA in July. MMIS has also prepared a presentation summarizing lessons learned with behavior change and communications for injection safety and drafted a document on "hints for good practices" on the same topic. The latter will be an easy-to-use synopsis of "do's and don'ts" for communicating about injection safety.

During this reporting period, MMIS presented a poster session at the PEPFAR Implementers' Meeting in Durban, South Africa, on the topic, "Reducing Unnecessary Medical Injections: Implications for Action from Formative Research in Ten Countries." The project will make an oral presentation on this subject at the SIGN meeting in October 2006 and is also preparing a paper that presents the information in greater detail.

#### ***Task 4: Establishing a Standardized System for Proper Sharps Disposal***

MMIS continues to take a multi-pronged approach to strengthening sharps waste management systems in MMIS countries, combining global-level collaboration, work at the local level to introduce improved waste management practices, and support at the national level to build policy and high level prioritization of medical waste activities. Experience with locally appropriate systems for waste segregation, handling, treatment, and disposal has helped MMIS countries identify practical approaches that consider their staff, equipment, and financial limitations. These country-appropriate experiences are applied in the national planning process to create an experience-based national plan that is tailored to each country. In most MMIS countries, the national policy development process is underway and receiving significant guidance and support from MMIS.

##### ***Global collaboration***

MMIS continues to collaborate closely with WHO to refine global HCWM policy. In October 2005, MMIS sponsored an international meeting in Addis Ababa to review global policy and define practical options for HCWM. Led by WHO, MMIS, and MMIS field staff and their counterparts from the Ministry of Health and Ministry of Environment reviewed WHO-endorsed approaches and identified those systems most appropriate to MMIS countries.

WHO's recently released HCWM guidelines, "Management of waste from injection activities at district level", were strongly influenced by MMIS experiences. MMIS played an important part in reviewing and revising this document. Inclusion of MMIS field-level experience served to make the document more realistic and the solutions more sustainable.

In June 2006, MMIS staff from Uganda, Kenya, Tanzania, and Rwanda participated in a 7-country WHO workshop to develop national health care waste management plans. WHO will provide GAVI funding to these countries to facilitate national plan development. MMIS will provide technical support for national planning activities in MMIS participating countries. MMIS countries will use south-to-south collaborations to share national planning experiences and lessons learned.

##### ***National Plan Development***

MMIS countries conducted several national HCWM planning and training activities. These meetings and workshops served to raise stakeholder awareness of the importance of medical waste issues and helped countries develop detailed plans for waste management systems. Examples include:

- Ethiopia drafted National HCWM standards and guidelines and held a national stakeholders meeting to refine them;
- Uganda held a national Stakeholders Meeting to finalize a strategy for development of a national HCWM plan
- In Côte d'Ivoire, a task force for health care waste management has been established representing the key stakeholders, including MOH, MOE, NGOs and international institutions. This task force will be developing the national HCWM policy and plan.
- The MMIS team in Rwanda is working with WHO/Rwanda to develop terms of reference for a national assessment of health care waste management, the results of which will inform national policy and action plan development.

In all of these national-level HCWM activities, MMIS played a critical advisory role by highlighting practical field-based MMIS experiences into the process.

### ***Leveraging Partnerships***

MMIS is leveraging partnerships to support the implementation of medical waste systems in several countries. In Nigeria, a partnership with the Federal Ministries of Environment and Health was established to develop and finalize the National Health Care Management Plan and to leverage support from WHO, UNICEF, the World Bank and JICA. A microplan workshop was conducted in order to coordinate the roles of the public and private sectors. MMIS worked with state government authorities to determine an environmentally friendly site for an incinerator donated by Chevron Texaco. MMIS also worked with the World Bank-supported Corridor Project to provide an incinerator and to share appropriate information among partners.

MMIS is helping countries to identify new funding mechanisms to support medical waste infrastructure and capacity building. For example, MMIS is working closely with MOH counterparts in Uganda and Kenya to include medical waste strengthening in GAVI's Health Systems Strengthening Support applications. Leveraging guidelines were introduced to all MMIS country directors to help identify approaches to development of a national leveraging strategy. MMIS support will help each country identify funding mechanisms and make donor contacts.

### ***Modeling Improved Practices***

All MMIS countries are refining their medical waste system approaches as they expand their zones of implementation. A primary focus continues to be the establishment of well-defined segregation systems. Safety boxes are now routinely used in all countries and color-coded segregation of infectious and non-hazardous medical waste is being expanded. To facilitate the purchase of medical waste segregation supplies and protective equipment, MMIS developed specifications that can be adapted by several countries for the in-country purchase of equipment by stakeholders.

As the program expands, improvement of simple disposal methods, such as installation of protected medical waste pits, has expanded in several countries. Others are improving the quality of existing incinerators and providing the training and supplies required to properly segregate and incinerate infectious waste to reduce incinerator emissions.

### ***Behavior Change to Strengthen Medical Waste Practices***

As a relatively new area of work within the health system, the issue of health care waste management/sharps disposal presents challenges in terms of identifying specific roles and responsibilities and articulating clear messages that serve as a call to action. Collaboration between project staff with expertise in waste management and BCC has resulted in draft messages and positive behavior changes. Collaboration between the MMIS/Nigeria team and MMIS experts in waste management and BCC resulted in the development of a concise material that may be useful in several countries, depending upon their specific needs.

## ***Task 5: Private Providers and the Informal Health Sector***

In the past year, MMIS worked with USAID/Washington and CDC/Atlanta to establish a process for developing country-specific strategies for addressing injection safety in the informal health sector. Each MMIS country has undertaken a review of available documentation on the informal health sector in their respective countries. This included review of relevant policies, legislation, report, and published literature to better understand the nature of informal sector care and injection practice, the relationship to the formal health sector institutions and governments, and to describe what types (if any) of interventions had been

implemented to date to reach informal sector providers. Reports from Uganda and Nigeria are available and the Ethiopia report is pending. Due to the delays MMIS/Mozambique has experienced, the production of this report has also been delayed until further notification from the Ministry of Health.

In collaboration with USAID and CDC leadership, MMIS developed a focus group discussion guide and protocol for use in program countries. The in-country documentation review completed in FY 06 will inform the adaptation of the generic focus group discussion guide for use in each country during the upcoming year. This qualitative formative research will be complemented by the quantitative community survey, which will provide data on source and frequency of injections. All of this information will assist MMIS in developing country-specific strategies for how to address the challenges of injection safety in informal health care settings.

### ***Task 6: Policy Environment***

In all four countries, MMIS continued to spearhead the development and finalization of relevant policies, guidelines, norms and standards for injection safety and healthcare waste management. A special emphasis has been put on including the health care worker safety aspect in these documents where it was lacking. Uganda made a significant breakthrough by adopting syringes equipped with reuse prevention features as the national standard equipment. This will probably influence other countries to adopt similar laws.

With funds from CDC, MMIS is planning to conduct a study of needlestick injuries in health workers in Tanzania. A study protocol was developed by JSI's Director of HIV/AIDS. Administrative steps have been taken with MMIS/Tanzania and in-country counterparts to get the necessary approvals for the research. The study aims to document the circumstances in which health workers are exposed to needlestick injuries and their reporting behavior after exposure. The final goal of the study is to gather information that will help MMIS to refine its strategy to improve health workers' safety throughout all MMIS countries.

### ***Task 7: Monitoring and Evaluation***

In October 2005, MMIS included an overview of long-term M&E plans in the MMIS Life of Project Plan and presented country-specific monitoring and evaluation (M&E) plans to USAID/Washington. The draft plans were shared with the USAID Missions by the in-country MMIS teams, and their inputs continue to be incorporated as needed. These plans will be continuously updated throughout the life of the project as new data is received.

### ***Follow Up Assessments***

At a joint USAID/CDC conference call for planning related to M&E issues in February 2006, USAID confirmed acceptance of the project's general M&E approach, which consists of conducting follow up assessments in original pilot areas to develop lessons learned for strengthening program implementation, plus conducting baselines and a series of two follow up assessments in the expansion areas to provide evaluation data against the key indicators. Two of the country programs (Uganda and Ethiopia) have already conducted a follow up assessment in pilot areas. The Uganda report is now available. The Ethiopia report is undergoing final revisions and will be available the second week of October 2006. Of the two remaining countries, Nigeria began collecting data for the pilot follow up survey in June 2006.

Data entry is expected to take place in October with a final report issued by December 2006. Data collection for the survey in Mozambique is scheduled for October 2006.

### ***Expansion Baseline Surveys***

Data collection for expansion baseline surveys has been completed in each country, and the reports are expected to be ready by the end of the first quarter of FY 2007, with the exception of Nigeria's report, which will require some revisions to the dataset to facilitate analysis of variables in Section 3 (observations of injection practices). That report is scheduled to be issued by February 2007. The midterm assessments in the expansion areas of all four countries will be scheduled around the last quarter of FY 2007.

### ***Health Facility Assessments (HFA)***

In March 2006, USAID and CDC agreed upon a revised health facility assessment (HFA) questionnaire. Following this agreement, the questionnaire was finalized, and the HFA analysis plan, indicator table, and training guidelines were updated accordingly. These revised tools were then translated into Portuguese for the survey in Mozambique. Country programs with surveys scheduled from June 2006 forward (beginning with the Nigeria follow up assessment mentioned above) are using the revised tools. These materials were posted to the MMIS website, where they are available to partner organizations as needed.

To further improve the quality of survey reports received from local consultants, MMIS developed a detailed template based on the Uganda pilot follow up report. In August and September 2006, MMIS created a set of materials for use in training data collectors for health facility assessments so that issues of standardizing data collection across countries could be addressed effectively. These materials were field tested in Kenya and are posted on the MMIS website. MMIS has also created a standard dataset in SPSS to facilitate data entry of the HFA data. In FY 2007, MMIS plans to expand upon this basis by creating a standard set of syntax files in SPSS that will be used to analyze the HFA data. The addition of these training materials, analytical tools, and the report template is expected to enhance the quality of data collected in HFAs as well as the reports by local consultants hired as survey coordinators. It is expected that they will also contribute significantly to assisting the project in streamlining the technical review process and completion of final reports.

### ***Proposed Injection Safety Indicators in Service Provision Assessment (SPA) Tool***

In March 2006, MMIS participated in a meeting of cooperating agencies that was held at ORC MACRO. At this meeting, the group discussed addition of injection safety questions and concepts into the infection prevention and control component of the Service Provision Assessment (SPA) tools and report template that ORC MACRO is currently revising. MMIS presented the key indicators for injection safety (which had been agreed upon with all PEPFAR partners in FY 2005) and the MMIS questions for collecting that data. MMIS suggested some key indicators that could be incorporated into the SPA tool. MMIS shared this list of proposed questions and comments on the tools as they relate to injection safety with the other PEPFAR partner organizations subsequent to this meeting to allow them an opportunity to comment. This dialogue continues as needed to address new questions that arise related to injection safety.

### ***M&E Tools/Materials Development***

In addition to the formal HFAs in project expansion areas, MMIS developed a tool in June 2006 for use in collecting data on key indicators during routine MOH supervision visits. This tool was distributed to all MMIS countries.

In September 2006, MMIS M&E staff reviewed the draft phlebotomy module that has been developed by WHO. Extensive comments were sent to WHO to assist them with finalizing their tool, but in general,

the questions were found to parallel Tool C with a few additional phlebotomy-specific questions. The MMIS health facility assessment tool is a modified Tool C and therefore already includes most of the material found in the WHO draft phlebotomy module. MMIS data collection has always included blood draws and laboratory settings. However, the project does plan to add a few additional phlebotomy questions to the standard HFA tools to complete this work.

In addition to the HFA work in this reporting period, MMIS's M&E and BCC officers and a consultant versed in cluster sampling finalized the questionnaire for community surveys and drafted the methodology for its implementation. The evaluation of BCC efforts includes an inquiry with the intended target group for each material and method to determine several factors, including the level of exposure to the message, knowledge and understanding of the message, and intent to take action or the actual behaviors. Because the strategy for BCC messaging varies by country, a second facility-based evaluation tool was developed that is appropriate to assess the reactions of health workers and patients at facilities to messages and materials that target them. Ethiopia served as the pilot test site of a minimum set of these questions at health facility level (which is the level at which their BCC has been directed to date in that country) while Uganda served as the pilot test site for the community-level questionnaire. The report from that field test has undergone technical review and will be finalized in the near future. Lessons learned from this experience will then be used to develop a minimum set of questions for use either as a standalone assessment of the effectiveness of BCC materials directed at the health facility level or for possible addition to the general HFA tools as the situation warrants.

In the area of prescription record reviews, MMIS worked with local consultants in Uganda to develop tools for an assessment of rational injection use. Uganda served as the field test site for this work. The draft report by the local consultants has undergone technical review, and additional data is being added to it for a more complete report. It is expected that the final survey report will be available by the end of October 2006. In the meantime, Mozambique and Ethiopia are currently beginning development of similar activities on a smaller scale. In Mozambique, initial planning for this activity began in September 2006 with a review of potential sentinel sites and their data to take place in October 2006. An initial trip to set up the activity in Ethiopia is planned for December 2006. As with the HFAs, a standard set of materials will be developed that can be subsequently adapted to country-specific settings. These materials are scheduled to be developed in October 2006. MMIS M&E staff met with Initiatives in September to begin planning the baseline prescription record review in Guyana. The initial trip for this activity is tentatively scheduled for November 2006.

### ***Training Database***

In addition to these special types of data collection, improvements have been made in tracking routine program data on the training of health workers. During the last two quarters, MMIS has developed a database in Microsoft Access that tracks training data for each country. Data from prior years has been entered into this database so that, beginning with this annual report, the project will be able to report on the cumulative number of workers trained as well as the training in each specific reporting period. Training activities in this report include all training of trainers, health providers and other workers in injection safety, interpersonal communications, logistics, procurement, and waste management.

During this same period, an intensive effort has been made to collect denominator data so that the raw training numbers can also be presented in terms of the proportion of each type of health worker to be trained in a given country. Training denominators are presented, where available, for facilities in 'covered' geographic areas. Constraints faced in gathering this denominator data include high facility staff turnover, difficulty classifying workers, poor or inaccessible staff records in facilities or local health

offices, and difficulty collecting data in geographic areas where MMIS is not yet working, but the project is making its best effort at providing denominators.

MMIS has also collected information on numbers of facilities and geographic areas in which the project has initiated its interventions in order to show how coverage is increasing over time toward the goal of national coverage.

As is clear from the list of activities, data collection and analysis efforts have ramped up in FY 2006. To meet the increased need for assistance in these areas, MMIS hired two additional staff as full-time Associate Technical Officers in Monitoring and Evaluation in June 2006.

For more country-specific activities, please refer to the country reports.

### **Task 8: Conference Participation**

The MMIS project continues to strengthen its role as a global leader in injection safety through consistent presence at key international conferences and meetings of cross-cutting areas including HIV/AIDS, infection prevention and control and other public health topics. Conference participation gives the project an opportunity to share data and lessons learned from implementation while also establishing itself as an authority on injection safety among partners and other organizations.

The *annual international meeting of the Safe Injection Global Network (SIGN)*, a coalition of safe injection experts from around the world, was convened in Hanoi, Vietnam from November 14-16, 2005. The successful participation of MMIS in the 2004 SIGN meeting, led to the project's invitation to participate in the meeting. Dr. Jules Millogo, Project Director, Ms. Vanessa Richart, Technical Officer, and several MMIS country teams, together with host government counterparts from Nigeria, Ethiopia, Côte d'Ivoire, and Rwanda, presented an update on the project's work and shared recent programmatic successes, innovative approaches, and challenges.

The Nigeria team's presentation was given by Dr. Antonia Idowu Erinle of the Department of Hospital Services of the Federal MOH and featured the successful injection safety champion program being implemented at state, district, and national levels. Due to a last minute conflict in schedule, the Ethiopian MOH counterpart was unable to attend. MMIS Ethiopia Country Director Dr. Solomon Worku presented on the efforts to establish a sustainable injection safety program in Ethiopia in his place. Dr. B. Guessan Bi, Director of Population and Community Health, Ministry of State and Ministry for Health and the Population, presented on behalf of MMIS's efforts in Côte d'Ivoire. Dr. Bonaventure Nzeyimana of the Quality Assurance Unit from the Rwanda MOH presented on leveraging efforts in Rwanda to improve and promote safe health care waste management. Based on the success of MMIS participation in the past two SIGN meetings, participation in the 2006 meeting in October of 2006 is planned. Representatives from



*MMIS/Mozambique's Poster Presentation on Participatory Training Methods for the PEPFAR Implementers Meeting.*

MMIS/HQ, as well as Mozambique, Uganda, Botswana, and Haiti are scheduled to attend and present at the meeting.

In March 2006, Dr. Jules Millogo, Project Director, presented an overview of the MMIS project at CDC-sponsored *International Conference on Emerging Infectious Diseases (ICEID)*. The conference brings together public health professional to encourage the exchange of scientific and public health information on global emerging infectious disease issues. Major topics include current work on surveillance, epidemiology, research, communication and training, bioterrorism, and preventions and control of emerging infectious diseases, both in the United States and abroad.

In June 2006, MMIS country directors and staff participated in the *PEPFAR 2006 HIV/AIDS Implementers' Meeting* in Durban, South Africa, using the opportunity to learn from other programs while sharing their own experiences. Hosted by the Office of the U.S. Global AIDS Coordinator (OGAC), the conference discussed the successes and ongoing challenges of the rapid expansion of HIV/AIDS services around the world. Conference sessions allowed implementers to share lessons learned during the implementation of HIV/AIDS programs, focusing on the areas of prevention, treatment, care, and cross-cutting issues. MMIS's participation included three oral presentations: MMIS/Ethiopia Country Director, Solomon Worku's *Impact and Sustainability of Injection Safety Interventions in Ethiopia*; MMIS/Uganda Country Director, Victoria Masembe's *Rational Injection Use Study in Uganda*; and MMIS/Rwanda Country Director, Mamadou Adama Diallo's *Leveraging Partner Resources to Support Improved Waste Management Systems in Rwanda*. Additionally, the following were selected for poster presentations: MMIS/Mozambique Country Director, Américo José Ubisse's *Participatory Training Methods: Improving Capacity of Injection Providers in Mozambique*; ; MMIS/ Nigeria Country Director, Abimbola O. Sowande, *Use of Qualitative and Quantitative Assessment Findings for Developing the National Behavior Change*; and MMIS/Haiti Country Director, Gerald Lerebours' *Improving Health Care Waste Management Through Partnership in Haiti Communication Strategy in Nigeria*; and AED Senior Program Officer Rebecca Fields' *Reducing Unnecessary Medical Injections: Implications for Action From Formative Research in 10 Countries*.

In July 2006 Dr. Millogo also presented at the *7th Annual Congress of the International Federation of Infection Control (IFIC)* in Stellenbosch, South Africa. His presentation focused on the project's technical approach and shared data from the project's implementation, including health care worker safety data from Ethiopia and injection prescription prevalence data from Uganda. MMIS staff also distributed project information via one of the meeting's information booths.

MMIS Country Directors and HQ staff attended the *Country Directors Meeting* in July 2006 in Arlington, VA. Representatives from USAID, CDC, SIGN, WHO/AFRO, IASIT) and other PEPFAR partner organizations had an opportunity to meet with country directors to share experiences and focus on the theme of the meeting: "*Towards a common understanding of nationwide coverage and how to achieve it.*" The meeting's interactive sessions focused on the project's technical approaches and strategies for expanding each to national scale. Following the three day external event, JSI hosted the Country Directors and subcontracting partners PATH, AED and Manoff for two days of internal meetings to address administrative and programming issues.



MMIS staff discuss scaling up to nationwide coverage at the MMIS Country Directors Meeting in July 2006.

MMIS/Rwanda Country Director Dr. Mamadou Adama Diallo presented on his team's successful *partnership for Healthcare Waste Management with the World Bank* at the Bank's Headquarters in Washington, DC. The presentation was well received and is hoped to serve as a model for future partnerships.

### **Communications and Knowledge Management**

Over the past project year, the Communications Team has focused on determining key information needs of USAID and CDC, project partners, and project staff, developing standard products and templates to efficiently share information from the project, and further developing the project website.

Core materials for project documentation have been identified and development was initiated for several products. Project documentation has been categorized between outreach and technical products. Products developed included: Case Studies for four country programs (Ethiopia, Nigeria, Rwanda, and Tanzania), a quarterly Program Highlights piece, monthly Injection Safety News, occasional Issue Briefs (initial procurement brief) and success stories (Uganda, Botswana, Kenya). Additional products under development include a recommendations paper on waste management partnerships (Rwanda), as well as additional success stories, issue briefs, and other program documentation for all project countries.

In early July 2006, Mr. John Nicholson, Communications Program Coordinator and Mr. Mike Wang of PATH traveled to Kenya to work with the MMIS/Kenya team to both document and photo-document MMIS program activities in Kenya. Mike Wang is a professional photographer by training and provided technical support in taking a diverse group of photos that captured many of the MMIS technical approaches. Final photo selection and program documentation are being finalized and are expected to be completed by the end of 2006. This activity is intended to serve as a model for future documentation efforts. Expected documentation products include success stories, program highlights and an outreach case study.



*A photo by Mike Wang of injection safety supplies being offloaded at the KEMSA warehouse in Nairobi. Wang's photos will be used to supplement success stories and in the project's communications' products.*

The Case Studies provide in-depth detail about the HIV/AIDS and injection safety situations in each country as well as what MMIS is doing to address specific challenges. Additionally, the project has released two editions of *MMIS Program Highlights*, a quarterly publication that shares programmatic approaches from across the project with partners, funders, stakeholders and staff. The MMIS website, which was officially launched in September 2005, has been updated regularly and will undergo further refinement to maximize its usefulness to the injection safety community and field staff during late 2006.

The Communications Team is planning to expand and update website content and partner with other injection safety-related organizations (i.e. SIGN, project partners, etc) to cross-link content for improved usability.

The knowledge management and global advocacy components of the communication strategy continue to be implemented. CDC and global branding guidelines have been completed, with USAID branding plan nearing finalization. The audience survey was completed in August 2006 and the impact on MMIS communications efforts is being discussed.

## **B. Country Activities: to October 2005–September 2006**

### ***Ethiopia***

The MMIS project in Ethiopia works closely with the MOH as well as other stakeholders to strengthen existing injection safety programs and promote the safety of health care workers. During the reporting period from October 2005 to September 2006, a national assessment on the state of health care waste management in health facilities in Ethiopia was conducted and was used to inform the drafting of HCWM guidelines and policy. An assessment of current BCC activities was conducted and the data used to develop a multi-year BCC strategy for the remainder of the project timeframe.

Key activities related to injection safety commodity procurement, training and capacity building, and health care waste management continued in the pilot areas of the project (53 health facilities in the Oromiya and SNNP regions). In the expansion areas, project activities have been introduced in all 89 health facilities in the Tigray, Harari, Amhara, and Dire Dawa regions. In these 6 regions, the project currently covers 22 hospitals and 120 lower-level facilities, which include health centers and health posts.

During the last half of this fiscal year and continuing into FY07, under the guidance of USAID/Ethiopia, MMIS plans to scale up project activities to 393 districts (woredas) in order to achieve national coverage. This includes 393 health centers as well as 1335 affiliated satellite health posts where ART, VCT, PMTCT, TB, and OI activities are starting to be implemented. Currently, the National HIV/AIDS coordination office has provided the project with a list of 297 health centers. The project expects to forge collaborative relationships with other PEPFAR partners to achieve this goal without duplicating efforts or available resources.

### ***Task 1: Commodity Management and Procurement***

- Between October and December 2005, an informal gap assessment on import volume of syringes and safety boxes was conducted to estimate future consumption and provide information for the country's five-year strategic framework.
- During FY 2006, a total of 4,000,000 syringes, 180,000 safety boxes, and 220 needle cutters were procured. Data available for April-September 2006 indicates that 1,018,800 syringes and 18,300 safety boxes were distributed to project sites.
- The MMIS logistics advisor provided technical assistance to a health facility in Harari to strengthen warehouse capacity and performance. Results included a 50% increase in storage space, disposal of expired commodities, and a redistribution of overstocked commodities to Harari regional stores. A similar exercise was conducted for the regional stores of Harari and Dire Dawa.
- The warehouse capacity improvement and performance activity will be scaled up to other health facilities and regional stores. A rapid assessment of warehouses was conducted, a proposal developed, and a fundraising meeting organized to help support and sustain this activity. To date, MMIS has provided pallets for this activity while partners have provided the following: JSI/DELIVER: training on warehouse management; ICAP-Columbia University: computers; and MSH/RPM+: office furniture.
- A common agreement was reached by MMIS and JSI's DELIVER project to provide assistance to each other in the following areas: LMIS, supervision visits to common woredas to improve stock level reporting, and warehouse improvement.

- In July 2006, MMIS/Ethiopia was selected for a consumption tracking study with the main objective being to determine the number of injections/person/year (per capita injection). Since then, 236 health facilities in the regions of Harari, Dire Dawa, Ada, and Adami-Tullu have been identified as data collection sites. A two-day training workshop was attended by 22 supervisors from the selected districts. Over 500 bin cards, 1,500 reporting forms, and 4,500 tick sheets were distributed to all health facilities in the selected districts.
- Six health facilities of Harari and Dire Dawa regions are now beneficiaries of the JSI/MMIS strategy of ensuring safe injection commodity security. All of these facilities have active Revolving Drug Fund (RDF) pharmacies. The main objective of this strategy (outlined in a memorandum of understanding (MOU) signed by heads of the RHBs and the health facilities) is to ensure the continuous and adequate availability of single use syringes by selling MMIS commodities at a reasonable mark up. The profit from the sales would be earmarked for the support of MMIS activities (waste management, provision of PEP, and hepatitis vaccinations). A total of \$19,000 worth of supplies was obtained for the RDF pharmacies of the six health facilities.

### ***Task 2: Capacity-Building and Training***

- During the first 6-month reporting period (October 2005 – March 2006), cascade training was conducted for health workers and waste handlers from the Harari, Oromiya, and SNNP regions.
- During the second 6-month reporting period (April 2006 – September 2006), cascade training was conducted on health workers and waste handlers from the Tigray, Amhara, and SNNP regions.
- From October 2005 to March 2006, training-of-trainer workshops were conducted for health workers from Dire Dawa administrative council and Tigray and Amhara regions.
- Discussions were initiated with the Carter Center and the Public Health Initiative Council on how to incorporate injection safety issues into existing health care worker training curricula. It was suggested that all training institutions be involved during the adaptation process of the injection safety training module developed by MMIS and WHO/AFRO.
- The MMIS Logistics Officer attended a three-week training course organized by JSI/DELIVER in Addis Ababa.
- Training activities are currently being conducted in health facilities in 10 woredas. As a result of discussions with USAID/Ethiopia on an expansion strategy to achieve nationwide coverage, woreda coverage is set to increase substantially during FY 2007. It is expected that training activities will be introduced to 393 woredas during this time period. In these woredas, TOT workshops will be organized for personnel at 393 health clinics. Subsequent cascade training workshops will reach health workers at another 1335 affiliated satellite health posts in those woredas.
- Training and facility coverage data for MMIS activities in Ethiopia is summarized in the following Tables 6 and 7.

**Table 6: MMIS/Ethiopia Facility Coverage as of October 1, 2006**

Region	Facilities Covered by MMIS*	Total Number of Facilities in Woredas Covered by MMIS	Proportion Covered by MMIS
Amhara (2 Woredas)	28	28	100%
Oromiya (2 Woredas)	31	31	100%
SNNPR (2 Woredas)	22	22	100%
Tigray (2 Woredas)	27	27	100%
Diredawa (1 Woreda)	12	12	100%
Harari (1 Woreda)	20	20	100%
<b>TOTAL</b>	<b>140</b>	<b>140</b>	<b>100%</b>

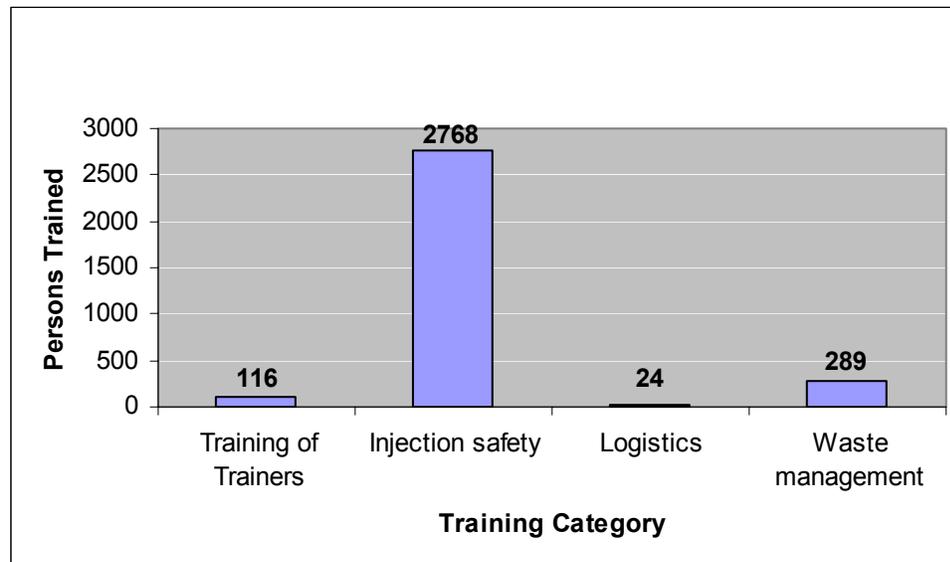
\*Includes 4 referral hospitals, as well as regional hospitals and lower level health facilities

**Table 7: MMIS/Ethiopia Number of Persons Trained by Category**

Training category	Persons Trained by MMIS (April – September 2006)	Persons Trained by MMIS to Date (Since September 2004)
Training of Trainers	0	116
Injection safety	1,137	2,768
Logistics	0	24
Waste management	125	289
<b>TOTAL</b>	<b>1,262</b>	<b>3,197</b>

Note: Country team is still in the process of collecting training denominators

**Figure 2: Ethiopia Training to Date (since September 2004)**



### ***Task 3: Behavior Change & Advocacy***

- MMIS produced and disseminated 2,000 desktop monthly calendars with 12 messages on medical injection safety practices to target health facilities of the project and partner organizations.
- MMIS produced and distributed 3,000 job aid posters, 3,000 pocket-size reference guides, 3,000 brochure, and 400 agendas to health facilities.
- The first three issues of the quarterly “Dewel” newsletter were published and distributed to all MMIS project sites and partner organizations in both English and Amharic. During the third quarter, approximately 1,000 copies of the third newsletter were distributed to project sites, policy makers, and pre-service institutions.
- The team participated in an expo on December 1, 2005, organized by USAID during the World AIDS Day Symposium in Addis Ababa and a US Government Partners Meeting on December 15, 2005, attended by the President of Ethiopia, the Minister of Health, and US Embassy officials.
- In March 2006, the MMIS BCC advisor attended a one-day meeting of the Ethiopian Emergency AIDS Plan (ETEAP) committee, consisting of BCC PEPFAR partners. The objective of the meeting was to share resources and lessons learned, establish a forum to create linkages for strengthening programs, and ensure coordination among PEPFAR partners.
- A two-hour program on injection safety for the general public was produced and broadcast on FM radio on World Health Day 2006. The program consisted of informing the public about unsafe injections and the importance of protecting children from the hazards of used sharps and needles, as well as proper management of sharps waste.
- A panel session on injection safety was conducted during the annual Ethiopian Public Health Association (EPHA) meeting in October 2005 and during the annual Ethiopian Pharmacy Association (EPA) meeting in January 2006. In addition, MMIS sponsored the Ethiopian Nurses Association (ENA) annual conference in November. During the meetings, discussions centered on how MMIS and the associations can work collaboratively to disseminate information regarding injection safety, the role of pharmacists and nurses in keeping stocks of injection safety devices, and how providers can improve injection safety in their settings.
- In April 2006, MMIS conducted a BCC monitoring study in 10 health facilities from pilot areas (Ada and Dale). The aim was to review and determine the effectiveness of BCC materials and identify critical gaps related to MMIS project objectives.
- The results of the BCC monitoring study were used to develop a multi-year BCC strategy at a workshop in Nazareth in June 2006. A total of 23 participants from the MOH, RHBs, National Injection Safety Taskforce and partner organizations contributed to the development of the strategy. As part of a south-to-south collaboration, the BCC advisor from Botswana participated in this activity.
- In June 2006, the MMIS country director attended and presented at the PEPFAR Implementers Meeting in Durban, South Africa. The title of the presentation was “Impact and Sustainability of Injection Safety in Ethiopia.”
- In June 2006, MMIS organized an exposure visit to a health facility for graduating nursing students from the Addis Ababa University Nursing School. A total of 93 participants and 2 instructors participated in the visit and half-day classroom session, which helped to orient students on best practices in injection safety and sharps waste management.
- In September 2006, discussions were held with the Medical Director and Administrator of the Adwa Hospital.

#### ***Task 4: Establishing a Standardized System for Proper Sharps Disposal***

- The International Conference on Injection Safety and Sharps Waste Management was hosted in Addis Ababa, Ethiopia in October 2005. Representatives from Ministries of Health, Ministries of Environment, and MMIS from 12 countries collaborated to develop practical strategies for health care waste management.
- A national HCWM assessment was conducted in 141 health facilities between January and March 2006. In May 2006, the final report from the national HCWM assessment was completed. The document was circulated to key stakeholders for comments and national health care waste management guidelines were drafted. In August 2006, the first national HCWM partners' meeting was conducted. The assessment outcome and draft national HCWM guidelines were reviewed. Minimum HCWM standards were developed, and a national HCWM work plan was developed and endorsed by participants.
- Technical guidance on incinerator maintenance continues to be provided to project health facilities. These activities took place in the Oromiya, Dire Dawa, and SNNP regions, and appropriate maintenance has been carried out.
- Supervisory visits were conducted in 3 hospitals and 2 health centers of the expansion sites. Facility heads were informed of the findings so that service quality in HCWM can be improved at their facilities.
- District-level supervisors were trained in the SNNP Region on injection safety and HCWM so that they are now able to conduct supervisory visits of health facilities and provide on-the-job training in a continuous manner.
- MMIS/Ethiopia continued to procure and distribute HCWM commodities. These commodities include: safety goggles, helmets, dust masks, heavy duty gloves, plastic aprons, plastic boots, and color-coded bins.
- The waste handlers training manual developed by PATH and adapted at the country level was translated to Amharic and distributed to health facilities.

#### ***Task 5: Private Providers and the Informal Health Sector***

- To enhance the participation of the private sector in the consumption tracking study described in Task 1, a two-day training on injection safety was conducted for health workers from private and NGO health facilities.
- In September 2006, MMIS/Ethiopia partially sponsored the second annual conference of the Medical Association of Physicians Public-Private partnerships (MAPPP). As part of its advocacy efforts, presentations were made by MMIS on health care waste management, the global and national situation of injection safety, and current plans for sustainability of the MMIS project in Ethiopia.
- In September 2006, a consultant was hired to perform a literature review of material and information on informal health sector injection practices with the aim of guiding the development of appropriate strategies targeting the informal sector.

### ***Task 6: Policy Environment***

- Good relations have been established with PEPFAR partners (including JHPIEGO, INTRAHEALTH, FHI, and MSH) and MMIS is participating in three subcommittees established under the network: BCC, IP/UP, and blood safety.
- The Second Annual Review and Partners Meeting was conducted in Nazareth in February 2006. Stakeholders, including the Ministry of Health, were provided a summary of activities accomplished during the prior year and future activities planned for the upcoming 18 months.
- In April 2006, the National Injection Safety Task Force of Ethiopia (NISTF-E) met to introduce the new NISTF-E chairperson, review the annual MMIS progress report (April '05 – March '06) and review the MMIS workplan (April '06 – September '07).
- The logistics advisor provided a review of the draft “Administrative Drug Disposal Guidelines,” which have been developed to solve problems associated with the disposal of damaged and expired drugs in health facilities.

### ***Task 7: Monitoring and Evaluation***

- Supervision visits took place in more than 20 health facilities. These visits took place in Dilla, Sodo, Arbaminich, Gurmo Koyisha, and Mesenkella health facilities.
- Baseline qualitative and quantitative assessment reports of the injection safety situation in the new expansion sites were provided by a consultant and are under technical review.
- The follow up assessment report covering the pilot project sites was completed and reviewed. A comparison of these results and the initial project area baseline was presented to USAID at the PEPFAR Partners Meeting in April 2006.
- Ethiopia also served as the site to field test a new tool for monitoring the effectiveness of BCC materials at health facilities. This data collection will serve to inform the next stage of development of the BCC monitoring as well as aid in developing a multi-year BCC strategy.

### ***Challenges***

The high turnover of trained health care workers and a lack of storage space for supplies at the health facility level remain challenges for the program. The warehouse improvement plan may help alleviate the latter problem as health facility managers/pharmacists are trained to better manage their current inventory.

Additionally, woreda health officials pay little attention to completing reporting forms, which are necessary to provide the data on supplies. This is compounded by the fact that inadequate supervision exists by the woreda supervisory committee at the regional and woreda levels. Training of district-level supervisors to perform supervisory visits in the last quarter is a step towards building the capacity needed to address this issue.

In most health facilities, the responsibilities of coordinating HCWM activities are given to a single individual. In fact, this practice hinders the advancement of HCWM activities because usually the additional workload is too much for only one person. The project is currently trying to establish HCWM committees in health facilities so that they have the overall responsibility of overseeing activities related to waste management.

Issues surrounding inconsistent reporting on stock quantities have begun to be addressed, but continue to affect the ability of the project to correctly forecast future commodity procurements.

Major areas of focus currently include the issue of sustainability of supplies and the inclusion of injection safety issues in the existing curricula of health care workers. Ownership of the issues by the MOH at this stage of the project is of vital importance.

The revised scale up plan, as proposed by the USAID/Ethiopia, will be a great human resource challenge to implement, as the health centers identified are very scattered and under-staffed. Additionally, coordinating training sessions at the central level will be difficult. To address this, the project plans to use a pool of facilitators from different regions to serve as trainers at health facility and district levels.

## **Mozambique**

For the reporting period between September 2005 and September 2006, MMIS/Mozambique has worked closely with the Ministry of Health (MOH) at the central, provincial, and health facility level to promote MOH ownership of the program. During this reporting period, MMIS established sub-committees for each technical area. These committees are instrumental in inter-departmental coordination within the MOH and create synergy among various partners who work in injection safety and infection prevention and control (IPC). The Mozambique Team continues working to integrate training activities into the national health system through the involvement of the MOH Training Department and training institutes at both provincial and national levels, as well as other MOH departments. A draft BCC strategy was developed and is being finalized to incorporate suggestions from the MOH and other partners. The project continues to work with the MOH and health facilities to promote segregation and safe disposal of sharps waste. In the policy review and subsequent implementation, MMIS's contribution to improved injection safety was not limited to the review of STI Protocol, but also included development of training material as well as the organization of training courses for health workers.

### ***Task 1: Commodity Management and Procurement***

- MMIS has coordinated various stakeholders and MOH departments involved in supply procurement and logistics to ensure synergy and sustainability based on the National Health System Standardized Management Style.
- The MMIS/Mozambique team, in coordination with the MOH and provincial directorate of health, has successfully promoted good stock management practices at project health facilities to ensure no stock outs of auto-disable (AD) syringes. This success serves as an example to injection providers and store managers in expansion sites.
- The Procurement and Logistics Subcommittee was established in early 2006. The subcommittee is under the leadership of the Deputy National Directorate for Administration and Management (DAG). MMIS is assuming responsibility of secretariat services. The terms of reference for the subcommittee have been developed and distributed among members.
- The Logistics Advisor worked in close collaboration with MOH authorities and relevant government department to ensure proper follow-up and delivery of injection safety equipment, including AD syringes and needle removers.
- Between October 2005 and March 2006, over 250,000 syringes, 8,525 safety boxes, and 14 needle removers were distributed facilities in Nampula, Quelimane, Xai-Xai, and Mavalane Cities.
- Discussions with Central Medical Store personnel led to the rapid distribution and storage of injection safety material in the new scale up areas with MMIS providing technical support.
- Four supervision visits (one visit per pilot site) were conducted in the Maputo, Gaza, Nampula and Zambezia Provinces in order to restart the implementation of injection safety activities through the national health system.
- In addition to the supervision visits, the Logistics Advisor monitored the distribution of injection safety supplies at the intervention before restarting activities.
- Visits to 3 of the 7 expansion provincial capitals Sofala (Beira City), Manica (Chimoio City) and Maputo (Matola City) were completed.
- Despite the temporary MOH-initiated cessation of the project's injection safety interventions, MMIS was able to maintain a minimum level of control on supplies issues. This was possible

due to the MOH officers at provincial level, who continued providing MMIS with relevant logistic information, including written reports.

### ***Task 2: Capacity-Building and Training***

- Between October 2005 and April 2006, training continued in coordination with both MOH and NGO partners. The activities were conducted via provincial injection safety technical groups (ISTG) and with involvement of infection prevention and control (IPC) task force members. The Mozambique Team, including a new technical officer, focused on training, worked to integrate training activities into the national health system through the involvement of the MOH Training Department and Training Institutes at both provincial and national levels and other MOH departments.
- An interactive CD-ROM for facility-based training-of-trainers, including all training materials, was produced. The Mozambique Team has begun exploring local resources to assist in the development and production of a large quantity of CD-ROMs with training materials for use by the MOH and partners in expansion areas.
- Preliminary information was collected and links were established for planned rapid assessment of prescriptions and prescribers' behaviors.
- MMIS participated in a meeting to establish a training subcommittee that was formalized in April 2006. The relevant documents, including proposed terms of reference and a list of members, were distributed among the selected members of the proposed training subcommittee.
- No trainings were conducted between April and June 2006 due to the negotiations to restart project implementation. During this hiatus, MMIS/Mozambique staff worked to refine training materials, as well as develop new training strategies and approaches that correspond with the MOH approach and reinforce the provision of on-the-job training for health workers using TIPS methodology, peer education, and adult learning principles.
- In September 2006, training courses for health workers were conducted in Bilene District, Gaza Province. The first course trained staff from 11 health facilities on injection safety, infection prevention and control, logistics, and waste management. The second training course focused on interpersonal communication.
- The MMIS/Mozambique Country Director gave a poster presentation at the PEPFAR Annual Meeting in Durban, South Africa in June 2006 on the participatory training techniques implemented by MMIS in Mozambique.
- Emphasis was placed on the need to have operational working systems, training strategies and approaches in place. This exercise is ongoing and is aimed towards the Provincial Director of Health, Medical Chiefs, and nurses. Supervision would come from the central, provincial, and district level.
- MOH and DPS staff involved in organizing training activities initiated a new strategy that emphasizes the organization of training for health workers in their own health facilities.
- Regularly held joint review meetings with all of the stakeholders in IS/IPC activities were organized per province. These meetings facilitate a dynamic exchange of learning experiences among the implementing partners.



*Participants of the TOT course in Nampula.*

- Training and facility coverage data for MMIS activities in Mozambique is summarized in the following tables.

**Table 8: MMIS/Mozambique Geographic Coverage Nationwide as of October 1, 2006**

Province/City	Districts Covered by MMIS	Total Number of Districts	Proportion Covered by MMIS
Gaza Province*	2	12	17%
Nampula Province*	2	21	10%
Zambezia Province*	2	17	12%
Maputo City/Mavalane Health sub-area	1	3	33%
<b>Subtotal</b>	<b>7</b>	<b>53</b>	<b>13%</b>
Remaining Provinces (7)	<b>0</b>	<b>91</b>	<b>0%</b>
<b>TOTAL</b>	<b>7</b>	<b>144</b>	<b>5%</b>

\*In these provinces, provincial capital cities are counted as '1' District.

Note: Expansion in FY07 will include 40 new districts of 80 designated HIV/AIDS 'priority' districts in Mozambique.

**Table 9: MMIS/Mozambique Facility Coverage as of October 1, 2006**

Province/City	Facilities Covered by MMIS*	Total facilities in Districts covered by MMIS	Proportion Covered by MMIS
Gaza Province (2 Districts)	18	18	100%
Nampula Province (2 Districts)	20	20	100%
Zambezia Province (2 Districts)	10	10	100%
Maputo City (1 Health sub-area)	11	12	92%
<b>TOTAL</b>	<b>59</b>	<b>60</b>	<b>98%</b>

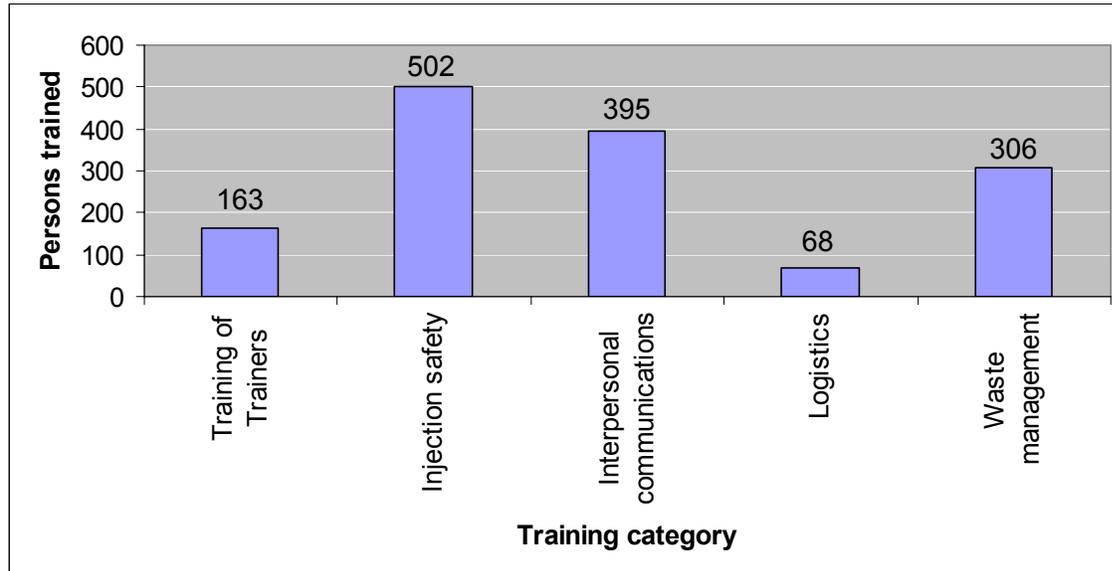
\*Includes public hospitals and lower level facilities.

**Table 10: MMIS/Mozambique Number of Persons Trained by Category**

Training Category*	Persons Trained by MMIS April-September 2006	Persons Trained by MMIS to Date (since September 2004)
Training of Trainers	0	163
Injection safety	19	502
Interpersonal communications	33	395
Logistics	0	68
Waste management	0	306
<b>TOTAL</b>	<b>52</b>	<b>1,434</b>

\*There are 7,009 health workers in the provinces covered by MMIS, but it is not yet clear what proportion of them should be included in injection safety training denominators.

**Figure 3: MMIS/Mozambique Training to Date (Since September 2004)**



### ***Task 3: Behavior Change and Advocacy***

- The Mozambique Team is moving forward to formalize a national BCC subcommittee.
- A draft of the BCC strategy was completed and translated into Portuguese. The final draft has been given to MOH and partners for final comments.
- Injection safety BCC materials (e.g. posters, calendars, etc) that target prescribers, health workers, and clients/patients were developed and tested with the involvement of the MOH. The materials were tested in two selected project sites at Mavalane Health District in Maputo and Quelimane City. Prior to being finalized and printed, the materials will also be shared with other key players in the field of infection prevention and control for their comments prior to being finalized and printed. The BCC materials were approved by the MOH and are in the process of production. The material being printed will be distributed in both pilot and expansion project areas.
- As a result of meetings and discussions with the MOH, a need for increased advocacy was identified. The project intends to focus on the project expansion areas and, in particular, to discuss future injection safety activities planned with the directors of the seven (7) remaining provincial capital cities. Discussions were held with the Chief of the Nursing Department to determine the most effective means of involving the provincial directors in the project's plans.
- MMIS Mozambique Country Director and a senior MOH Officer visited all seven provincial capital cities to inform the Provincial Directors of Health about the inclusion of their provinces in the scale up of injection safety activities. The MMIS project was presented in three of the new scale up project areas: Maputo Province (Matola City); Sofala Province (Beira City) and Manica Province (Chimoio City). Presentations are planned for the remaining project scale up areas, which are: Tete, Lichinga, Pemba, Inhambane, and Maxixe.
- Mr. Mario Marrengula, the new BCC advisor, was hired and began work in April 2006.
- MMIS/Mozambique participated in discussions for the national communication strategy for HIV/AIDS – CNCS/JHU.

- MMIS/Mozambique participated in the USAID S08 Partner Coordination Meeting.
- Contact was established with DANOSA for the June nursing conference for future south-to-south collaboration.
- Training is being modified to place a greater emphasis on on-the-job training, and combine the trial of improved practices (TIPS), adult principles of education, and peer education techniques. Advantages of on-the-job training are the interaction between the facilitator and the health workers in their own environment and the ability to directly apply newly-learned practices. Additionally, on-the-job training does not interrupt the provision of health services because the health workers are always in their usual workplace, giving the facilitators an opportunity to better understand the environment in which health workers are providing the health services.

***Task 4: Establishing a Standardized System for Proper Sharps Disposal***

- MMIS provided technical assistance for construction of approximately 71 needle pits in Xai-Xai, Mavalane Health Area, Nampula, and Quelimane, completed between October 2005 and March 2006.
- The project continues to promote the safe management of medical waste, which includes protecting waste treatment areas with fences so that sharps waste is not a serious threat to public or the environment.
- A Waste Management Subcommittee was established and terms of reference were defined. The committee has already started working on key policy documents for waste management.
- Supervision visits were conducted at the project sites, resulting in key action points and recommendations for practical waste management solutions in the designated areas.
- Waste management strategies are under development with technical assistance from PATH.
- To fill the gap of relevant supportive technical information on the needle remover devices currently in use in the project sites, MMIS prepared and provided a package of technical information on needle removers to the following partners and stakeholders: MOH, IPC Task Force, JHPIEGO, USAID, WHO, and UNICEF.
- MMIS/Mozambique focused on the development of a revised draft of HCWM policy and strategy, and a revised draft of Technical Guidelines on HCWM. These revised documents were submitted to MOH/ Environmental Health Department.
- A model for a protected (fenced) infectious waste pit was designed and MMIS/Mozambique has identified a company to build waste treatment areas at some health facilities.
- The conditions of the waste management treatment areas in all the health facilities in the Bilene District were assessed. The Waste Management Advisor conducted visits to ensure improvement of the treatment areas. About 11 waste management treatment areas in all facilities of Bilene District were improved through the addition of fences to protect the areas. Visits indicated that sites in Bilene are following the WM technical recommendations document and the segregation of the waste is done from the point of production to the point of disposal.
- The MMIS/Mozambique Waste Management Advisor, Country Director, and Health Project Officer participated in the WHO-sponsored Maputo Regional Workshop on Waste Management. Members of the MMIS/Botswana Team were also represented at this meeting and met separately with the MMIS/Mozambique Team to share experiences in waste management and strategic approaches.

### ***Task 5: Private Providers and the Informal Health Sector***

- To address the role played by the private and informal sectors, two main networks of institutions that are working with those sectors have been identified: the Business Against AIDS (Eco-SIDA) and the Association of Traditional Healers of Mozambique (AMETRAMO). The MOH has been engaged in this initiative, and MMIS has conducted preliminary discussions with both groups. During the discussions, it was clear that the initiative of working with the private and informal sectors will be done not only with those two institutions, but also in close coordination with other stakeholders and partners, including the MOH.
- MMIS made several informal contacts with key people from both the public and private sectors to gain understanding of the informal sector's working environment in Mozambique. Informal meetings with MOH staff were held in order to understand the MOH vision of the informal sector.
- A draft report of the literature/policy review on the informal sector is being finalized by the hired consultant and will be available by the end of the year.

### ***Task 6: Policy Environment***

- The Mozambique Team collected relevant policy documents and guidelines with the intention of assisting the MOH in refining or implementing them as needed. Examples include: Bio-safety and Safe Injection Policy, Policy on Biomedical Waste Management, STI Clinical Guidelines, and the revised STI treatment algorithm.
- During this reporting period, MMIS has worked to improve relationships with stakeholders and to improve technical coordination with all groups supporting the MOH in the implementation of infection prevention and control, injection safety, and waste management activities.
- The Mozambique Team participated in various meetings held with the USAID local mission, MOH, and United Nations agencies. Also, meetings were organized to build partnerships with NGOs involved in IPC activities, including JPHIEGO, Project HOPE, Save the Children USA, WHO, UNICEF, Columbia University, MSF Sweden, MSF Luxemburg, and Village Reach.
- In December 2005, the Country Director participated in the IPC Task Force Meeting.
- During the reporting period, MMIS successfully advocated to establish subcommittees for each technical area. The subcommittees serve as good channels to ensure more effective coordination with all interested parties that support the implementation of injection safety activities through the MOH.

### ***Task 7: Monitoring and Evaluation***

- Monthly reports were produced and sent to the USAID local mission outlining MMIS project activities.
- A baseline health facility assessment (HFA) was conducted in the expansion district areas in the project sites of Bilene, Mocuba, and Nacala Porto with technical assistance from MMIS HQ in planning and data analysis. The draft technical report is under review.
- The follow up HFA survey in the original pilot areas to develop lessons learned for strengthening program implementation is being planned for October and November 2006.
- MMIS continues to refine practical monitoring and supervision tools that were developed to gather key information related to the implementation of injection safety activities and to collect

data in the project sites. These tools will be used in the remaining seven provincial capital cities, which are areas of injection safety project expansion activities.

- The supervision checklist was translated and submitted to both the MOH and DPS for review. It was determined that separate but complementary supervision tools will be needed for each level, therefore each level will use its own checklist from the MOH, DPS and DDS staff in facilities.

### *Challenges*

In the initial stage of the project, MMIS was working in Mozambique with an agreement with Ministry of Foreign Affairs, not the MOH. During this reporting period, the project faced major administrative issues with a request from the Minister of Health to all cooperative agencies to sign an agreement document before being authorized to implement their activities. This decision affected the pace of implementation of MMIS activities for several months. With the support of USAID/Mozambique Mission, MMIS staff worked with the relevant departments of the MOH to develop a collaborative agreement between the MOH and JSI. However, through strong relationships with project partners, activities were maintained at a minimal level. Since the resolution and finalization of the agreement, activities have been fully reinstated with renewed support and engagement from the MOH.

## Nigeria

MMIS/Nigeria is currently focusing implementation in public health facilities to facilitate rapid expansion to sites in PEPFAR target states. With the addition of new staff, the project has strengthened its training and capacity building capability for scale up. The project is also conducting a mapping and micro-planning exercise for safe health care waste management in the target states/local government areas (LGAs). MMIS is building upon early successes by initiating exchange visits between health facilities to observe good practice and the program is actively pursuing collaborations with international organizations, national government agencies and ministries, as well as partners in the business sector.

### *Task 1: Commodity Management and Procurement*

- Injection safety commodities that have been received for FY 2006 include: 550,575 safety boxes and 15,344,600 syringes.
- As part of strengthening the Logistics Management Information System, 10,000 stock cards and 5,000 consumption/requisition cards designed by the National Logistics Sub-Committee on Injection Safety were printed. The cards are designed to facilitate gathering of consumption data at implementation sites; distribution of these materials is on-going.
- In the period of October 2005 through September 2006, 1,837,350 needles and syringes, 19,287 safety boxes, 360 needle cutters, 92 waste bins, and 200 request booklets were distributed in Lagos. Additionally, 8,500 syringes and needles varying types and sizes as well as 185 safety boxes were supplied to the State House Clinic Abuja (also known as the ASO Villa Clinic and where senior government officials receive medical care).
- From October 2005 to September 2006, 614,000 safety syringes were distributed to Cross Rivers State and 648,000 to Kano State. Approximately 2,500 waste bins of various colors to facilitate segregation of infectious waste and disposal were also received and distributed to intervention health facilities. Bin liners were supplied to Aminu Kano Teaching Hospital, Gwagwalada Specialist Hospital in FCT, and Mainland Hospital in Lagos. Injection safety commodities were also supplied to National Hospital Abuja.
- From July to September 2006 health care workers in Cross River and Edo States received training and injection safety commodities were delivered to both.
- As part of an initiative to effectively monitor injection safety stock distributed at all levels (LGA and facility level), MMIS established the Stock Monitoring Network (MMIS STOMONNET). This involves identifying one focal person to monitor stock in each implementing facility and making them responsible and accountable for commodities received.
- Both 21G and 22G 5ml, Kojak syringes are being registered with NAFDAC because of high demand by most of the MMIS implementing facilities.
- Meetings of the National Logistics Sub-committee were held throughout the year. The meeting included officers from Federal Ministry of Health, WHO, NPI, Pharmacists Council of Nigeria, and MMIS/Nigeria. The group discussed updates on commodities received and distributed; modalities for distribution of commodities from the central level to states tertiary, and private



*Injection safety commodities are presented by a USAID Official to the Nigeria Commissioner of Health.*

facilities; and involvement of members of the committee in stock monitoring at the different MMIS sites.

- In June 2006 representatives from MMIS/Nigeria met with the Managing Director of Salenab Nigeria Ltd., the largest private sector importer of European manufactured syringes, which is significant because the syringe market in Nigeria is private-sector driven. The purpose of the meeting was to better understand the efforts being made by the private sector to expand the acceptance and use of safe injection devices. Private sector importation of safe injection devices increases product availability which in turn can help support long term sustainability.
- As a result of advocacy with the Ministry of Health, a warehouse at the Federal Medical Store in Lagos was allocated to MMIS for commodity storage. Also, MMIS identified alternative warehouses for the storage of commodities in the Gwagwalada area and a regional store in Benin City to serve Anambra, Edo, and Cross River States.
- To support local production of safety boxes, MMIS/Nigeria, with technical assistance from PATH, conducted informal evaluations of safety box sample from local suppliers and provided manufactures with feedback to improve them.

### ***Task 2: Capacity-Building and Training***

- MMIS facilitated a training-of-trainers on supply chain management with 48 senior store keepers and pharmacists from 21 LGAs in Anambra State in November 2005.
- In April 2006, 30 pharmacists and senior store keepers were trained in Benin City, Edo State, while a similar training was conducted for 23 of the same cadre of staff in the health care system for Lagos State. Participants in both training exercises were selected from public health facilities within MMIS-covered LGAs and other PEPFAR sites in the two states. Key components of the training included logistics management information system, storage requirements, space calculation, receipts and issuing of commodities, assessing stock status, inventory control system, max-min. inventory control system, forecasting and commodity quantification, monitoring, evaluation, and introduction to injection safety devices.
- In a deviation from the initial phase of the project when health care workers of both public and private health facilities were trained at the four pilot local government areas, MMIS/Nigeria is now focusing on the public health facilities to facilitate the coverage of PEPFAR sites in six states.
- Between October 2005 and September 2006, training-of-trainers (TOT) sessions on infection prevention and control in the context of injection safety and health care waste management were conducted in Anambra, Cross River, FCT, and Edo States. In addition, health care workers were trained at facility level in Badagry and Ajeromi Ifelodun LGAs in Lagos State, Aminu Kano Teaching Hospital in Kano, and National Hospital State House Clinic in Abuja.
- MMIS also conducted a National TOT for 18 top management staff of registration bodies and senior tutors of health institutions in September 2006 in Abuja.
- MMIS has accelerated training activities by recruiting additional training consultants.
- Training and facility coverage data for MMIS activities in Nigeria is summarized in the following tables.

**Table 11: MMIS/Nigeria LGA Coverage Nationwide as of October 1, 2006**

State	LGAs Covered by MMIS	Total LGAs	Proportion Covered by MMIS
Anambra	2	21	10%
Cross Rivers	2	18	11%
Edo	8	18	33%
Kano	8	44	18%
Lagos	8	20	40%
Federal Capital Territory (FCT)	5	6	83%
<b>Subtotal</b>	<b>33</b>	<b>127</b>	<b>26%</b>
Remaining MMIS-targeted states (12)	0	TBD	0%
<b>TOTAL</b>	<b>33</b>	<b>TBD</b>	<b>TBD</b>

**Table 12: MMIS/Nigeria Facility Coverage as of October 1, 2006**

State	Facilities Covered by MMIS*	Total Facilities in LGAs Covered by MMIS	Proportion Covered by MMIS
Anambra (2 LGAs)	59	59	100%
Cross Rivers (2 LGAs)	47	47	100%
Edo (8 LGAs)	105	138	76%
Kano (8 LGAs)	79	128	62%
Lagos (8 LGAs)	154	243	63%
FCT (5 LGAs)	102	168	61%
<b>TOTAL</b>	<b>546</b>	<b>783</b>	<b>70%</b>

*\*Numbers include hospitals and lower level facilities of all types of ownership – public, private, NGO, FBO*

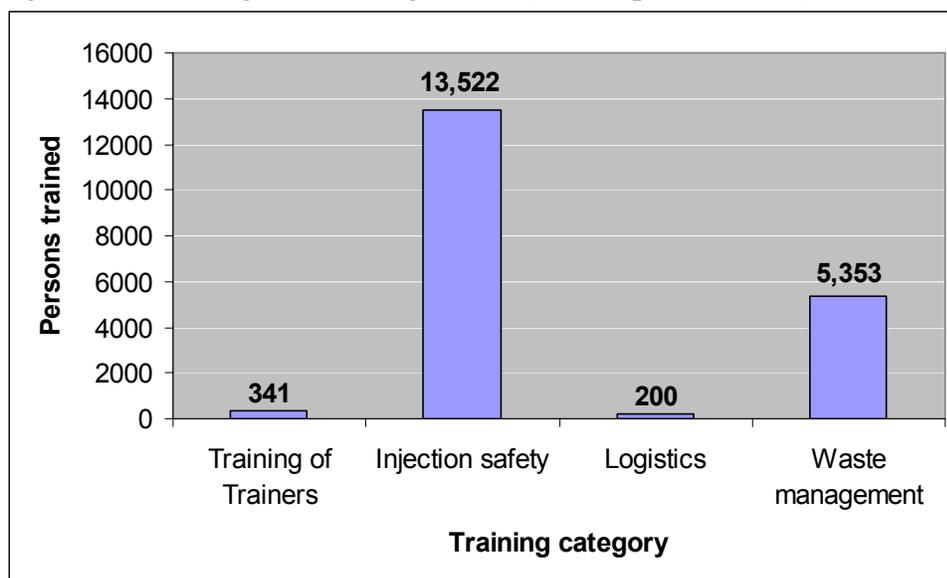
**Table 13: MMIS/Nigeria Number of Persons Trained by Category (April – September 2006)**

Training category	Persons trained by MMIS
Training of Trainers	18
Injection safety	8,458
Logistics	93
Waste management	4,159
<b>TOTAL</b>	<b>12,728</b>

**Table 14: MMIS/Nigeria: Number of Persons Trained by Category to Date (Since September 2004)**

Training category	Persons Trained by MMIS to Date	Total Health Workers in LGAs Where MMIS Works	Proportion trained by MMIS
Training-of-trainers	341	341	100%
Injection safety	13,522	16,886	80%
Logistics	200	230	87%
Waste management	5,353	9,079	63%
<b>TOTAL</b>	<b>19,416</b>	<b>26,536</b>	<b>73%</b>

**Figure 4: MMIS/Nigeria Training to Date (since September 2004)**



- MMIS is initiating an experience-sharing exchange visit between health facilities. Aminu Kano Teaching Hospital has a well-functioning infection control committee whose experiences will be shared with other states to promote post exposure prophylaxis and encourage hepatitis B vaccinations. As part of implementing the injection safety policy initially drafted by MMIS, the State House Clinic staffs are all fully vaccinated.

**Task 3: Behavior Change and Advocacy**

- The MMIS/Nigeria team has been collaborating closely with the National Agency for Food, Drug Administration and Control (NAFDAC) to facilitate the dissemination of messages to encourage the reduction of unnecessary injections and promotion of oral alternatives when appropriate. This has led to collaboration with NAFDAC in its grassroots mobilization campaign held in Keffi in Nasarawa State. These activities complement the project’s efforts to foster not only government ownership but also community participation in the project. In partnership with NAFDAC, MMIS organized a three-day Community Based Strategy Development Workshop in Kano to develop messages aimed at the community regarding injection safety. Developed messages targeting the community include: reducing the demand for unnecessary injections, promoting oral medication, safe waste management, and the importance of logistics and supply management. The group also discussed appropriate and effective channels for the delivery of these messages to the target audience.
- Collaboration with NAFDAC is continuing, especially in producing, airing and monitoring injection safety messages on the radio and safe waste management posters.



*A poster is pre-tested for storekeepers at General Hospital Badagry.*

- The Nigeria Behavior Change Communication Strategy, which was signed by the Minister of Health, has been produced and distribution to relevant stakeholders has commenced.
- The BCC materials developed and printed late 2005 were distributed to pilot sites and new scale-up areas, Materials include: posters, leaflets, and fliers on injection safety for providers and waste handlers, as well as posters for promoting use of oral medications targeting prescribers. A guideline for the proper placement of materials in health facilities accompanied distribution to focal facilities.
- Three new BCC support materials were designed, including pocket-size job aids for waste managers, supervisors, and health workers as well as a poster for pharmacists/store keepers. The materials were pre-tested in the four pilot LGAs and are currently being revised based on the pre-test findings.
- In order to evaluate and improve the BCC support materials already in circulation, evaluation tools in the form of questionnaires were adapted and produced. These were directed at injection prescribers, providers, waste handlers, and clients/patients. The evaluation was done in the four MMIS pilot LGAs of Ajeromi Ifelodun and Badagry in Lagos State, Gwagwalada in the Federal Capital Territory and Tarauni in Kano State. The purpose of the evaluation was to determine how the BCC materials had been utilized, check recollection of messages by target audiences, and assess how the messages had affected health workers' practices. It also included an individual client exit questionnaire for clients who had received treatment at the facility to determine to what degree prescribers were explaining the benefits of oral medications and practicing reduction of unnecessary injections.
- National injection safety champion Prof. Dora Mkem Akunyili made public awareness announcements on injection safety that have been aired on national television.
- A draft advocacy fact sheet for policy makers at all levels for support of injection safety was developed and is currently under review.
- MMIS conducted advocacy visits to support the project by meeting with the political and administrative heads in the new states of Anambra, Cross River, and Edo. The State Steering Committees on Injection Safety and Health Care Waste Management were inaugurated in these states with the Honorable Commissioners of Health as Chairmen.
- The MMIS/Nigeria Team attended a one-day advocacy and sensitization meeting for stakeholders on issues of injection safety and health care waste management organized by the Lagos State Ministry of Health.
- MMIS participated in and supported the Nigerian Medical Association Annual General Conference. Doctors were sensitized on the importance of reducing unnecessary injections and promoting oral medications.
- MMIS hosted the third editorial board meeting of the USAID.IT newsletter and contributed lead articles to the publication.
- The project participated in the 2006 West African Health Conference in Lagos that reached 300 health practitioners, mainly doctors, to encourage reduction of unnecessary injections and promotion of oral alternatives.

#### ***Task 4: Establishing a Standardized System for Proper Sharps Disposal***

- Health care waste management (HCWM) training was completed in Aminu Kano Teaching Hospital (AKTH), Kano State, Ajeromi-Ifelodun, Badagry and Tarauni LGAs between October 2005 and March 2006.
- With MMIS's influence, AKTH is taking initiative to improve sharps waste disposal through the construction of two new needle pits by hospital management.

- Segregation materials (color-coded waste bins and bin liners) have been procured and distributed to pilot LGAs to reinforce segregation concepts that were taught during training.
- A micro-planning workshop to facilitate mapping of the LGAs for waste management activities was conducted in Calabar, the Cross Rivers State capital in May 2006.
- Health care waste mapping was conducted in Edo State for the two LGAs (Oredo and Egor); in Kano State at Dala Orthopedic Hospital, IDH Kano, Murtala Mohammed Hospital, and Hasiya Bayero Hospital. The PEPFAR sites in Lagos state that the project is supporting that include Lagos Island LGA: Island Maternity Hospital, Lagos General Hospital, Massey Street Children's Hospital, Lagos Mainland LGA: Lagos Mainland General Hospital and National Institute for Medical Research (NIMR).
- MMIS/Nigeria participated in the State Action Committee on AIDS's (SACA) five-year strategic plan review retreat in Lagos State, providing input into Health Care Waste Management and advocating to include injection safety activities into the plan.
- The waste management plan for Badagry LGA was completed with technical assistance from MMIS.
- Technical assistance has been given to the CORRIDOR for installation of a DeMontfort incinerator at the Salvation Army Hospital, Seme. Plans are being made to install a second incinerator at the general hospital in Badagry.
- A safety box storage facility at Akere PHC in Ajeromi Ifelodun LGA was created during this reporting period.



*Operational De Montfort incinerator, Salvation Army Hospital, Seme, Badagry*

#### ***Task 5: Private Providers and the Informal Health Sector***

- Training and implementation is on-going, both at the private and public facilities; MMIS has trained health workers from 101 private facilities and 4 faith-based health facilities.
- A desk review of the literature on informal section injection practices was conducted and is under review.

#### ***Task 6: Policy Environment***

- MMIS/Nigeria participated in the strategic planning meeting of the Nigerian Business Coalition Against AIDS in Lagos. The meeting was convened to gather information from stakeholders concerning implementation activities for the next five years. A STEP and SWOT analysis was conducted to refine their strategy and map out ways to improve their services.
- The project has established relationships with several new officers at the Federal and Lagos Ministries of Health, including the new Public Health Directors at FMOH and in Lagos State to solicit support for injection safety.
- In a bid to improve the capacity of the State Action Committee on AIDS in Calabar, MMIS participated in their one year strategic work plan retreat in Cross River State. The strategic work

plan retreat was facilitated by FHI and DFID to strengthen the national response to the epidemic. MMIS/Nigeria promoted key activities in injection safety and health care waste management.

- The Government of Cross River State donated a large store for the injection safety commodities the project has supplied. Several advocacy visits were made to the Director of Nutrition and Family Health to gain support for the project and to chart the way forward with staff at the focal LGAs.
- MMIS/Nigeria made several advocacy visits to Federal Ministries of Health and Environment senior management officials to move the Health Care Plan and Policy Finalization forward. The process is still on going at the reporting time.
- Advocacy visits to the various focal state commissioners for health, state officials, and LGA Heads of Departments of Health were made by the project.
- MMIS continues advocate for the adoption of the draft National Policy on Injection Safety and Healthcare Waste Management by the Honorable Minister of Health's office.
- The project is also advocating for Chevron Texaco to support treatment of expected sharp wastes from the Lagos State measles campaign.

### ***Task 7: Monitoring and Evaluation***

- MMIS staffs (including training consultants) are devoting one week of every month for program monitoring at the implementation sites, which includes supportive supervision and on-the-job training to ensure skill acquisition and sustainable behavioral change from trainings. This is integrated across the technical areas of BCC, commodity and logistics management, and waste management to facilitate covering the maximum number of facilities each month.
- During the FY 2006, monitoring was done in Ajeromi Ifelodun and Badagry LGA in Lagos; Tarauni LGA in Kano; and Gwagwalada LGA in the Federal Capital Territory.
- During this period, MMIS/HQ assisted the Nigeria Team with responding to the USAID/Nigeria's request for a Performance Monitoring Plan (PMP).
- MMIS is institutionalizing supportive supervision by training the training facilitators on the use of the MMIS supervision tool. The facilitators, in turn, train the supervisors of the facilities.
- Technical review and finalization of the Nigeria expansion area baseline report has been delayed due to problems with the database and analysis, particularly in Section 3 (injection observations). Since this data provides the core of the project's indicators and will need to be compared to the midterm data later in 2007, MMIS/Nigeria is proceeding with data re-entered for Section 3, including a re-working of the analysis and report writing. A new consultant will be used for this process.
- In June 2006 MMIS/Nigeria trained teams of data collectors and completed data collection for the pilot area follow-up study. A total of 108 health facilities (including both public and private hospitals and lower-level facilities) were visited in 4 LGAs. The analysis and report writing of this activity are currently underway. Completion of the pilot area follow-up has been prioritized above the expansion area baseline report since the follow-up study will provide key information on progress in the project's key indicators.

### ***Challenges***

Low literacy levels of waste handlers in private and public clinic has been a challenge for the training of this category of personnel. In order to overcome this barrier, MMIS conducts on-the-job trainings followed by supportive supervision visits.

There was a major movement of LGA staff from the Lagos pilot sites to sites outside of the project's focal areas, which has slowed down programmatic activities during the transition period. Injection safety activities compete with major health priorities, including disease control and eradication activities. In addition, social unrest, including health workers strikes, make it difficult to maintain MOH and community focus on injection safety activities.

## **Uganda**

Working in close collaboration with the MOH, MMIS/Uganda successfully introduced the project's interventions in 6 expansion areas. A total of 4033 health workers were trained and a total of 7,260,350 needles and syringes and 83,362 safety boxes were distributed. A national stakeholders meeting was held to gain consensus on the way forward regarding health care waste management. One of the key outcomes of the meeting was the decision to develop a detailed national waste management action plan that can be leveraged for funding. BCC community outreach expanded through radio messages, community film shows and drama groups, and through members of the village health committees. Several stakeholders responded to requests for additional funding for injection safety activities, which includes CDC support for training in 10 districts, WHO support for training in an additional 10 districts, proposed USAID mission support for health care waste management in the MMIS districts, and construction by BD of 2 large-scale incinerators for the Mbale and Hoima Districts. Through project efforts, injection safety has been incorporated in several training curricula including; registered midwifery, registered general nursing, enrolled comprehensive nursing, public health dental assistants, Public Health Nurses College, Makerere Medical School (Yr IV), and the Infectious Disease Institute.

### ***Task 1: Commodity Management and Procurement***

- From September 2005 to September 2006 shipments containing a total of 14,280,800 syringes, 261,275 safety boxes, and 995 needle cutters were received by the National Medical Stores (NMS).
- A total of 7,260,350 syringes and 83,359 safety boxes were distributed between September 2005 and September 2006.
- Logistics review meetings were held in 8 MMIS districts (Mpigi, Mbarara, Pallisa, Hoima, Mbale, Manafwa, Ibanda, and Isingiro) between April and June 2006, with a total of 150 in-charge personnel attending. Review meetings were held in the form of one-day workshops in each district with the health unit in-charges, where the logistics system performance in each district was assessed, problems identified and solutions proposed. Challenges and potential solutions of the logistics situation of each individual health unit were discussed, including the delay in supply delivery, stock outs of various items, and challenges in reporting.
- During September 2006, an additional logistics review meeting was held in Mpigi. This one-day workshop was modeled after the other meetings with in-charge personnel earlier in the year and emphasized assessing the logistics systems' performance, addressing challenges and proposing solutions, and the importance of the Logistics Information Management System. A total of 45 supervisors attended the meeting.
- The MMIS/Uganda Team conducted a review meeting with the Manager of NMS in January 2006. During this meeting, it was agreed that the NMS will supply 20% of requested commodities with payments deducted from district credit line funds. MMIS will provide the remaining 80% of the commodities requested.
- Distribution of syringes and safety boxes to the four new districts (Hoima, Kabale, Mbale, Yumbe) in August 2006 was followed by rapid introduction of auto-disable (AD) syringes, which included opening stock cards for the different sizes of needles and syringes, demonstrating the use of AD syringes and safety boxes, and assessing the knowledge level of health workers that had been trained.
- A facility-level data collection form was designed and disseminated to all facilities receiving commodities from the project. Monthly data on consumption, quantity received, and quantity on

hand for syringes and safety boxes are collected on this form. A complimentary requisition was also introduced to ease the process of ordering refills.

- District stores managers and injection safety focal personnel were trained to correctly handle injection commodities, including proper storage, record keeping, timely ordering of commodities, and improved communication between individual facilities and the district health teams.
- In December 2005, the MMIS Senior Logistics Advisor provided technical assistance to the Uganda Team in the reviewing, recording, and reporting system from service delivery points to central stores and assisting in identifying the next steps needed to improve the logistics systems.
- The NMS intends to revise its billing system to handle fees charged on all MOH programs to reflect the behavior of different products against the various cost elements under warehousing and distribution functions. The new billing system, to be approved after review by MOH, is based on the volume stored and volume distributed at the end of each month.
- A National Stakeholders' meeting on procurement, distribution and use of re-use prevention injection devices in the curative sector took place in late September 2006 and was attended primarily by importers of pharmaceuticals, including syringes. Discussions were intended to sensitize importers, especially in the private sector, on the MOH policy of switching from standard disposable syringes to syringes with re-use prevention features in the curative services. In the same meeting, specifications for injection devices, including different types of needles, syringes, and safety boxes were developed and agreed upon. The drafted specifications will be presented to the national committee concerned with hospital equipment.

### ***Task 2: Capacity-Building and Training***

- Between September 2005 and March 2006, MMIS supported districts that had not yet finished training health workers in completing their training as well as expanding the training to new areas.
- Tutors from medical training institutions around Kampala were introduced to the Facilitator's Guide. They are included in MMIS training as a strategy for ensuring that pre-service training will include key concepts and improved practices in the area of injection safety.
- MMIS responded to requests from institutions and a district outside of the current project areas by including their staff in training workshops.
- A workshop, facilitated by a team from WHO/AFRO, was held with tutors from 20 different medical training institutions with the aim of assisting them to identify areas where injection safety could be incorporated within their existing training curricula. The tutors are in the process of making the necessary revisions for the identified areas.
- Health workers in expansion areas were trained in interpersonal communication skills as part of their injection safety training in workshops held between April through June 2006.
- Training and facility coverage data for MMIS activities in Uganda is summarized in the following tables.

**Table 15: MMIS/ Uganda's District Coverage\* Nationwide as of October 1, 2006**

Province	Districts Covered by MMIS	Total Number of Districts	Proportion Of Districts Covered by MMIS
Western	2	8	25%
Southwestern	5	10	50%
Eastern	5	20	25%
West Nile	2	7	29%
Central	6	16	38%
<b>Subtotal</b>	<b>20</b>	<b>61</b>	<b>33%</b>
Northern	0	9	0%
Semi-operational districts*	0	6	0%
<b>National coverage</b>	<b>20</b>	<b>76</b>	<b>26%</b>

\*Because Uganda is currently undergoing re-districting, the numbers of districts and their exact boundaries are not yet well defined.

**Table 16: MMIS/Uganda Facility Coverage as of October 1, 2006**

Province	Facilities Covered*	Total Facilities in Districts Covered by MMIS	Proportion covered by MMIS
Western (2 Districts)	132	132	100%
Southwestern (5 Districts)	278	278	100%
Eastern (5 Districts)	98	98	100%
West Nile (2 Districts)	72	72	100%
Central (6 Districts)	450	1100	41%
<b>TOTAL</b>	<b>1,030</b>	<b>1,680</b>	<b>61%</b>

\*Facilities include hospitals and lower level facilities of all ownership types: public, private, NGO, FBO.

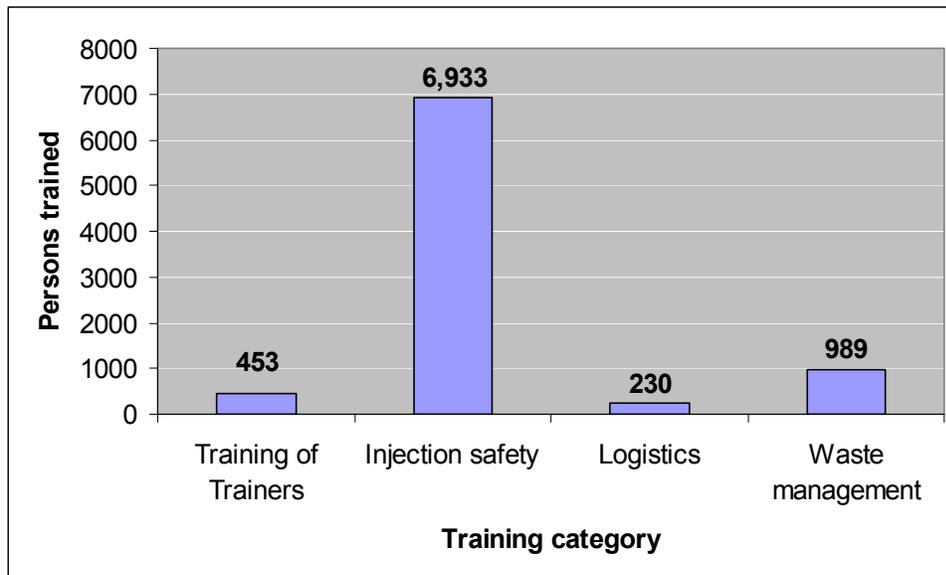
**Table 17: MMIS/Uganda Number of Persons Trained by Category (April – September 2006)**

Training category	Persons trained by MMIS
Training of Trainers	175
Injection safety	2,282
Logistics	230
Waste management	155
<b>TOTAL</b>	<b>2,842</b>

**Table 18: MMIS/Uganda: Number of Persons Trained by Category to Date (Since September 2004)**

Training category	Persons Trained by MMIS to Date	Total Number of Health Workers in the Districts where MMIS Works	Proportion Trained by MMIS
Training of Trainers	453	522	87%
Injection safety	6,933	13,304	47%
Logistics	230	897	26%
Waste management	989	1,744	57%
<b>TOTAL</b>	<b>8,605</b>	<b>16,467</b>	<b>52%</b>

**Figure 5: MMIS/Uganda Training to date (since September 2004)**



### ***Task 3: Behavior Change and Advocacy***

- Two BCC posters with targeted injection safety messages in a local dialect were developed, and the posters were pre-tested in areas where the respective languages are spoken. In January 2006, posters that promote oral alternatives to injections were translated into eight local languages and widely distributed to the relevant districts.
- Additional posters were developed for different audiences between July and September 2006. Posters on safe injection practices were developed for health workers in the new districts and posters on tablets have been developed for patients in health facilities. Also in development are wall charts targeting injection providers with the “rights” of injection safety, as well as a wall chart on waste management targeting health workers and health facility managers.
- Ongoing radio messages were translated into eight local languages and used across the project districts. In three districts, Nebbi, Mbarara, and Mpigi, eight talk shows were held and panelists were given copies of talking points to guide presentations. Between September and December of 2005, around 3,600 messages were disseminated in eight different languages on 14 radio stations.



*A large crowd gathers to view the injection safety video at a community film show using a mobile van.*

- New radio messages were developed and were reviewed by MOH officials and the MMIS/HQ team. These messages were aired by 12 radio stations beginning in August 2006. Five injection safety messages in the local languages per day will be aired through December 2006. Additional messages will be developed in December 2006.
- Awareness meetings were held with the District Local Councils and department heads of Mbale, Kabale, and Hoima. About 180 participants were sensitized on injection safety. Members agreed to follow up activities in their districts.
- A community video was developed for use in film vans. The video was launched in March of 2006. Between June and August 2006, about 53,556 people were educated on injection safety issues using mobile film vans in the Yumbe, Nebbi, Pallisa, Mbale, and Manafwa Districts. The community educational video was provided to various districts for translation into local languages. The next step is for the project to produce the community film in local languages.
- MMIS staff participated in the exhibition at the National Health Assembly. Policy documents were distributed to 70 Directors of District Health Services in the Assembly, and the team fielded questions on injection safety. Also, staff exhibited injection safety educational materials and devices at the ECSACON conference. At the conference, injection safety strategies, messages, and devices were shown to participants from 7 participating countries.
- In order to educate the general population on the dangers of unsafe injection practices, each district has identified and oriented 2 to 4 drama groups to spread injection safety and healthcare waste management messages. The groups have developed and performed community drama shows at sub-county level in various districts from April to June 2006. The community education through drama groups continued in the Kiruhura, Pallisa, and Manafwa Districts between June and August 2006.
- In April 2006, a review meeting was held at national level to review existing BCC and advocacy strategies and activities and to discuss achievements and constraints. A revised strategy combined the two and will guide BCC and advocacy efforts for both the project and non-project districts.
- Meetings with village health teams in Mpigi and Kabale Districts were held in order to raise awareness of injection safety at the household level. Village health teams were identified as instrumental in reaching households, and key lessons learned from the two districts will be used to scale up this approach in other districts.
- An awareness workshop was held with officers from the Ministry of Education. The participants generally agreed that the injection safety initiative should be given higher priority and that vaccination of students should be enforced in the training schools.
- An advocacy strategy was developed in August 2006 to promote AD syringes nationwide, in coordination with the introduction of AD syringes nationally. The implementation of this strategy is anticipated to begin in December 2006.

#### ***Task 4: Establishing a Standardized System for Proper Sharps Disposal***

- To reinforce the idea of waste segregation, over 6,240 color-coded waste bins, 415,000 bin liners, and 985 needle cutters were procured and distributed to health units in 13 of the Project's districts in this reporting period. MMIS/Uganda also distributed over 22,000 liters of kerosene for final waste destruction to intervention districts as well. All health facilities in Hoima and Mpigi Districts were mapped using GPS for the purpose of developing a district-level waste management system. PATH assisted the Uganda Team in developing maps showing various placement options. In March 2006, existing waste disposal options were identified from all units in the Hoima District using a checklist that was developed.

- In a Uganda National Injection Safety Task Force Meeting (UNISTAF) meeting, discussions were initiated with the MOH to establish mechanisms whereby each program contributes a percentage of funds towards safe health care waste management for each waste-generating activity implemented in the districts.
- As previously reported, the MOH decided that each facility should have self-contained waste management capacity so that there is no reliance on transportation for proper disposal. Ten health care waste pits for both the Hoima and Mpigi districts were installed and visited by a joint team from the departments of Infrastructure, Environmental Health and MMIS/Uganda. Meetings with staff and health unit in-charges to train on proper use of the waste pits were conducted. Ten pits each in both the Mbarara and Isingiro Districts were completed, and eight health care waste pits were built in the Ibanda District. Maintenance meetings were held with the appropriate health units, and the service providers now safely and properly dispose of needles, the residue from burned syringes, and infectious waste in these pits.
- Between January and March 2006, over 400 health care waste handlers were trained in the expansion districts of Kabale, Hoima, Manafwa, Mbale, and Yumbe (as reported in Task 2 above). The training was conducted at health sub-district level in all of the districts.
- To enhance segregation at the sites where waste is generated, 10,000 posters were distributed to all MMIS districts to guide service providers in segregation. The poster was pre-tested during a training of healthcare workers in the new districts and was approved by the Office of the Commissioner-Clinical Services, Commissioner-Infrastructure and the Department of Environmental Health.
- The module on health care waste management from the *Facilitators' Guide* created by MMIS and WHO/AFRO was adapted for use in Uganda and is now available for facilitators to use while training the District Health Teams (DHT) and the health care waste handlers.
- Quarterly district health care waste management review meetings were conducted in the Hoima and Mpigi districts. The one day meetings in each district were attended by health sub-district managers, health unit in-charges, health assistants, and members of the DHTs. Key areas of discussion included the less than optimal waste segregation practices still being reported among health workers and how it relates to misuse of the medical waste pits, proposals for off-site transportation of health care waste for the facilities in water logged areas, and the general progress of the project. Participants agreed that health unit supervisors should reinforce desired behavior through the Continuous Medical Education (CME) sessions that are conducted weekly in most of the units. Efforts will be made to regularly supervise waste handlers, especially in units with new pits.
- Quarterly review meetings were conducted in the Hoima, Mpigi, Isingiro, Mbarara, and Ibanda districts. Issues discussed included: ensuring full supply of waste management commodities, promoting the practice of waste segregation, and using health care waste pits and their maintenance.
- One hundred waste handlers were trained in Mulago National Referral Hospital.
- MMIS provided support for the maintenance of incinerators in the districts of Mpigi and Kabarole. One incinerator at Gombe Hospital (Mpigi District) was assessed for minor repairs. Funding for the repairs was provided by MMIS. The project also supported an assessment of an incinerator and user training at Fort Portal Regional Hospital (Kabarole district), where a new incinerator had been constructed by the MOH. Disposal of bottles, vials, and tins remains a challenge.
- In June 2006, the MMIS/Uganda Waste Management Advisor and MMIS/HQ Waste Management Technical Backstop participated in a WHO/GAVI waste management meeting in Nairobi. At the meeting, information was shared on the WHO/GAVI process and available

funding for development of national health care waste management plans. MMIS is contributing to this effort in Uganda through a waste management sub-committee.

- A two-day national stakeholders' meeting was conducted in early July, 2006. Participants included: local representatives from WHO/Uganda, heads of departments in the Ministry Of Health (i.e. Planning, Infrastructure, Environmental Health, Aids Control Program/Infection Control, and expanded program on Immunization), The National Environmental Management Authority (NEMA), Directors of District Health Services from Mulago National Referral Hospital, Rubaga Catholic Hospital, Uganda Medical Association, representatives of Medical Bureaus, NMS, manufactures form BD and TATA Uganda, and MMIS/Uganda staff. International participants included MMIS Technical Officer David Pyle, waste management expert, Sophie Newland from PATH, Mr. Fredrick Okuku, MMIS/Kenya Waste Management Advisor, and manufacturers from the Nairobi BD office. Key recommendations and key outcomes included:
  - HIPAC will act as the steering committee for all HCWM plans and activities.
  - A technical working group on HCWM should be proposed to the MOH top management for approval.
  - Terms of reference for the group were developed, and as a priority the working group was assigned to draft a detailed national work plan on waste management. The detailed plan was to be divided into, immediate, mid term and long term goals. The immediate plan was to be submitted as a proposal to GAVI for possible funding under the Health Sector Strengthening Program (HSSP).
  - BD promised to fund construction of incinerators for Hoima and Mbale Regional Hospitals.
- Local metal works manufacturers have designed a vial crusher that is being pre-tested. A detailed report on the outcome will be disseminated in November 2006.

#### ***Task 5: Private Providers and the Informal Health Sector***

- A literature review of the behavior and practices of injection providers in the informal sector was conducted. In addition, key informants, including community injection providers, cultural leaders, and community members, were interviewed and current behaviors were documented. The preliminary conclusions of the literature review and interviews indicate that the informal practices commonly occur within the formal sector. Furthermore, several health programs have tried to reach their coverage target by expanding their services beyond the formal sector. Further studies are needed to better understand the situation of injection practices in this sector, and arrangements are being made to assess the role of the informal sector in injection use. Next steps will be determined in coordination with MMIS/HQ in the late fall of 2006.
- MMIS/Uganda continued to offer training courses for private practitioners.

#### ***Task 6: Policy Environment***

- The Uganda Team is working closely with the MOH and WHO to put in place a statute governing immunization of health workers. MMIS/Uganda has been requested to consult on the development of a plan to immunize all in- and pre-service health workers with hepatitis B vaccine, for which the MOH has budgeted funding.
- WHO continues to support the development of waste disposal facilities in MMIS districts.

- The Uganda Medical Association has continued to advocate for the project and has conducted several trainings targeting hard-to-reach doctors and nurses. Through the Association, districts that are not yet directly benefiting from the project are being reached.
- The National Pharmacy Department has agreed to revise the essential drug list to incorporate injection safety concerns in the next financial year.
- The MOH conducted an assessment of current prices of ADs on the open market. Findings revealed little difference in prices between the standard disposable syringes and the AD syringes. Based on this finding, the MOH is preparing to restrict devices without re-use prevention features.
- The project has continued to advocate for the vaccination of health workers against immunizable diseases like hepatitis B. MMIS funded a consultancy that resulted in the formulation of a statute that will make immunization of health workers a requirement by law.
- WHO has agreed to support the MOH to develop waste management policies, guidelines, and work plans.

### ***Task 7: Monitoring and Evaluation***

- In March 2006, a baseline assessment on the behavior and practices of health workers was conducted in Mulago Hospital, one of the expansion areas for 2006. Mulago is the biggest training institution in Uganda with over 3,000 health workers and 56 service delivery areas. Preliminary results show that unsafe practices were common in the hospital and were more likely to occur in the medicine and pediatrics' departments. The data collection is complete, and the data is currently being analyzed along with that of the August 2005 expansion area baseline survey.
- During January and February 2006, a Rational Injection Use study was conducted in the initial project districts (Pallisa, Mbarara-Ibanda, Nebbi and Mpigi) to document the trends in injection use before and after MMIS interventions in comparison with one control district where no MMIS interventions have been introduced. Preliminary results showed a significant reduction in injection use in three of four districts where interventions were implemented in contrast to a significant increase in injection use in the control district. (The one intervention district where injections increased started with a low proportion of prescriptions being treated with injectable medications.) A detailed report of the findings will be available in November 2006.
- Quarterly supervisory visits indicate better performance in areas where supervision is conducted every two (2) months, compared to areas where supervision is conducted every three (3) months. The project will continue to support bi-monthly supervision.
- Quarterly supervision reports indicate a reduction in injection use in the phase 1 and phase 2 districts. Training was done well but presently districts have recruited new staff representing approximately 20 -30% of the current staff in the districts. There will be a need to train the new staff on safety issues. The majority of the facilities have adequate stocks of needles and syringes except in 2 districts where there was a delay in delivery of commodities by NMS. A few facilities in these districts experienced brief stock outs of commodities.
- Quarterly supervision reports also indicate that segregation of waste continues to be a major challenge especially in the big hospitals. Health workers are attempting to segregate but the few that have not yet changed their behavior need to be brought on board. In response to this problem, posters with information on how to segregate waste have been widely distributed in all the project districts. The project plans to conduct focus group discussions to find out how the situation can be further improved.

- Injection safety focal persons from the districts of Mpigi, Mbarara and Nebbi were assisted to go out and support other districts in planning and supervision of health workers.
- The BCC community survey tool was field-tested by 4 interviewers from April 27-28 in Mpigi district in preparation for a full community survey to be conducted in FY 2007 to test the effectiveness of BCC materials at the community level. This Uganda field test served to inform the project on further development of the tool and methodology for this type of data collection. For the field test, a total of 32 interviews were conducted. The report is currently under technical review, but examples of preliminary findings included:
  - Most people seem to have heard messages about using a needle from an unsealed package and/or that orals are as good as injections.
  - The main source of information was health workers – either public or private.
  - The next most common source of information about injection-related messages was radio, especially local ones.
  - Most people had received multiple injections and orals in the past 6 months.
  - Only a few of the interviewees admitted to have been treated by non-formal providers

### ***Challenges***

Challenges during this reporting period include limited supervision of health workers. Health workers report that they only get supervision from visiting teams, resulting in inadequate on-site supervision of the health workers in the health units by their immediate supervisors. This lack of supervision from immediate supervisors has delayed desired behavior change, especially in the area of waste segregation, where continuous reinforcement is crucial. To address this challenge, the district leaders and health unit managers have been encouraged to conduct regular CME.

MMIS/Uganda continues to face the challenge of scaling up project activities nationally. After determining that districts frequently return to their former practices without proper supervision and that stock outs significantly impact delivery of health services, the project is concerned about scaling up training of health workers without proper plans to ensure availability of the necessary commodities and adequate supervision. In order to address and resolve these concerns, the MMIS/Uganda staff continues to have dialogue with the MOH to determine how best to proceed in a sustainable manner.

## V. Annual Financial Reporting

TASC Injection Safety Contract  
 Contract Number: GHS-I-00-03-00026-00

Cumulative Expenditures/Accruals Statement  
 as of 30 September 2006

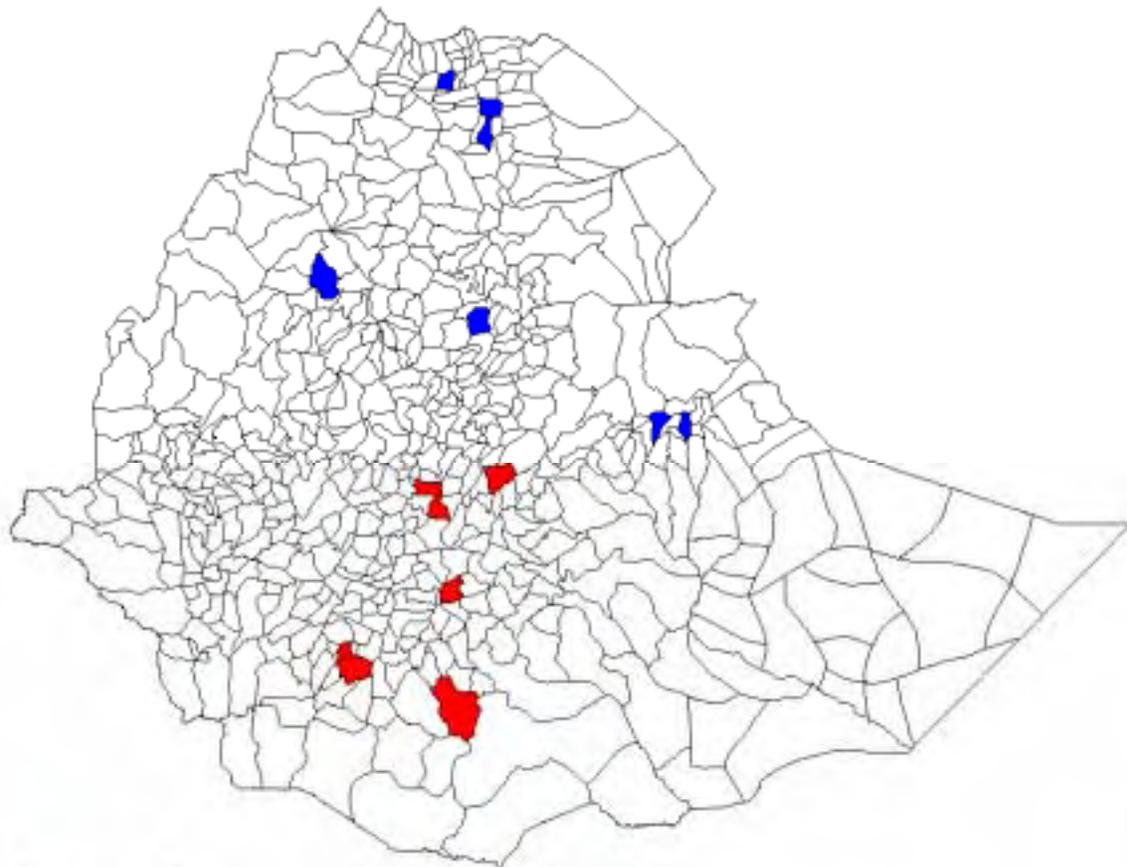
Line Item	Budget	Admin	Ethiopia	Mozambique	Nigeria	Uganda	Total
Workdays Ordered	\$6,115,807	\$1,003,092	\$162,518	\$525,757	\$466,833	\$313,494	\$2,471,693
Other Direct Costs	\$47,491,944	\$7,238,627	\$1,489,340	\$1,732,383	\$3,999,665	\$2,818,355	\$17,278,400
Fee	\$3,216,465	\$494,503	\$99,111	\$135,488	\$267,992	\$187,911	\$1,185,006
<b>Total</b>	<b>\$66,824,216</b>	<b>\$8,736,222</b>	<b>\$1,750,969</b>	<b>\$2,393,628</b>	<b>\$4,734,520</b>	<b>\$3,319,759</b>	<b>\$20,935,099</b>

**Notes:**

Injection Safety staff are sharing space and resources with existing JSI projects in Ethiopia, Mozambique, Nigeria and Uganda.

## **Annex A: MMIS Coverage by Country**

## MMIS/Ethiopia Coverage by Woreda 2004-2006



### Legend

- MMIS Woreda Coverage 2004
- MMIS Woreda Coverage 2005-6

*This map is intended to demonstrate the progress of MMIS activities at the time of publication. The use of names of countries, areas, and territories in this map does not imply their acceptance or accuracy by PEPFAR, CDC, USAID, or JSI*

# MMIS/Mozambique Coverage by District and Provincial Capital 2004-2006

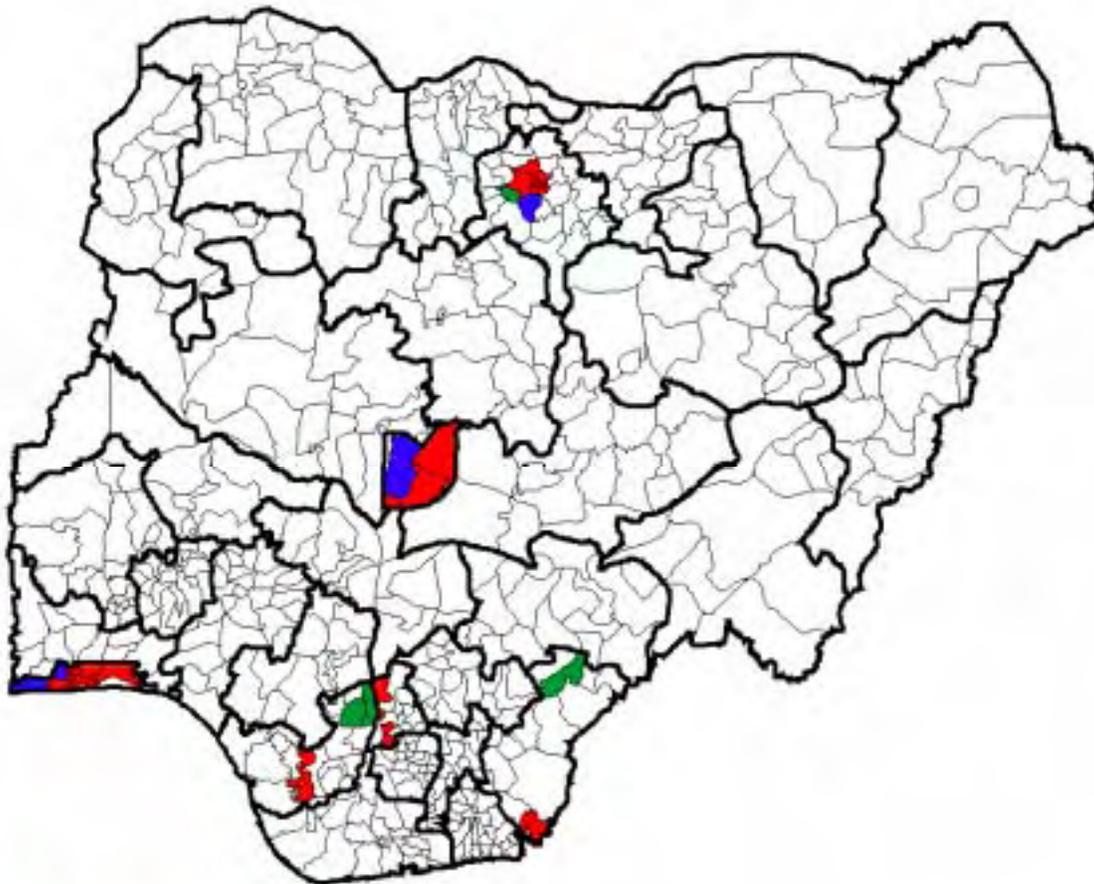


## Legend

- MMIS Provincial Capital Coverage
- MMIS District Coverage

This map is intended to demonstrate the progress of MMIS activities at the time of publication. The use of names of countries, areas, and territories in this map does not imply their acceptance or accuracy by PEPPAR, CDC, USAID, or JSI.

## MMIS/Nigeria Coverage by LGA 2004-2006



### Legend

- MMIS LGA Coverage 2004
- MMIS LGA Coverage 2004-2005
- MMIS LGA Coverage 2004-2006

*This map is intended to demonstrate the progress of MMIS activities at the time of publication. The use of names of countries, areas, and territories in this map does not imply their acceptance or accuracy by PEPFAR, CDC, USAID, or JSI.*



## **Annex B: Logistics Consumption Data**

**UGANDA LMIS APRIL 2006**

<b>DISTRICTS</b>	<b>Mpigi</b>	<b>Mbale</b>	<b>Manafwa</b>	<b>Isingiro</b>	<b>Ibanda</b>	<b>Nebbi</b>	<b>Hoima</b>	<b>ALL DISTRICTS</b>
District population	432,806	361,067	429,785	346,762	215,337	469,396	402,748	<b>2,657,901</b>
Total number of syringes used	18,999	22,579	3,717	19,368	9,836	36,794	10,580	<b>121,877</b>
Number of syringes per person per year	0.53	0.75	0.10	0.67	0.55	0.94	0.32	<b>0.55</b>
EPI syringes VS total	2.26%	1.31%	15.95%	8.14%	21.21%	5.50%	10.26%	
Number of HF that reported	10	12	4	25	23	28	19	<b>122</b>
Number of HF in the district	62	32	29	44	34	58	48	<b>320</b>
Completeness	16.13%	37.50%	13.79%	56.82%	67.65%	48.28%	39.58%	<b>38.13%</b>
Corrected NSPY	3.27	2.00	0.75	1.18	0.81	1.95	0.80	<b>1.44</b>

**UGANDA LMIS MAY 2006**

<b>DISTRICTS</b>	<b>Mpigi</b>	<b>Mbale</b>	<b>Manafwa</b>	<b>Isingiro</b>	<b>Ibanda</b>	<b>Pallisa</b>	<b>Budaka</b>	<b>Nebbi</b>	<b>Hoima</b>	<b>ALL DISTRICTS</b>
District population	432,806	361,067	429,785	346,762	215,337	428,047	154,808	469,396	402,748	<b>3,240,756</b>
Total number of syringes used	12,608	26,847	22,122	22,956	9,097	1,060	6,916	39,127	8,228	<b>148,961</b>
Number of syringes per person per year	0.35	0.89	0.62	0.79	0.51	0.03	0.54	1.00	0.25	<b>0.55</b>
EPI syringes VS total	4%	4%	17%	11%	20%	29%	16%	8%	10%	
Number of HF that reported	9	19	8	18	17	2	8	31	17	<b>129</b>
Number of HF in the district	62	33	29	44	34	41	13	58	48	<b>362</b>
Completeness	15%	58%	28%	41%	50%	5%	62%	53%	35%	<b>36%</b>
Corrected NSPY	2.41	1.55	2.24	1.94	1.01	0.61	0.87	1.87	0.69	<b>1.55</b>