John Snow, Inc.

TASC ANNUAL REPORT

October 2006 – September 2007

Summary

As of September 30, 2007, JSI is currently managing 5 Task Orders under the TASC mechanism: Djibouti, Injection Safety, Tanzania, MEASURE and EE Family Planning projects. Over the last year, two Task Orders under TASC2 were completed and closed: Albania and Russia. One new project was awarded under TASC3 over the last year: MEASURE Evaluation Task Order.

Below is a chart the summarize JSI's current awards, amounts and dates of the project.

Contractor Quarterly Financial Report
TASC Contract No: HRN I-98-00032-00
TASC 2 Contract No: GSH I-00-03-000026
TASC 3 Contract No: GHS-I-00-07-00002-00

Inception to Quarter 4, 2007 12/31/2007

Contract/TO Number	Country	Authorized Expenditures	Actual Expenditures	Balance	Estimated Completion Date
HRN-I-806-98-00032-00	South Africa	$5,597,890	$5,560,677	$37,213	Ended - 4/30/2005
HRN-I-00-98-00032-00, No. 04	Dominican Republic	$974,729	$954,587	$20,142	Ended - 2/28/2002
HRN-I-00-98-00032-00	Russia	$9,949,023	$9,947,561	$1,462	Ended - 4/7/2007
GHS-I-00-03-00026-00	Injection Safety	$56,824,216	$26,761,063	$30,063,153	9/30/2009
GHS-I-00-03-00026-00/800	Djibouti	$9,195,958	$7,213,365	$1,982,593	7/26/2008
GHS-I-00-03-00026-00	Albania	$1,325,000	$1,325,000	$0	Ended - 6/30/2007
HRN-I-00-98-00032-00	Ukraine	$4,992,549	$4,992,549	$0	Ended - 9/29/2006
GSH-I-801-03-00026	Ukraine	$999,996	$999,996	$0	Ended - 9/29/2006
GHS-I-00-03-00026-00	Tanzania	$1,552,959	$487,939	1,065,020	9/30/2010
GHS-I-00-07-00002-00	MEASURE	$30,188,410	$412,266	$29,776,144	02/02/2009
GHS-I-00-03-00026-00	FP/RH-EE/EA	$1,144,362	$304,028	$840.334	09/30/2008
TOTAL		**$122,745,092**	**$58,959,031**	**$63,786,061**	

SUMMARY TASK ORDER REPORTS

ALBANIA: ALBANIA FAMILY PLANNING PROJECT (AFPP)

In September 2004, the United States Agency for International Development (UAID/Albania) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract II (TASC II) to implement a two-year "Albania Family Planning Activity," which came to be called the Albania Family Planning Project (AFPP). AFPP's objective was to "increase access to family planning services, thereby addressing the continuing family planning needs of Albanian women and men."

AFPP's contractual statement of work (SOW) was to work with the Albanian Ministry of Health (MOH) to:

- Reinvigorate and strengthen the Contraceptive Security Commission;
- Complete the family planning training of the country's remaining 16 of 36 Districts; and
- Develop an awareness campaign to promote the nationwide availability for quality family planning services.

In August 2006, Task Order Modification #1 increased AFPP's funding ceiling, expanded the SOW and extended the project completion date to June 30, 2007. In February 2007, a two week Administrative Extension to July 15, 2007 was approved by USAID/Albania to allow for an orderly closeout process after the June 2007 End of Project Conference.

Major Achievements of AFPP over the life of the project include:

Contraceptive Security

Although the MOH decided not to revive the National Contraceptive Security Commission, the National Contraceptive Security Strategy (2003) remained the MOH's framework for ensuring contraceptive security in Albania. Most importantly, the MOH honored its commitment to procure an increasing percentage of its contraceptives requirements; the government percentage will increase in stages until the MOH will be procuring 100% of its contraceptives by 2010. AFPP produced a Contraceptive Security Report in 2006 to update the 2003 National Strategy and also carried out an innovative contraceptive market segmentation analysis to provide policy guidance to the MOH.

Logistics Management Information System (LMIS)
In mid-2005, the MOH shifted the existing LMIS from the MOH's Reproductive Health Unit to the Institute of Public Health (IPH), where there is more technical and administrative support for contraceptive logistics and LMIS. This shift worked well, and the LMIS appears well-institutionalized at IPH.

In May 2007, AFPP conducted a contraceptive forecasting workshop using JSI/DELIVER PipeLine Software where staff from IPH and PRO Shendetit learned

forecasting skills. In July 2007, just prior to project close out, AFPP assisted the government to prepare an updated contraceptive forecast that the MOH can use as the basis for requesting UNFPA to place an immediate contraceptive order.

Behavior Change Communications

Mass Media: TV Spots and TV Programs
AFPP developed three television spots and conducted four mass media campaigns with follow-up media recall surveys. In the AFPP endline survey, 79% of married women of reproductive age (MWRA) reported seeing at least one AFPP spot and could recall at least one message.

Outreach Negotiation Counseling (ONC)
In mid-2006, based on formative research results as well as the needs suggested by the Reproductive Health Survey 2002, AFPP introduced an innovative approach to community outreach and mobilization called Outreach Negotiation Counseling. Piloted in Fier and Diber Districts, ONC's intent was to increase women's access to information about the benefits of family planning and the modern methods available to help women/couples achieve their reproductive health goals. This pilot effort utilized community midwives to communicate directly with married women and couples regarding family planning, usually in their homes. The ONC pilot results were extremely promising.

National Family Planning Logo
AFPP actively promoted the national family planning logo (developed in the mid-1990s by the JSI/SEATS II/Albania project) via project documents, signs at MOH service facilities and mass media. In response to requests from providers, AFPP designed a family planning lapel pin, showing the logo and the phrases: "Want more?" "Ask me..." In the AFPP endline survey, 77% of MWRA connected the logo when seen without context with family planning and 79% connected the logo with family planning when seen in context.

Utilization of Services and Couple Years of Protection (CYP)

In April 2007, 429 MOH Service Delivery Points (SDPs) reported providing family planning services. To support this expansion of family planning services, AFPP updated and revised a three-day family planning curriculum (now adopted as the national curriculum by the MOH,) developed a cadre of local trainers to conduct the FP training, and refined a monitoring and evaluation follow-up system to support FP service delivery. AFPP supported FP training for a total of 730 physicians, nurses and midwives between 2004 and 2006.

First visits and total visits increased markedly over AFPP's lifetime, nationwide and especially in the 16 AFPP target Districts, as did re-visits, counseling visits, and CYP.

First Visits and Total Visits: All 36 Districts

First Visits	Annual Change	Total Visits		Percent Annual Change
2004	**13,474**		**60,230**	
2005	**15,101**	**+ 12 %**	**65,806**	**+ 9 %**
2006	**24,308**	**+ 61 %**	**93,419**	**+ 42 %**
Life of Project	**52,883**	**+ 80%**	**219,455**	**+ 55 %**

First Visits and Total Visits: 16 AFPP Target Districts

First Visits	Annual Change	Total Visits		Percent Annual Change
2004	**3,233**		**14,214**	
2005	**4,603**	**+ 42 %**	**17,026**	**+ 20 %**
2006	**8,798**	**+ 91 %**	**31,670**	**+ 86 %**
Life of Project	**16,634**	**+ 171 %**	**62,910**	**+ 123 %**

End of Project Conference

In June 2007, AFPP hosted a successful End of Project Conference that highlighted the accomplishments, outputs and results of AFPP assistance. The conference was well attended by Albania's family planning stakeholders, including senior MOH and USAID officials.

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

JSI was awarded the TASC II contract for Djibouti, "Expanded Coverage of Essential Health Services," in late April 2004. Initially funded for three years, the Project has been extended for 15 months ending on July 2008 (titled "Expansion Phase"). The contract stipulates the following anticipated results for the entire 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 was revised in early 2006.

Major Achievements of PECSE over the last year include:

- Distribution of equipment and materials according to the Project extension plan, such as computers for the urban health centers, photocopiers for the central level and the district hospitals, office furniture, laboratory freezers for the avian influenza activities, water distillers, and other assorted items.
- Assistance for the development of the national five year plan with direct COP participation and related funding of office supplies for the participants of a national meeting to validate the previous five year plan assessments.
- Seventeen health structures have been rehabilitated, including 16 in rural areas and one in Djiboutiville that was damaged in the floods of 2004. All the rehabilitated health posts have been provided with water reservoirs to supply continuous water. PECSE continues to work with the US Military to coordinate and finance drilling of new wells in sites where there is no water supply and new wells are technically feasible.
- Distribution of new medical equipment and furniture for all renovated health facilities and some items for district hospitals was completed, and training in the use and maintenance of equipment was completed as required.
- Training of providers in infection prevention for all five districts. For the first time, the health providers have the means to sterilize their medical instruments, and in this way comply with international norms in this area.
- Complete coverage of all the villages having health posts with social mobilization activities. All of the 23 health posts have Health Committees consisting of men and women, as well as four or five trained community health workers, including at least two per site who are women.
- A change in law to reflect the legal existence and recruitment by the Ministry of Health of the Community Health Workers.
- Data entry for 2006 was completed for each district, and most districts are up to date for 2007. For the first time, monthly reports arrive in Djiboutiville on time and include data from the majority of health posts.
- Supervision at PECSE Project health posts was universal during PY 3, jointly conducted by the MOH and PECSE. Along with providers training, supervision emphasizes quality of care and allows for joint problem-solving. Clinical training in STI management and HIV/STI prevention and child nutrition took place during PY 3.

- PECSE funded a number of technical assistance visits to support MOH activities, including polio eradication, EPI policy, data collection and analysis, surveillance, and improving routine EPI. In addition, PECSE coordinated efforts for an improved national health information system including all important components of EPI.

Over the last year, the Year 4 targets were reduced since the MOH withdrew the project training officer and it has been difficult to get a replacement. The MOH also changed all the rural nurses and delayed the training and TA missions until 2008. The MOH also replaced most of the heads of departments. This caused delays in activities in the field. On the other hand, these nominations allowed the creation of a new position, a focal point at the MOH level for the USAID activities, which will likely facilitate the implementation of the planned PECSE activities. There were also delays in getting approval from the MoH for activities, including technical assistance to the district health management teams, training that is intended to enable the district team members to better ensure an effective supportive supervision in all levels, and the other trainings for the health providers in nutrition, infection control, etc. During this second quarter of the extension phase, the PECSE Project worked with the MOH on implementation of the study tour to Madagascar, supervision and social mobilization activities in urban and peri-urban areas, HMIS implementation and supervision, procurement of a radio system, and completion of improved access to water in some health posts.

RUSSIA: MATERNAL AND CHILD HEALTH INITIATIVE (MCHI)

The goal of MCHI was to ensure the adoption of internationally recognized maternal and child health (MCH) standards and practices by the targeted health facilities in Russia. MCHI contributed to USAID/Russia's Strategic Objective 3.2: *Use of Improved Health and Child Welfare Practices Increased.* Directly related indicators included: *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 achievements over the life of the project included:

- MCHI staff registered as an indigenous Russian nongovernmental organization to be called the *Institute for Family Health*. The original intention was to form a nonprofit Russian organization but, as IFH began the registration process, it was discovered that the process to register as a nonprofit would take many months to complete, if not several years. As a result, while IFH initially began (and continues) its application process for registration as a nonprofit NGO, it followed local legal advice to register as a for-profit organization, which was completed in a matter of weeks rather than months or years.

- Memorandum of Understanding between Russian Society of Obstetricians/ Gynecologists (RSOG) and JSI signed;
- MOH agrees on partnership with RSOG to implement MCHI;
- Initial monthly collaborative meetings with RSOG leadership;
- Identification of persons responsible for MCHI-RSOG coordination of joint activity;
- RSOG participation in MCHI Interregional Working Group activities;
- RSOG participation in Regional Coordinating Teams activities;
- RSOG participation in joint MCHI workplan development at national and regional levels;
- RSOG and JSI jointly organize MCHI conference in the frame of the National Congress, "Mother and Child";
- RSOG regularly publishes MCH/MTCT/RH evidence-based updates in RSOG journal;
- RSOG has a follow-on strategy to continue MCHI activities by the end of the project;
- Development of MCHI Replication Package.

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.

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.

Over the last year, Dr. Salgado has achieved the following results:

- Provided feedback to Muleba IRS report and NMCP IRS strategy;
- Worked on a proposal to Jeffrey Sach's Earth Institute;
- Worked on the roll out for training of inpatient nurses with JICA and ZTCs;
- Completed and submitted data table for Report to Congress II;
- Completed draft assessment of PMI's RDT activities;
- Conducted an analysis of PMI Tanzania funding in comparison with other PMI countries;
- Reviewed and provided feedback to NMCP's new 5-year strategy;
- Traveled to Zanzibar to participate in ZMCP's new case management protocol;
- Provided additional review and feedback to ZMCP's new case management protocol;
- Reviewed and prepared data on availability of ACTs and SP in health facilities on the mainland;.
- Reviewed and provided feedback to two TSPA briefs on child health and malaria.

EUROPE AND EURASIA REGIONAL FAMILY PLANNING ACTIVITY

Europe and Eurasia – The Quality Family Planning and Reproductive Health project is 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 identifies best practices in policy and programmatic arenas that have improved FP/RH service delivery, packages essential elements in tools, exposes interested country stakeholders to these best practices and provides technical assistance and mentoring for their implementation.

- A concept paper detailing the Regional Activity's proposed work in Central Asia was submitted to the CAR Mission to expand family planning service delivery, which increased the ceiling of the Regional Activity's budget by $220,000;
- In collaboration with the USAID-funded Healthy Women in Georgia (HWG) program, a concept paper for the Regional Activity's work in Georgia was submitted to USAID/Caucasus Mission to expand family planning supportive supervision, which increased the ceiling of the project by additional $100,000;
- Conducted the Regional Family Planning (FP) Activity workshop in Bucharest, Romania on September 10-13, 2007 in collaboration with PSP-One. With the goal of strengthening and promoting local family planning programs, this meeting brought together key FP/RH stakeholders from the EE region to discuss best practices, successful strategies and approaches in FP. The workshop also oriented participants to the goal and objectives of the Regional Activity and its capacity to contribute to country and regional FP service delivery programs;
- Finalized and disseminated of desk reviews for Albania, Azerbaijan, Georgia, Kyrgyzstan and Tajikistan;
- Regional Training Curriculum - job aides and tools on Supportive Supervision developed for training in Georgia;

- Contraceptive Security Activities in Albania developed and initiated;
- "Do you know your family planning choices?" wall chart translated (into Russian), printed and distributed;
- Project fact sheet developed for distribution to bilateral programs, USAID country missions, and other interested parties;
- Preparation for the development of an interactive Regional Activity internet website.

GLOBAL: PREVENTING THE MEDICAL TRANSMISSION OF HIV: REDUCING UNSAFE AND UNNECESSARY INJECTIONS IN SELECTED COUNTRIES OF AFRICA AND THE CARIBBEAN (MMIS)

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).

Successes over the last year include:

- Commodity Procurement & Management: Across the 4 countries, MMIS has ensured adequate supply levels of syringes and safety boxes in 29 districts, 6 states (including districts), and over 100 special intervention facilities, protecting an estimated 54 million people from the medical transmission of HIV. The addition of MMIS commodities to existing in-country resources is improving the safety of over 80 million injections per year (based on WHO estimates of 1.5 injections per person per year).

- Training and Capacity Building: Health worker training and capacity building in injection safety, health care waste management and infection prevention is critical for improving injection practices. MMIS trainings have strengthened the effectiveness of other PEPFAR prevention, care and treatment programs by reinforcing safe injection practices and proper sharps waste management. To date, MMIS has trained over 52,000 public sector health workers in injection safety, increasingly using active learning approaches that enhance the effectiveness of training and lead to lasting improvements in health worker practices. Pre-service training, another critical component of the MMIS project, ensures that improved injection safety practices will be sustained. MMIS has worked closely with in-

country training institutions to incorporate injection safety content into pre-service training programs for health professionals. For example, Nigeria's major nursing school has integrated injection safety and standard precautions into its national curricula, ensuring that all future nurses will have this knowledge. In Uganda, MMIS is training trainers in nursing and medical schools as well as targeting teaching hospitals to ensure continuity in the application of safe injection practices for students and recently graduated health professionals. In order to ensure improved practices in the long term, MMIS' approach to capacity building includes the strengthening of supervisors' ability to monitor and reinforce safe practices, adoption and introduction of norms and standards for safe practice, development of job aides, and the creation of feedback mechanisms to strengthen capacity and guide decision-making.

- Behavior Change and Advocacy: MMIS implements behavior change and communication (BCC) strategies to reduce unnecessary injections, improve safe injection practices among health workers, and promote safe health care waste management. By promoting less invasive forms of treatment when possible, MMIS works to decrease the potential exposure of health workers and patients to HIV infection through injections. MMIS's behavior change interventions target policymakers, health workers, their supervisors, waste handlers, patients, and community members to promote specific key behaviors, and create professional and social norms of only safe and necessary injections. These interventions are bolstered by messaging that reinforces and encourages change among target groups. For example, the Uganda team developed injection safety video messages to reduce the demand for unnecessary injections that reached an estimated 400,000 community members using mobile vans equipped with screens. Advocacy strategies are another integral part of the MMIS approach to ensuring the long-term impact of injection safety interventions. For instance, advocacy efforts in Mozambique led to the revision of national standard treatment guidelines for sexually transmitted infections, reducing the high number of injections once given.

- Health Care Waste Management: Contaminated needles in medical waste pose a risk of needlestick injury and HIV infection to health workers and the community. MMIS has pioneered efforts to systematically improve the management of health care waste to better protect health workers and the community, including the introduction of safety boxes and segregation of waste and syringes. Due to the rapid scale-up of HIV/AIDS prevention and treatment activities through programs like PEPFAR, the volume of contaminated health care waste has substantially increased in recent years. MMIS's efforts to improve waste management practices are designed to minimize health care worker and community exposure to infectious waste. National-level efforts to bring partners together to address the challenge of health care waste management have involved government ministries, WHO, the World Bank, and international donors as well as local NGOs and other partners. MMIS has been a catalyst for application for and utilization of GAVI (formerly the Global Alliance for Vaccines and Immunization) funds to develop

national health care waste management plans, bringing together major stakeholders to develop a strategy and action plan for improving the situation in these four USAID-funded countries.

GLOBAL: MEASURE EVALUATION

The MEASURE Evaluation Task Order (TO) is an 18-month task order awarded on August 2007 under the TASC3 task order mechanism. It will run until February 2009. The overall objective of the MEASURE Evaluation TO is to improve the collection, analysis, and presentation of data to promote better use of data in planning, policy-making, managing, monitoring, and evaluating population, health, and nutrition programs. There are five specific tasks to achieve this objective:

Task 1: Increased user demand for quality information, methods, and tools, and facilitation of information use in decision making.

Task 2: Increased in-country individual and institutional technical capacity and resources for the identification of data needs and the collection, analysis and communication of appropriate information to meet those needs.

Task 3: Increased collaboration and coordination in efforts to obtain and communicate health, population, and nutrition data in areas of mutual interest.

Task 4: Improved design and implementation of the information gathering process including tools, methodologies and technical guidance to meet users' needs.

Task 5: Increased availability of population, health, and nutrition data, analyses, methods, and tools.

The MEASURE Evaluation TO is designed to continue work initiated under the MEASURE Evaluation Phase II Cooperative Agreement. The MEASURE Evaluation TO will build on the broad range of approaches developed under MEASURE Evaluation Phase II to implement the five tasks including: development and implementation of training programs; technical assistance; preparation and presentation of papers; organization of international meetings; design and testing of monitoring and evaluation tools and methods; development, testing, and administration of data collection protocols and instrumentation; strengthening of routine health information systems; performance monitoring and evaluation; development of tools to facilitate data use; and data utilization workshops.

The major activity since the beginning of the project was the development of the project workplan. The workplan outlines 88 different activities funded as of November 1, 2007, including the 26 activities that were included in the initial work plan submitted at the end of August. The work plan covers the full period of the Task Order award (August 3, 2007

– February 2, 2009) but the majority of activities will be implemented during the period October 1, 2007 – September 30, 2008. Each activity represents a discrete cost center and associated scope of work. Many of these activities are continuations of those undertaken under the MEASURE Evaluation Phase II project, while others are new to the Task Order.

DETAILED TASK ORDER REPORTS

Albania

MINISTRY OF HEALTH

USAID/ALBANIA
ALBANIA FAMILY PLANNING ACTIVITY
September 30, 2004 - July 15, 2007
Contract # GHS-I-00-03-00026-00
Order # 802

FINAL TECHNICAL REPORT

August 2007

Laurel A. Cappa, MD, MPH

ACKNOWLEDGEMENTS

Many hands and many voices contributed to this document. Certainly, special thanks are due to every speaker and participant at the June 2006 End of Project Conference, "Family Planning: Increasing Demand While Improving Access and Quality". The presentations and the obvious enthusiasm of all made this USAID- supported Albania Family Planning Activity really come alive.

Always helpful and informative were those directly charged with implementing what came to be called the Albania Family Planning Project (AFPP): Project Director Manuela Murthi, Agim Kasaj, Dr. Gazmend Koduzi, Dr. Eduart Oga, Altina Peshkatari, Gjergji Kokushta, and Erxhan Abazi from the John Snow, Inc (JSI)/Albania office in Tirane; Mary Lee Mantz, Rob Chamberlin, Matthew Osbourne-Smith, Susan Roberts, and Franchesca Minikon-Reece from JSI's Boston headquarters; Patrick Dougherty, Paul Dowling, and Dr. Laurie Cappa from JSI's Washington office; and Dr. Laurie Krieger from The Manoff Group, Inc.

All of the Project's work was done in collaboration with the Ministry of Health (MOH) and the Institute of Public Health (IPH) at the central, District and health facility levels. Special acknowledgement is due Dr. Eduart Hashorva, Dr. Zamira Sinomeri, Dr. Agim Shehi, and Dr. Nedime Ceka at the MOH; Dr .Eduart Kakarriqi, Dr. Gazmend Bejtja, Dr. Miranda Hajdini, and Dr. Elizana Petrela at the IPH; and the MOH trainers and District Directors. Throughout, AFPP benefited from close collaboration with UNFPA, the USAID-supported PRO Shendetit Project, and the USAID-supported Albania Child Survival Project. Special thanks are due them all.

Finally, special thanks also go to USAID/Albania for its support and contributions over the life of the Project, especially to the AFPP CTO, Dr. Zhaneta Shatri.

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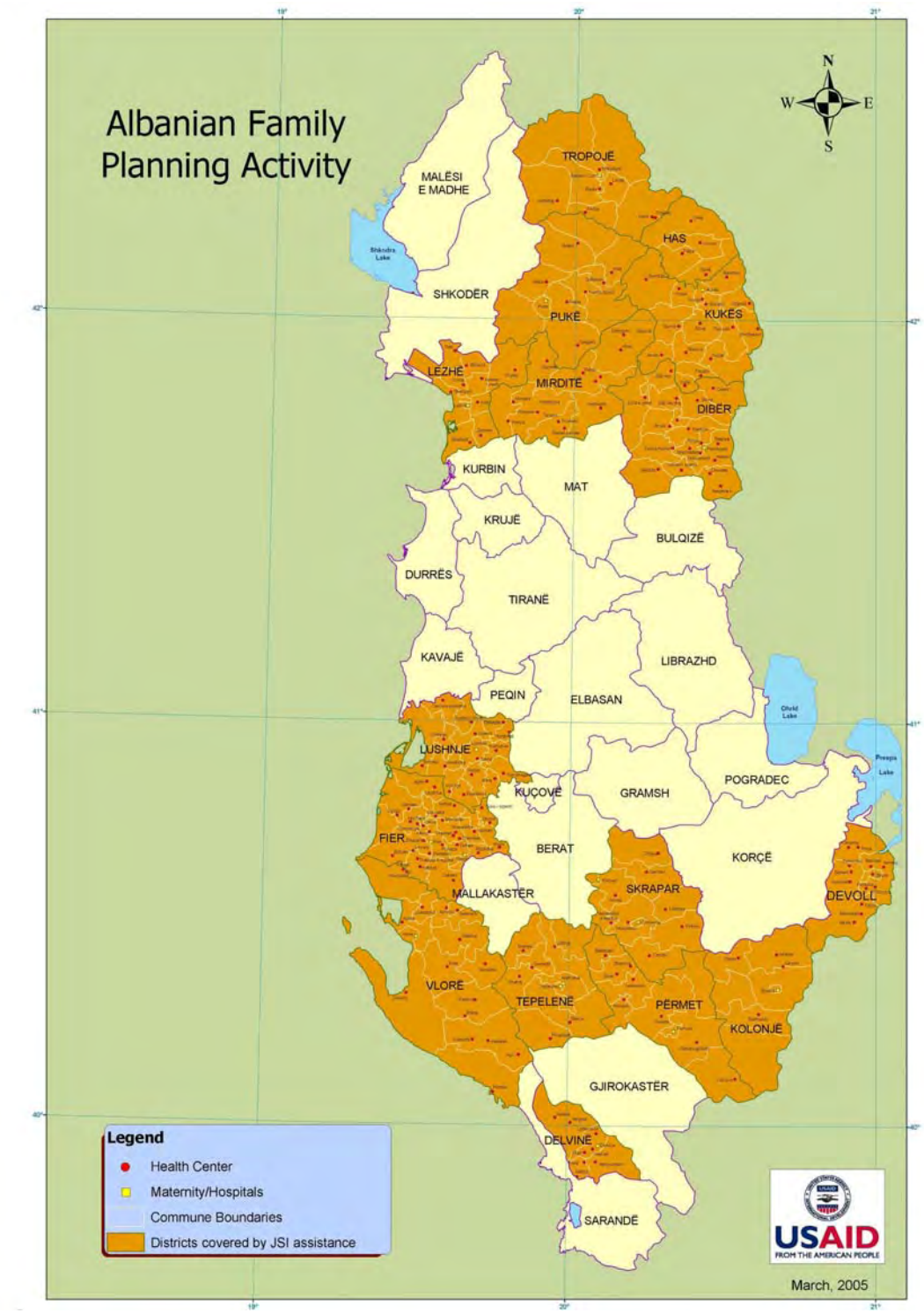
ACRONYMS

ACPD	Albanian Center for Population and Development
ACSP	Albania Child Survival Project
AFPA	Albanian Family Planning Association
AFPP	Albania Family Planning Project
AIDS	acquired immunodeficiency syndrome
AIDAR	Agency for International Development Acquisition Regulations
AIHA	American International Health Alliance
ASMA	Albanian Social Marketing Association
BCC	behavior change communication
CA	Cooperating Agency
CDC	Centers for Disease Control and Prevention
CPR	contraceptive prevalence rate
CTU	contraceptive technology update
CYP	couple years of protection
DHHS	Department of Health and Human Services
DHS	Demographic and Health Survey
ENI	Europe and Newly Independent States Bureau
GoA	Government of Albania
HC	health center
HII	Health Insurance Institute
HIV	human immunodeficiency virus
IEC	information, education and communication
IPCC	interpersonal counseling and communication
IPH	Institute of Public Health
IPPF	International Planned Parenthood Federation
I.R.	Intermediate Result
IUD	intrauterine device
JSI	John Snow, Inc.
KfW	Kreditanstalt für Wiederaufbau (German Reconstruction Credit Institute)
LAM	Lactational Amenorrhea Method
LMIS	logistics management information system
MMR	maternal mortality rate
MOH	Ministry of Health
NCSC	National Contraceptive Security Commission
NGO	non-governmental organization
ONC	Outreach Negotiation Counseling
PHC	primary health care
PHN	Population, Health and Nutrition Bureau
PHRplus	Partners for Health Reform Plus
PMP	performance monitoring plan
POP	progestin-only pill
PSI	Population Services International
PTT	participatory training techniques
RHS	Reproductive Health Survey

RHU	Reproductive Health Unit
SDP	service delivery point
SEATS	Family Planning Service Expansion and Technical Support
SEED	Support to Eastern European Democracy
S.O.	strategic objective
SOW	scope of work
STI	sexually transmitted infection
TASC	Maternal and Child Health Technical Assistance and Support Contract
TO	task order
TOT	training of trainers
TFR	total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WCR	women's consultation room

Map of Albania
Showing MOH Facilities in AFPP Target Districts



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I. EXECUTIVE SUMMARY

Mandate

In September 2004, the United States Agency for International Development (USAID/Albania) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract II (TASC II) to implement a two-year "Albania Family Planning Activity" which came to be called the Albania Family Planning Project (AFPP). AFPP's objective was to "increase access to family planning services, thereby addressing the continuing family planning needs of Albanian women and men."

AFPP's contractual statement of work (SOW) was to work with the Albanian Ministry of Health (MOH) to:

- reinvigorate and strengthen the Contraceptive Security Commission;
- complete the family planning training of the country's remaining 16 of 36 Districts; and
- develop an awareness campaign to promote the nationwide availability for quality family planning services.

In August 2006, Task Order Modification #1 increased AFPP's funding ceiling, expanded the SOW and extended the project completion date to June 30, 2007. In February 2007, a two week Administrative Extension to July 15, 2007 was approved by USAID/Albania to allow for an orderly closeout process after the June 2007 End of Project Conference.

Implementation and Results

The Albania Family Planning Project simultaneously implemented **three major components** to improve the quantity and quality of family planning services available in the public sector and to increase the public demand for these improved services: **family planning training, contraceptive security, and behavior change communication (BCC).** Working at both the District and national levels, an emphasis was placed on **public sector capacity building** to increase the likelihood of sustainability over time.

Geographic Coverage and Family Planning Training

Building on the work initiated by the previous USAID-funded JSI/SEATS II/Albania and JSI/TASC I/Albania projects, AFPP **completed the integration of family planning services into primary health care down to the commune level** nationwide into all of Albania's 36 Districts. During the previous projects, access to family planning services had been greatly expanded in 20 of Albania's 36 Districts; the major AFPP task was to **expand access in the remaining 16 Districts to reach the remaining 32% of the population.** Ten of the 16 AFPP target districts had only one functioning family planning service delivery point (SDP) in 2004.

Baseline Data for 16 AFPP Target Districts

16 AFPP Target Districts	Percent of Total Population	Total # of Potential SDPs	Total # of Potential SDPs by Type			# of SDPs Reporting Family Planning Services in 2004
			Mat	WCR	HC	
Delvine	0.35 %	5	1	1	3	1
Devoll	1.13 %	6	1	1	4	1
Diber	2.79 %	16	1	1	14	3
Fier	6.48 %	19	1	2	16	7
Has	0.64 %	5	1	1	3	1
Kolonje	0.56 %	8	1	1	6	1
Kukes	2.07 %	16	1	1	14	1
Lezhe	2.21 %	11	1	1	9	4
Lushnje	4.68 %	17	1	1	15	8
Mirdite	1.20 %	8	1	1	6	2
Permet	0.84 %	11	1	1	9	1
Puke	1.12 %	11	1	1	9	1
Skrapar	0.97 %	10	1	2	7	1
Tepelene	1.05 %	11	1	1	9	1
Tropoje	0.91 %	9	1	1	7	1
Vlore	4.78 %	17	1	4	12	8
TOTAL	31.78 %	180	16	21	143	42

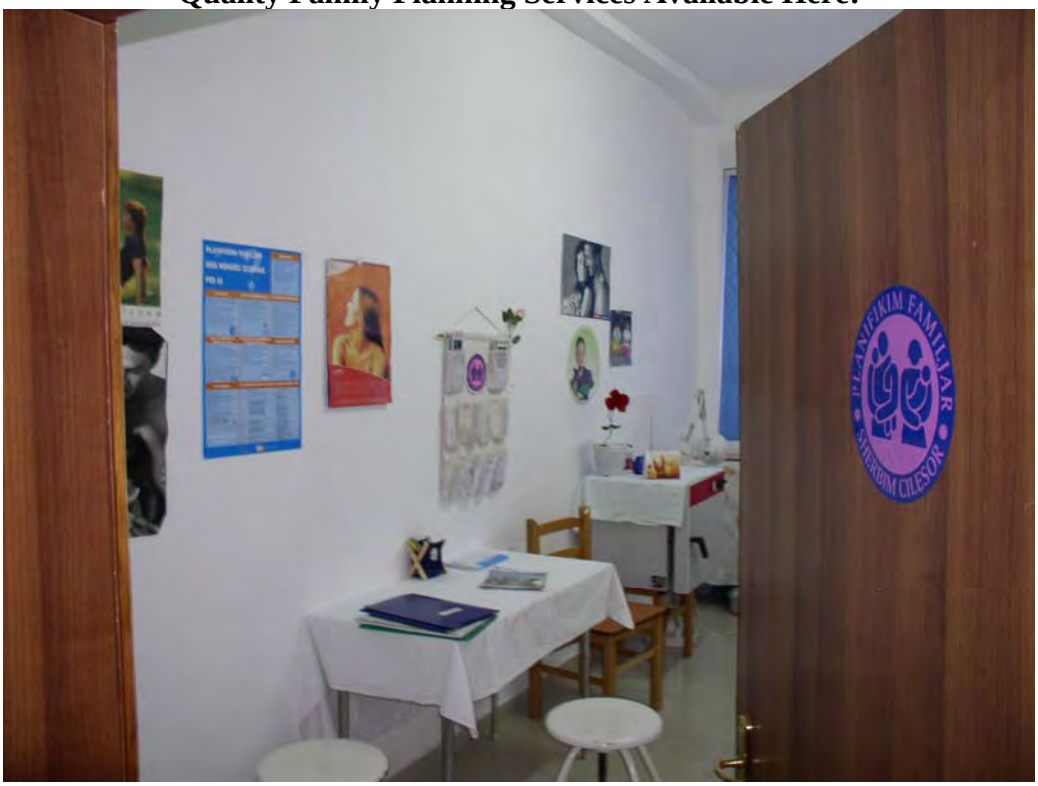
AFPP's strategy was to focus initially on the most populous Districts, and those Districts that overlapped the project areas of two other USAID-funded projects, the Albania Child Survival Project (ACSP) in Diber and PRO Shendetit in Lezhe. Consequently, Diber, Fier, Lezhe, Lushnje, and Vlore were the first target Districts to receive family planning and logistics management information system (LMIS) training in 2005, followed by Puke, Delvine, Devoll, Kolonje Mirdite, and Skrapar. In 2006, Permet and Tepelene were added, followed by Kukes, Has, and Tropoje. By June 2006, service expansion had been completed in all 16 target Districts, thus completing nationwide coverage as planned.

Summary of USAID-funded Family Planning Service Expansion, 1999-2006

# of New Districts Added	Cumulative # of Districts Covered	% Total Population Added	Cumulative % Total Population Covered	Existing SDPs in 2004 Baseline	# of New SDPs Added	Cumulative # of SDPs Covered
4 (1999)	4	28 %	28 %		65	65
2 (2000)	6	13 %	41 %		46	111
4 (2001)	10	7 %	48 %		37	148
8 (2002)	18	15 %	63 %		79	227
2 (2003)	20	5 %	68 %		17	244
(In the interval between the JSI/SEATS II/TASC I projects and AFPP, some SDPs closed, and some expanded and "divided" to report separately; the net gain was 5 SDPs for a total of 249.						
SDPS reporting in 2004 Baseline						249
5 (2005-Q2)	25	21 %	89 %	30	50	329
1 (2005-Q3)	26	1 %	90 %	1	10	340
5 (2005-Q4)	31	4 %	94 %	6	31	377
2 (2006-Q1)	33	2 %	96 %	2	20	399
3(2006-Q2)	36	4 %	100 %	3	27	429

In April 2007, **429 MOH SDPs** reported providing family planning services. To support this expansion of family planning services, AFPP updated and revised a three-day family planning curriculum (now adopted as the national curriculum by the MOH,) developed a cadre of local trainers to conduct the FP training, and refined a monitoring and evaluation follow-up system to support FP service delivery. AFPP supported FP training for a total of 730 physicians, nurses and midwives between 2004 and 2006.

Quality Family Planning Services Available Here!



Contraceptive Security

Contraceptive security was **a major focus** of AFPP assistance to the MOH.

National Contraceptive Security Commission and Market Segmentation Analysis
Although the MOH decided not to revive the National Contraceptive Security Commission, the **National Contraceptive Security Strategy (2003*)*** remained the MOH's framework for ensuring contraceptive security in Albania. Most importantly, the MOH honored its commitment to procure an increasing percentage of its contraceptives requirements; the government percentage will increase in stages until the MOH will be procuring 100% of its contraceptives by 2010. AFPP produced a **Contraceptive Security Report in 2006** to update the 2003 National Strategy and also carried out an innovative contraceptive market segmentation analysis to provide policy guidance to the MOH.

Logistics Management Information System (LMIS)
In mid-2005, the MOH shifted the existing LMIS from the MOH's Reproductive Health Unit to the Institute of Public Health (IPH), where there is more technical and administrative support for contraceptive logistics and LMIS. This shift worked well, and the LMIS appears well-institutionalized at IPH.

MOH Stock on Hand, April 2007

Method	Central IPH Level Stock on Hand	District and SDP Level Stock on Hand	Total Stock on Hand	Q1 2007 Consumption (actual)	Estimated Quarters of Stock Remaining
IUDs	**3,758**	**2,134**	**5,892**	**649**	**9.1**
Injectables (Depo-Provera)	**27,435**	**10,790**	**38,225**	**4,389**	**8.7**
Low-dose COCs (LoFemenal)	**93,000**	**41,190**	**134,190**	**18,091**	**7.4**
POPs (Microval)	**2,014**	**12,251**	**14,265**	**3,423**	**4.2**
Condoms	**292,176**	**209,228**	**501,404**	**107,662**	**4.7**

Although it may appear that the MOH has a "cushion," **the MOH faces severe contraceptive stockouts,** given that up to 12 months are required to complete a contraceptive procurement In May 2007, AFPP conducted a contraceptive forecasting workshop using JSI/DELIVER PipeLine Software where staff from IPH and PRO Shendetit learned forecasting skills. In July 2007, just prior to project close out, AFPP assisted the government to prepare an updated contraceptive forecast that the MOH can use as the basis for requesting UNFPA to place an immediate contraceptive order. **See Appendix B for precise order quantities and costs**.

Behavior Change Communication

AFPP's BCC component was **especially strong and successful**.

Formative Research, Strategy Development, and Performance Monitoring
AFPP utilized **innovative formative research** to inform its media strategy and **national sample baseline and endline surveys** to measure results.

Mass Media: TV Spots and TV Programs
AFPP developed three television spots and conducted four mass media campaigns with follow-up media recall surveys. In the AFPP endline survey, **79% of married women of reproductive age (MWRA) reported seeing at least one AFPP spot and could recall at least one message.**

Outreach Negotiation Counseling (ONC)
In mid-2006, based on formative research results as well as the needs suggested by the Reproductive Health Survey 2002, AFPP introduced an **innovative approach to community outreach and mobilization** called Outreach Negotiation Counseling. Piloted in Fier and Diber Districts, ONC's intent was to increase women's access to information about the benefits of family planning and the modern methods available to help women/couples achieve their reproductive health goals. This pilot effort utilized community midwives to communicate directly with married women and couples regarding family planning, usually in their homes. The ONC **pilot results were extremely promising.**

National Family Planning Logo
AFPP **actively promoted the national family planning logo** (developed in the mid-1990s by the JSI/SEATS II/Albania project) via project documents, signs at MOH service facilities and mass media. In response to requests from providers, AFPP designed a family planning lapel pin, showing the logo and the phrases: "Want more?" "Ask me..." In the AFPP endline survey, **77% of MWRA connected the logo when seen without context with family planning and 79% connected the logo with family planning when seen in context.**

Utilization of Services and Couple Years of Protection (CYP)

First visits and total visits increased markedly over AFPP's lifetime, nationwide and especially in the 16 AFPP target Districts, as did re-visits, counseling visits, and CYP.

First Visits and Total Visits: All 36 Districts

	First Visits	Percent Annual Change	Total Visits	Percent Annual Change
2004	**13,474**		**60,230**	
2005	**15,101**	**+ 12 %**	**65,806**	**+ 9 %**
2006	**24,308**	**+ 61 %**	**93,419**	**+ 42 %**
Life of Project	**52,883**	**+ 80%**	**219,455**	**+ 55 %**

First Visits and Total Visits: 16 AFPP Target Districts

	First Visits	Percent Annual Change	Total Visits	Percent Annual Change
2004	**3,233**		**14,214**	
2005	**4,603**	**+ 42 %**	**17,026**	**+ 20 %**
2006	**8,798**	**+ 91 %**	**31,670**	**+ 86 %**
Life of Project	**16,634**	**+ 171 %**	**62,910**	**+ 123 %**

End of Project Conference

In June 2007, AFPP hosted a successful End of Project Conference that highlighted the accomplishments, outputs and results of AFPP assistance. The conference was well attended by Albania's family planning stakeholders, including senior MOH and USAID officials. **See Appendix A for the conference agenda.**

Conclusions and Needed Next Steps

As Albania seeks to more fully integrate itself into the European and global communities, the use of modern contraceptive methods is likely to increase significantly from current levels, and AFPP leaves behind a strengthened service delivery framework that will help the MOH meet the expected increased demand for family planning services. While the MOH undoubtedly has a heightened appreciation of the need for (and importance of) quality reproductive health services, compared with many other countries, the community of people committed to providing Albanian families with access to quality family planning services is neither sizeable nor strong. Lack of political commitment has got to be listed as a current family planning weakness in Albania.

More than five years have passed since the 2002 Reproductive Health Survey was conducted. Reportedly, major donors, including USAID/Albania, are negotiating with the Government of Albania (GoA) and each other to plan and fund a Demographic and Health Survey (DHS). A DHS would be extremely informative and useful for Albania. In the meantime, however, there is much that the GoA can do.

Integrating Family Planning into Primary Health Care (PHC).
Although family planning services are now available nationwide at the commune level, to fully integrate family planning into PHC, many more health care providers would require training and/ or refresher training. Generally, only a few providers have been trained at each site, and some were initially trained more than a decade ago. Training community midwives at the ambulanca level – as was done during JSI/SEATS II/Albania and again during AFPP – would help bring services and information even closer to Albanian families.

> "Governments should strive to ensure that by 2015 all primary health care and family planning facilities are able to provide, directly or thorough referral, the widest available range of safe and effective family planning and contraceptive methods."
> UN General Assembly, July 1999 (International Conference on Population and Development +5)

The MOH and IPH have the tools needed to roll out family planning training to a large group of providers, both facility-based and community-based. This rollout can be

accomplished at a relatively low cost since the major costs of developing a training program, developing the curricula and training the trainers, have already been incurred for both the standard family planning training for providers and for ONC. Anecdotally, there is certainly demand for more FP training, both pre-service and in-service.

More attention needs to be paid to **pre-service education** to assure quality, evidence-based information and practices are built into the basic education of all students of medicine, nursing, midwifery and pharmacy. It should be expected, for example, that a newly-graduated physician, nurse, midwife, or pharmacist would already be familiar with the contraceptive technology and counseling concepts included in the national family planning curriculum; in practice, this reportedly in not the case.

Family planning service quality would improve if reproductive health training included more **hands-on clinical skill development, especially IUD insertion, using the no-touch technique.**

Empowering Potential Family Planning Users

A **sustained BCC campaign** to greatly increase Albanians' awareness of their contraceptive choices and sources of contraceptive supplies continues to be a high priority for Albania. The majority of sexually active Albanians already contracept using withdrawal and the occasional condom, backed up by legal abortion. The real issue is that Albanians should have choice, and they **currently lack the information to make an informed choice** about modern contraception. They deserve to know there are ways to contracept that are more convenient, safe and offer better protection than withdrawal. AFPP's work promoting the national family planning logo, creating TV spots, and piloting ONC provides a firm foundation on which to build expanded awareness.

Extending Services to Those Most in Need

The women most in need of family planning information and services are women who have just delivered a baby or have just had an abortion. Albania has a **great need for upgraded/ expanded standardized postpartum/ post-abortion counseling and services** with a strong link to primary health care services. This is a significant missed opportunity that needs addressing. Exclusive breastfeeding and the **lactational amenorrhea method (LAM)** merit increased attention during both the antenatal and postpartum periods. For innovation, the MOH might **introduce family planning into postnatal and well-baby services.**

Expanding Method Choice

The contraceptive method mix in Albania is **skewed toward re-supply methods** (pills, condoms, injectables). **Permanent and long-term methods** (IUDs, female tubal ligation and male vasectomy) **have not been actively promoted** and are not yet readily available, or available at all. Access to even the re-supply methods is limited: progestin-only pills (POPs) are available only in the public sector; there is no non-hormonal IUD in the commercial for profit sector, only a very expensive hormone-releasing IUD. Emergency contraception is available only through social marketing outlets, when it should be available from public sector facilities. LAM is not well known, nor encouraged; likewise the Standard Days Method. Implants and female condoms are totally unavailable.

Not surprisingly, the 2002 Reproductive Health Survey revealed a considerable "unmet demand" from "limiters", i.e. families who have the family size they desire and who do not want additional pregnancies. This suggests a major need for increased emphasis on long term and permanent methods, especially IUD services using the "no-touch" insertion technique. **Health facility-dependent methods should increasingly be the MOH's "niche,"** with the private sector providing more and more of the re-supply methods – pills and condoms. For the MOH to concentrate on facility-dependent methods also makes sense economically, as can be seen when the cost per CYP is examined, using the contraceptive forecast of contraceptives needed by the MOH to cover needs through December 2008..

Estimated Cost per CYP by Method

Method	Quantity Required	Cost per Unit	Total Cost	CYP Equivalent	Cost per CYP
Low-dose COCs: Rigevidon (cycles)	**105,224**	**$ 0.338**	**$ 35,566**	**10,826**	**$ 3.29**
Progestin-only pills: Microval (cycles)	**14,668**	**$ 0.595**	**$ 8,727**	**978**	**$ 8.92**
Injectables: Depo-Provera (vials)	**30,561**	**$ 0.85**	**$ 25,977**	**7,640**	**$ 3.40**
IUDs (pieces)	**3,712**	**$ 0.30**	**$ 1,114**	**12,992**	**$ 0.085**
Condoms (pieces)	**403,874**	**$ 0.025**	**$ 12,992**	**3,366**	**$ 3.86**
Total Cost and Total CYPs			**$ 81,480**	**35,802**	
Average Cost per CYP All Methods					**$ 2.28**

For example, the cost of an IUD (30 cents) is less than a cycle of Rigevidon (34 cents), yet an IUD provides protection from unwanted pregnancy for up to 10 years, while a cycle of Rigevidon protects for only one month. In addition, once a woman has an IUD inserted, she need not return to the health facility until she wants it removed or unless she has problems or questions.

Assuring Contraceptive Security

The challenge facing the MOH is to ensure that contraceptive procurements **are timely and based on accurate forecasts** to avoid a repeat of the stockouts of recent years. Because contraceptive forecasts require regular updating, the MOH needs its own internal forecasting capacity. AFPP assisted the MOH to begin building this capacity within IPH, but additional external technical assistance will likely be needed.

Efficiency would be greatly improved and contraceptive security enhanced, if Albania were to implement an effective market segmentation strategy that expanded the range of contraceptive methods available, made these methods more accessible, and supported and encouraged the social marketing and commercial sectors in supplying contraceptives to clients who are able to

pay for them. A long term market segmentation strategy could also help shift the contraceptive method mix toward long-term and permanent methods, thereby addressing more effectively the large unmet needs of "limiters".

This next step toward contraceptive security requires a genuine public/private partnership in a way that has not been attempted to date in Albania. The key question -- how to segment the contraceptive market among the public, social marketing and commercial sectors – has not yet been seriously addressed, nor how and by whom such a market segmentation policy would be monitored and adjusted. Unfortunately, Albania lacks a tradition of public/private partnership that in other countries might facilitate the successful segmentation the contraceptive market. This is an area where Albania may wish to seek external technical assistance in the coming years.

The most urgent challenge facing family planning in Albania is the **severe contraceptive stockout** that the MOH will face in late 2007 or early 2008 if the contraceptive quantities included in AFPP's July 2007 contraceptive forecast are not ordered immediately (August 2007). **See Appendix B for precise order quantities and costs**

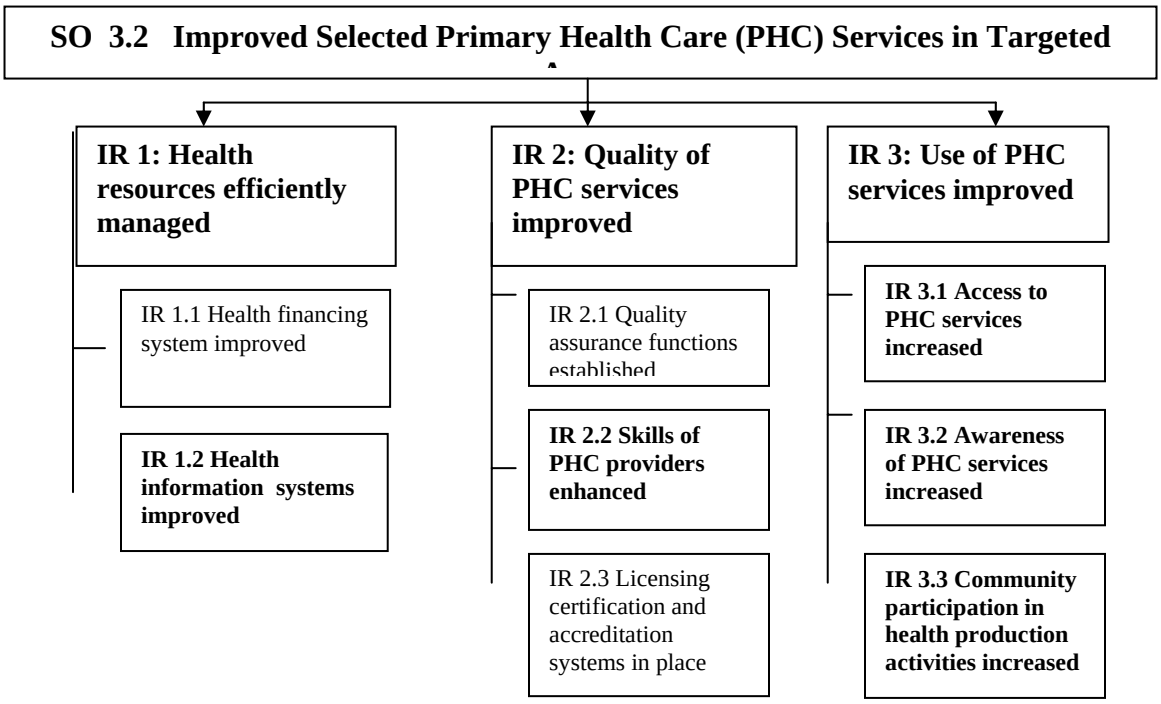
II. INTRODUCTION

In September 2004, the Albania Mission of the United States Agency for International Development (USAID/Albania) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract II (TASC II) to implement a two-year "Albania Family Planning Activity" which came to be called the Albania Family Planning Project (AFPP). AFPP's objective was to "increase access to family planning services, thereby addressing the continuing family planning needs of Albanian women and men".

AFPP's contractual statement of work (SOW) was to work with the Albanian Ministry of Health (MOH) to:

- reinvigorate and strengthen the Contraceptive Security Commission;
- complete the family planning training of the country's remaining 16 of 36 Districts; and
- develop an awareness campaign to promote the nationwide availability for quality family planning services.

AFPP was designed to make major contributions to all three intermediate results (IRs) and five of the eight sub-results (shown in bold below) included in USAID/ Albania's Results Framework for Strategic Objective (SO) 3.2:



In August 2006, TO Modification #1 increased the funding ceiling, expanded the SOW, and extended the estimated completion date to June 30, 2007. Modification #1 also incorporated updated Agency for International Development Acquisition Regulations (AIDAR) guidance in three areas (disability policy, personnel compensation, and medical evacuation). In March 2007, TO modification #2 incorporated updated AIDAR guidance in an additional area (voluntary population activities). In February 2007, a two week Administrative Extension to July 15, 2007

was approved by USAID/Albania to allow for an orderly closeout process after the June 2007 End of Project Conference.

III. BACKGROUND

A. Reproductive Health in Albania

In the early 1990s, Albania emerged from nearly 50 years of Communist rule and severe international isolation. Under the previous regime, Albania's government had strongly pro-natalist policies aimed at substantially increasing the country's population. Family planning and abortion were both illegal, although unsafe clandestine abortion became widely available over time. Despite this, Albania's total fertility rate (TFR) shrank, falling from 6.5 in 1960 to 3.0 by 1990, highlighting the clear desire of Albanian women to control their fertility, whether through traditional methods like withdrawal and periodic abstinence or through illegal voluntary abortion. While the TFR decreased, the maternal mortality rate (MMR) increased. By 1990, Albania's MMR was 60 deaths per 100,000 live births.

Following the collapse of Communism, family planning and abortion were both legally permitted. Abortion was first legally practiced at maternity hospitals in 1991, after which the MMR dropped by half to about 30 deaths per 100,000 live births. At present, the TFR is estimated to be 2.1 (UNICEF Database) and the MMR is officially given as 20, although this figure is thought to be somewhat under-reported (WHO Regional Office for Europe).

B. USAID-Supported Reproductive Health Programming

In 1995, JSI was asked by the then USAID/ Population, Health and Nutrition (PHN) and Europe and Newly Independent States (ENI) Bureaus and USAID/ Albania to participate in a collaborative reproductive health assessment to help USAID/ Albania determine if reproductive health activities should be added to the Mission's portfolio. As might be expected in a country emerging from 50 plus years of repression, isolation and strict pro-natalist policies, considerable need was found. Based on this assessment and other factors, USAID/ Albania decided to support activities to help build a solid base for sustainable, quality reproductive health services in Albania.

In 1996, at the Mission's request, John Snow Inc began implementing the first USAID-funded women's health project in Albania as part of its centrally-funded Family Planning Service Expansion and Technical Support (SEATS II) project, using both USAID/ Washington central funds and USAID/ Albania Support to Eastern European Democracy (SEED) funds.

Concurrent with JSI/SEATS II/Albania, two other USAID Cooperating Agencies (CAs) also worked in the health area in Albania: the Department of Health and Human Services (DHHS) in the area of health financing and the American International Health Alliance (AIHA) in a hospital partnership project.The global SEATS II project ended in 2000. In late 1999, USAID/Albania issued a TASC Request for Proposal to build on and expand the achievements of SEATS

II/Albania. JSI/TASC I was selected to implement the resulting three-year contract awarded in September 1999.

In mid-2000, after an extensive program review, USAID/Albania revised its health Strategic Objective to focus on primary health care, also the focus of the Ministry of Health's new strategy. The USAID-funded Partners for Health Reform Plus (PHRplus) project began work in Berat and Kucove Districts. The PHRplus Albania project was designed as a pilot effort to produce evidence for informed decision-making at the local and central levels and to demonstrate a modest cost, sustainable PHC delivery model for replication throughout Albania.

In May 2002, USAID modified the original JSI/TASC I/Albania contract. The revised JSI/TASC/Albania project was to continue integrating family planning services at the primary care level, as mandated by USAID/ Albania's revised health S.O., and to also integrate additional reproductive health services - antenatal care, exclusive breastfeeding, and STI/HIV/AIDS - so as to complement and expand the existing family planning focus. Project activities were to ultimately cover 20 Districts, nearly two-thirds of Albania's population. In addition to expanding the Logistics Management Information System (LMIS) established under JSI/SEATS II/Albania, the Project was to support the MOH to work toward achieving "contraceptive security".

In late 2003, the USAID-funded PRO Shendetit project began work with the MOH and the Health Insurance Institute (HII) to roll out and expand the PHC work begun by PHRplus.

During JSI/TASC I/Albania's final years, the Centers for Disease Control and Prevention (CDC) designed and implemented the data collection and data analysis for Albania's first Reproductive Health Survey (RHS). The RHS reported very low levels of modern method use, very high levels of traditional method use, and exceptionally low levels of contraceptive knowledge.

Percent of Married Women Aged 15-44 Reporting Contraceptive Use (2002 Albania RHS)

Modern Method Use		**8.0 %**
Condoms	**2.1 %**	
Spermicides	**0.0 %**	
Orals	**1.0 %**	
Injectables	**0.4 %**	
Intrauterine Devices (IUDs)	**0.5 %**	
Female Tubal Ligation	**4.0 %**	
Male Vasectomy	**0.0 %**	
Traditional Method Use		**67.1 %**
Total Contraceptive Prevalence		**75.1 %**

Once female tubal ligations are subtracted (many of which were likely performed for medical indications rather than to limit childbearing), the contraceptive prevalence rate for modern methods is very low indeed.

Percent of Women Aged 15-44 and Men Aged 15-49 Who Have Heard of Specific Methods of Contraception (2002 Albania RHS)

Specific Method	Percent of Women Who Have Heard of Method	Percent of Men Who Have Heard of Method
Modern Methods:		
Condoms	**81**	**89**
Spermicides	**5**	**4**
Orals	**68**	**32**
Injectables	**34**	**6**
IUDs	**23**	**8**
Female Tubal Ligation	**65**	**14**
Male Vasectomy	**6**	**4**
Emergency Contraception	**11**	**10**
Traditional Methods:		
Withdrawal	**82**	**85**
Periodic Abstinence	**24**	**21**

These are surprisingly low knowledge levels about modern contraceptives in a population that is highly literate. Men are significantly less informed about modern contraceptive methods than women. Although knowledge and use of the lactational amenorrhea method (LAM) was not covered in the survey, the duration of exclusive breastfeeding is only 2.8 months.

Most likely because of the high use of withdrawal, the 2002 Albania RHS defined unmet need as the proportion of *all women* who are fecund, currently sexually active, currently exposed to risk of pregnancy, not wanting to become pregnant, and not using *modern contraception*. This differs from the conventional definition that considers only *women in union* not using *any method* of contraception. The unmet need for limiting was more than twice the unmet need for spacing.

Unmet Need (2002 Albania RHS)

Unmet Need for Spacing	Unmet Need for Limiting	Total Unmet Need
22.0 %	**48.4 %**	**70.4 %**

IV. PROJECT IMPLEMENTATION

The Albania Family Planning Project simultaneously implemented **three major components** to improve the quantity and quality of family planning services available in the public sector and to increase the public demand for these improved services: **family planning training, contraceptive security, and behavior change communication (BCC).** Working at both the District and national levels, an emphasis was placed on public sector capacity building to increase the likelihood of sustainability over time.

Although the 2002 RHS showed a very low contraceptive prevalence rate (CPR) nationwide, a 2004 survey by the USAID-funded Albania Child Survival Project (ACSP) in Diber Prefecture (comprising Bulqize, Diber, and Mat Districts) suggested that this model introduced by the JSI/SEATS II/TASC I projects of extending family planning services to the commune level by

making trained providers, commodities and information, education and communication (IEC) materials available was achieving results. Of the three ACSP target Districts, Bulqize and Mat Districts had been included in the previous JSI/TASC I project while Diber District had not.

Contraceptive Prevalence Rates
(2004 ACSP Survey)

District	Contraceptive Prevalence Rate
Bulqize	10.8 %
Mat	11.8 %
Diber	5.9 %

A. Geographical Coverage

Background and Mandate

During the JSI/SEATS II/TASC I projects, access to family planning services had been greatly expanded in 20 of Albania's 36 Districts. By mid-2003, 98% of all maternities, women's consulting rooms (WCRs), and health centers (HCs) in the 20 Districts were providing family planning services – a total of 244 service delivery points (SDPs). In effect, family planning services were almost universally available at the commune level. These 20 Project Districts included 68% of Albania's total population.

Endline Data for JSI/SEATS II/TASC I Projects

# of New Districts Added	Cumulative # of Districts Covered	% Total Population Added	Cumulative % Total Pop Covered	# of SDPs Added	Cumulative # of SDPs Covered
4 (1999)	4	28 %	28 %	65	65
2 (2000)	6	13 %	41 %	46	111
4 (2001)	10	7 %	48 %	37	148
8 (2002)	18	15 %	63 %	79	227
2 (2003)	20	5 %	68 %	17	244

A major AFPP task was to expand access to the commune level in the remaining 16 Districts to reach the remaining 32% of the population. These 16 AFPP target Districts consisted of three large Districts (Fier, Lushnje, Vlore,) that included 16% of the total population and 13 very small (and predominantly rural) Districts that included the remaining 16% of the total population. The 16 AFPP target Districts were found to have 180 potential SDPs, only 42 of which were providing family planning services in 2004. Ten of the 16 AFPP target Districts had only one functioning family planning SDP, located in the major District town. As before, expansion into new Districts meant increasing the geographic access to services by expanding from the District capital to the commune level health centers throughout the District.

Baseline Data for 16 AFPP Target Districts

16 AFPP Target Districts	Percent of Total Population	Total # of Potential SDPs	Total # of Potential SDPs by Type			# of SDPs Providing Family Planning Services in 2004
			Mat	WCR	HC	
Delvine	0.35 %	5	1	1	3	1
Devoll	1.13 %	6	1	1	4	1
Diber	2.79 %	16	1	1	14	3
Fier	6.48 %	19	1	2	16	7
Has	0.64 %	5	1	1	3	1
Kolonje	0.56 %	8	1	1	6	1
Kukes	2.07 %	16	1	1	14	1
Lezhe	2.21 %	11	1	1	9	4
Lushnje	4.68 %	17	1	1	15	8
Mirdite	1.20 %	8	1	1	6	2
Permet	0.84 %	11	1	1	9	1
Puke	1.12 %	11	1	1	9	1
Skrapar	0.97 %	10	1	2	7	1
Tepelene	1.05 %	11	1	1	9	1
Tropoje	0.91 %	9	1	1	7	1
Vlore	4.78 %	17	1	4	12	8
TOTAL	31.78 %	180	16	21	143	42

Implementation and Results

AFPP's training strategy was to focus initially on the most populous Districts and those Districts that overlapped the project areas of other stakeholders, particularly the two USAID-funded projects, the Albania Child Survival Project in Diber and PRO Shendetit in Lezhe. Consequently, Diber, Fier, Lezhe, Lushnje, and Vlore were the first target Districts to receive family planning and LMIS training in 2005, followed by Puke, Delvine, Devoll, Kolonje Mirdite, and Skrapar. In 2006, Permet and Tepelene were the next Districts trained, followed by Kukes, Has, and Tropoje. By June 2006, all 16 target Districts had been trained, completing the countrywide coverage as planned.

Summary of USAID-funded Family Planning Service Expansion, 1999-2006

# of New Districts Added	Cumulative # of Districts Covered	% Total Population Added	Cumulative % Total Population Covered	Existing SDPs in 2004 Baseline	# of New SDPs Added	Cumulative # of SDPs Covered
4 (1999)	**4**	**28 %**	**28 %**		**65**	**65**
2 (2000)	**6**	**13 %**	**41 %**		**46**	**111**
4 (2001)	**10**	**7 %**	**48 %**		**37**	**148**
8 (2002)	**18**	**15 %**	**63 %**		**79**	**227**
2 (2003)	**20**	**5 %**	**68 %**		**17**	**244**
(In the interval between the JSI/SEATS II/TASC I projects and AFPP, some SDPs closed, and some expanded and "divided" to report separately; the net gain was 5 SDPs for a total of 249.						
SDPS reporting in 2004 Baseline						**249**
5 (2005-Q2)	**25**	**21 %**	**89 %**	**30**	**50**	**329**
1 (2005-Q3)	**26**	**1 %**	**90 %**	**1**	**10**	**340**
5 (2005-Q4)	**31**	**4 %**	**94 %**	**6**	**31**	**377**
2 (2006-Q1)	**33**	**2 %**	**96 %**	**2**	**20**	**399**
3(2006-Q2)	**36**	**4 %**	**100 %**	**3**	**27**	**429**

During the previous JSI/SEATS II/TASC I projects, family planning training included doctors, nurses, and midwives based in the maternities, WCRs, and HCs as well as community midwives at the health post (*ambulanca*) level. When the JSI/TASC I project was revised, the *ambulanca*-level training was discontinued. AFPP re-instituted the training of community midwives and also involved them in new ways of relating to their communities.

B. Family Planning Training

Background and Mandate

During the JSI/SEATS II/TASC I projects, considerable effort had been devoted to developing relevant curricula, cue cards, and cadres of trainers ready to train, as well as an integrated field monitoring and evaluation system.

JSI/SEATS II/Albania conducted training of trainers (TOT) courses and interpersonal counseling and communication (IPCC) courses for potential trainers from the Tirana and Durres Districts, after which two MOH training teams were formed, one based in Tirana and one based in Durres. Training facilities were equipped. A three to four day contraceptive technology update/ interpersonal communication and counseling (CTU/IPCC) curriculum for doctors, nurses and midwives was developed that covered contraceptive methods, client counseling and sexually transmitted infection (STI) prevention. A pre-test/ post-test measured knowledge acquisition and identified areas that needed more or different attention. Laminated cue cards were developed for the providers to use to support and improve their counseling skills and the content of the information they provided to clients. Nurses and midwives from the *ambulancas* as well as doctors, nurses and midwives from the health centers, women's consultation rooms and maternities were trained. Providers from the two maternities in Tirana and from the Durres maternity participated in postpartum/ post abortion care workshops.

A subcontract with the Albanian International Planned Parenthood Federation (IPPF) affiliate, then-named Albanian Family Planning Association (AFPA), now the Albanian Center for Population and Development (ACPD), targeted the nascent private sector by reaching out to the newly privatized pharmacists in the Project Districts. One-day courses offered an overview of the modern contraceptive methods available in Albania and oriented the participants to the use of the available IEC materials, specifically the method brochures and the family planning cue cards, with which each participating pharmacy was then supplied.

Early in TASC, the TOT and IPCC courses were repeated for potential trainers from Elbasan and Shkoder, after which two additional training teams were formed. In addition to these Districts, the CTU/ IPCC training was also provided to nursing school students in Tirana and Elbasan, as well as to the family practice interns attending the two-year Family Medicine Specialization program in Tirana. A postpartum/ post abortion care workshop was also held for 25 physicians and midwives from Elbasan, using the curriculum developed under SEATS II.

JSI/Albania/TASC I also provided CTU/ IPCC training to a number of donor organizations and NGOs struggling to deal with the effects of the 1997 social disorder and the 1999 Kosovar refugee crisis: the International Medical Corps, the International Rescue Committee, AGRITRA (an Albanian agricultural / veterinary NGO), Children's Aid Direct, the International Catholic Migration Commission, and the Land O'Lakes/ Albania micro-credit project.

Attempting to train the newly privatized pharmacists by engaging them in formal training had turned out to be exceedingly difficult during the SEATS II project so that, under TASC I, a more informal system of on-site visits and orientation to the use of the counseling cue cards and client brochures was adopted. Given that two social marketing projects that targeted pharmacists were by then operational in Albania, this approach seemed to function reasonably, if not optimally, well.

When USAID/Albania revised its health Strategic Objective and modified the original JSI/TASC I/Albania contract in 2002, JSI/TASC/Albania provided extensive expatriate technical assistance to help develop two-day curricula and provider cue cards for two new training technical areas: antenatal care/ exclusive breastfeeding and the prevention of STI/ HIV/ AIDS. As these two technical curricula were under development, it was recognized that the existing family planning curriculum was in need of considerable revision to make it similar in quality and approach to the new curricula. The family planning curriculum was restructured and revised to make it suitable for both basic and refresher training. The cue cards were also updated.

To roll out these new curricula, 45 MOH trainers from 10 geographically strategic Districts (from Shkoder in the north to Gjirokaster in the south) were each trained in participatory training techniques (PTT) and at least two of the three technical areas. These 45 trainers formed eight regional training teams. Generally, three staff from each health center in the 20 Districts – one doctor and two nurses or midwives – received training with each course on average having 25 participants.

To assess the quality of the training sessions and the ultimate integration at the health facility level of the three major components (training, LMIS, IEC), JSI/TASC I/Albania developed an

integrated field monitoring and evaluation system. The system consists of a series of monitoring checklists and forms that provide a guide for evaluation, promote a supportive approach to supervision, and elicit direct feedback from clients.

Implementation and Results

Standard Family Planning Training

In early 2005, AFPP organized a workshop for key partners (MOH, Pro Shendetit, and ACSP) plus local family planning experts to review the 2002 Albania family planning curriculum and outline areas in need of improvement and updating. Based on the results of this workshop, AFPP revised the family planning curriculum to more clearly emphasize needed counseling skills and also updated the supporting cue cards. This
revised curriculum was then officially approved by the MOH and a local technical expert appointed by the MOH.

To prepare the needed cadre of trainers, AFPP recontacted the MOH trainers previously trained by the JSI/SEATS II/TASC I projects. Based on previous proficiency, interim training involvement, interest, and availability, five MOH trainers were selected to be AFPP Master Trainers.

The District Directorates of the 16 target Districts were each asked to nominate a trainer candidate using the criteria previously used by the JSI/TASC I project:

- ✓ Excellent communication skills (speaking, writing, reading)
- ✓ At least three years' work in reproductive health field
- ✓ Personally and professionally available to conduct 2- to 3-day training courses as needed
- ✓ Able to travel domestically with occasional overnight stays
- ✓ Comfortable with public speaking
- ✓ Experience with public speaking (desirable)
- ✓ Enjoy learning and obtaining new skills
- ✓ Enjoy sharing information and teaching
- ✓ At ease discussing topics of a sexual nature
- ✓ Outgoing personality
- ✓ Open, non-judgmental attitude toward people from diverse backgrounds
- ✓ Previous training experience (desirable)

Twelve of the 16 Districts were able to identify suitable candidates; four (Delvine, Has, Kolonje, and Skrapar) were not able, due to lack of available manpower. These 12 new candidates plus six previous JSI/TASC I District trainers from a wide geographic range of Districts and two candidates from ASCP made up the AFPP pool of District trainers.

AFPP adapted the 2002 PTT curriculum to use for refresher training. The Project then organized four TOT workshops. The five Master Trainers participated in a two-day PTT TOT for Master Trainers and a four-day Family Planning TOT for Master Trainers. These Master Trainers then conducted a three-day PTT TOT and a four-day Family Planning TOT for the 21 District trainers (19 from the MOH and two from ACSP). AFPP held regular quarterly meetings with the Master Trainers to discuss work accomplished, the results of follow-up visits, and next steps.

At this time, AFPP also developed a training database to provide monitoring and evaluation data and to assist the MOH in planning future training. The Project also designed a training roll-out schedule, deciding to focus first on the most populous of the 16 target Districts and those AFPP target Districts that overlapped with PRO Shendetit and ACSP in order to have the greatest impact early in the Project and to allow longer time for follow-up.

As described in Section IV.D., as part of the TO Modification #1, AFPP also carried out a pilot intervention in Diber and Fier Districts using an innovative approach called Outreach Negotiation Counseling (ONC) that involved community midwives in new ways of relating to their communities. Everyone trained in ONC had previously received the standard family planning training. In Diber, ACSP provided this training using the standard family planning curriculum and the AFPP-trained trainers; in Fier, AFPP trained an additional 142 providers in anticipation of their involvement in the ONC pilot.

Numbers and Type of Staff Trained

Ultimately, AFPP trained 730 health providers using the MOH-approved standard family planning curriculum. Initially, the goal had been to train one doctor and two nurses or midwives from each potential SDP in the 16 target Districts; however, especially in the predominantly rural Districts, many of the SDPs did not have doctors and/or did not have two nurses or midwives. In addition, early on, multiple SDPs indicated an interest in having the community-based (ambulanca level) midwives attached to their respective SDPs included in the training courses. Ultimately, 491 facility- based providers (178 ob-gyns and general practitioners; 313 nurses and midwives) and 211 community-based midwives were trained. Given their important roles as mentors, motivators, supervisors and problem solvers, 28 staff from the District Directorates were also trained.

Numbers and Types of MOH Staff Trained by District

District	Facility-based Providers		Community-based Providers	Others	TOTAL
	Doctors	Nurses/ Midwives	Midwives		
Delvine	4	8	3	1	16
Devoll	4	8	8	1	21
Diber	11	20	15	2	48
Fier	50	74	101	5	230
Has	5	8	3	2	18
Kolonje	7	13	4	0	24
Kukes	19	20	8	3	50
Lezhe	9	16	14	2	41
Lushnje	14	24	11	1	50
Mirdite	4	13	4	2	23
Permet	9	18	8	1	36
Puke	8	20	5	3	36
Skrapar	4	14	10	0	28
Tepelene	10	12	8	1	31
Tropoje	6	14	4	3	27
Vlore	14	31	5	1	51
TOTAL	178	313	211	28	730

Because of the inclusion of community midwives in general and for ONC specifically, the number of doctors trained relative to the number of nurses and midwives trained was more in the proportion of one to three, rather than the originally planned proportion of one to two.

Number and Percent of Staff Trained

Number and Percent	Facility-based Providers		Community-based Providers	Others	Total
	Doctors	Nurses/ Midwives	Midwives		
Numbers	178	313	211	28	730
Percent	24 %	43 %	29 %	4 %	100 %

Family Planning Training (Devoll District)

Monitoring and Evaluation Follow-up

In September 2005, as planned, AFPP began systematic follow-up in the Districts where training first took place. To guide the follow-up and to ensure consistency, a standardized "Integrated Monitoring and Evaluation Follow-up Checklist" was developed and used, adapted in part from the Integrated Field Monitoring and Evaluation System developed under the previous JSI/TASC I/Albania project.

A follow-up visit was to include 1) using the facility-oriented Checklist which covers family planning services offered, equipment, commodities and record keeping; 2) administering a post-post-test to the trained providers; 3) observing providers conducting client visits for family planning; and 4) conducting client exit interviews to determine the level of client satisfaction with the family planning services received.

The purpose of training follow-up was to provide data on the outcome of project interventions as well as to provide on-the-job support and training when needed.
Ideally AFPP would have followed up all trainees, but this was not possible given time and resource constraints. Instead, a third of the SDPs were selected randomly in each AFPP target District using the training database which shows the number and names of SDPs with at least one trained service provider and the number of service providers trained by the Project. Within selected SDPs, all trained service providers were to be interviewed. In 2006, the follow-up was expanded to include a small sample of community midwives.

On-the job Training During a Follow-up Visit

After much discussion, AFPP decided that, in order to have impartial data, the follow-up interviewers should not be AFPP staff. Specific criteria for the persons to be selected as interviewers were established:

- ✓ they should be MOH staff
- ✓ they should themselves have been trained with the national family planning curricula
- ✓ they should be capable of providing on-the-job training
- ✓ they should have previous experiences in using questionnaires/assessment tools

The two interviewers chosen – a master trainer from Tirana and a regional trainer from Fier – received explicit training in the use of the questionnaires, including a day of field practice. A third interviewer was later hired and trained to do provider observations and client exit interviews.

In most visits, the District Inspectors for Mothers and Children participated in all follow-up activities, thus increasing 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).

Selected Findings from Follow-Up Visits to 125 SDPs in the 16 AFPP Districts

Signage and Services	
Family Planning logo displayed at front of facility	**82 % (102/125)**
Family Planning services available at any time	**95 % (119/125)**
Family Planning posters displayed in client areas	**82 % (102/125)**
Family Planning pamphlets visible and accessible in client areas	**59 % (74/125)**
Availability of Commodities	
Low-dose COCs	**86 % (108/ 125)**
Progestin-only pills (POPs)	**64 % (80/125)**
Injectables	**88 % (110/125)**
Condoms	**87 % (109/125)**
Other	
Appropriate physical storage of family planning commodities	**91 % (114/125)**
Storage of commodities by expiration date	**77 % (96/125)**
Timely submission of LMIS data	**75 % (94/125)**

Of concern is the low percentage (59%) of SDPs that had family planning pamphlets visible and accessible in client areas. When the national family planning logo was first developed as an identifier for quality family planning services, quality services were defined by three criteria: 1) the presence of trained health providers; 2) the availability of a choice of modern methods of contraception; and 3) the availability of informational/ educational materials for clients. AFPP was not designed or budgeted to either produce new client materials or reproduce existing materials. PRO Shendetit was to assume this role and did develop an all methods brochure which was first available in late 2005; however, insufficient quantities were available to meet AFPP's needs. In late 2006, the United Nations Population Fund (UNFPA) funded the reprinting of 50,000 copies of the PRO Shendetit all methods brochure, of which half were given to AFPP for distribution.

Selected Interview Findings from Follow-up Visits to a Sample of 246 FP Providers*

Presence of Family Planning Tools	
Cue cards located in client area	**80 %** (196/246)
Male model and condoms located in client area	**83 %** (205/246)
Blood pressure equipment located in client area	**91 %** (223/246)
Other	
Condom use correctly demonstrated	**47 %** (116/246)
Provider correctly states which day in the menstrual cycle a woman should start taking pills	**98 %** (241/246)
Provider correctly states when women who are using LAM for contraception should change to another family planning method	**80 %** (196/246)
Provider correctly states the difference between a 28-day packet of COCs and a 28-day packet of POPs	**94 %** (231/246)
Provider correctly states how to counsel client at high risk for STI/ HIV	**42 %** (107/256)

*256 total providers were interviewed; 10 interview forms were completed inaccurately and were excluded.

Average Pre-Test, Post-Test, and Post-Post-Test Scores for the 246 Interviewed Providers

District	Pre-Test Average	Post-Test Average	Post-Post-Test Average
Delvine	**13.0**	**15.3**	**19.0**
Devoll	**12.8**	**18.8**	**18.0**
Diber	**12.6**	**16.3**	**17.3**
Fier	**12.3**	**17.4**	**19.2**
Has	**12.3**	**18.7**	**18.3**
Kolonje	**11.8**	**17.2**	**16.3**
Kukes	**11.8**	**15.0**	**17.5**
Lezhe	**12.2**	**16.8**	**18.7**
Lushnje	**12.8**	**16.8**	**17.5**
Mirdite	**9.2**	**18.1**	**18.2**
Permet	**14.6**	**19.3**	**18.5**
Puke	**10.6**	**16.8**	**18.1**
Skrapar	**11.0**	**16.7**	**19.2**
Tepelene	**11.7**	**15.1**	**18.8**
Tropoje	**11.6**	**15.0**	**18.0**
Vlore	**13.4**	**17.6**	**17.4**

Selected Findings from 139 Provider Observations and Client Exit Interviews

Observation of Client Visits	
Provider greeted/ welcomed client	**99 %** (138/139)
Provider introduced himself/ herself to client	**86 %** (119/139)
Provider asked client how he/ she could help	**99 %** (138/139)
Provider provided privacy	**99 %** (138/139)
Client seemed comfortable and at ease with provider	**100 %** (139/139)
Client Exit Interviews	
Client stated provider made them feel welcome	**100 %** (139/139)
Client stated provider paid full attention during visit	**100 %** (139/139)
Client stated provider would keep information confidential	**99 %** (138/139)
Client stated provider informed them whether their method provides protection from STI/ HIV	**81 %** (113/139)
Client would recommend this clinic to friends and family	**100 %** (139/139)

C. Contraceptive Security

Background and Mandate

Assuring the reliable and uninterrupted supply of contraceptives for all who want them (the essence of contraceptive security) is one of the key requirements for developing and maintaining a quality family planning program. In Albania, contraceptives are available from three sources: at no cost from the government (although “informal” payments and “gifts” to providers are common); at subsidized prices from social marketing programs, currently, the German Kreditanstalt für Wiederaufbau (KfW)-funded NESMARK program; previously, also the USAID-funded Albanian Social Marketing Association/ Population Services International (ASMA/PSI) project; and at market prices from the commercial for profit sector (primarily Schering).

From the early 1990s, when family planning was legalized in Albania, until 2005, international donors provided all the contraceptives for the public and social marketing sectors. Except for oral pills, the quantity of contraceptives imported and sold by the commercial sector during this period was negligible.

Total Contraceptive Donations to MOH and Social Marketing Programs, 2001-2005

	IUDs (pieces)	Injectables (vials)	Orals (cycles)	Condoms (pieces)
UNFPA	**4,730**	**20,200**	**256,667**	**417,600**
USAID	**6,600**	**24,000**	**0**	**594,000**
KfW	**700**	**13,000**	**300,000**	**10,120,700**
International Planned Parenthood Federation (IPPF)	**405**	**2,524**	**10,670**	**29,630**

Sources: Ministry of Health and NESMARK

Under JSI/SEATS II/Albania, a Logistics Management Information System had been established that collects service statistics - first visits, revisits, counseling visits, total visits, CYP generated – as well as contraceptive logistics data to ensure the timely and optimal re-supply of contraceptives.

Contraceptive independence is defined as "complete self-reliance in maintaining contraceptive security with no need for external donors to fund contraceptives or related logistical technical assistance."

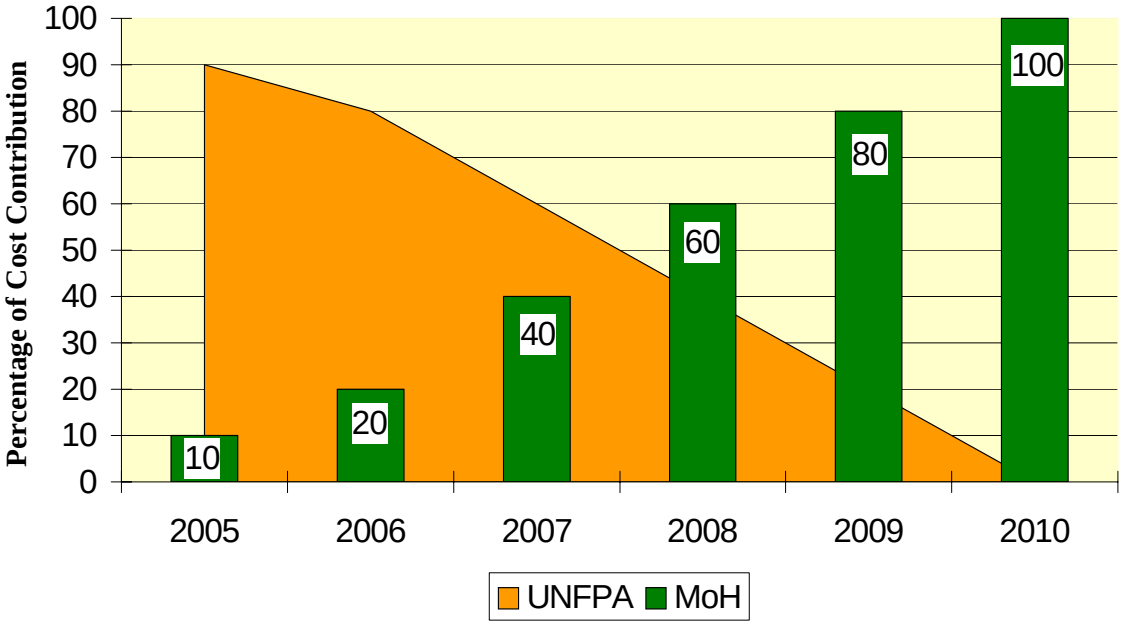
In 2001, Albania began to face increasingly severe contraceptive commodity shortages as donor inputs declined. UNFPA had been the sole provider of public sector contraceptives, and UNFPA's last shipment had taken place in early 2000. As a result, many SDPs were suffering contraceptive stockouts. JSI/TASC I/Albania was tasked by USAID with addressing this situation and with establishing a National Contraceptive Security Commission (NCSC). In collaboration with the MOH, UNFPA, and USAID/Albania; JSI/TASC/Albania's first step was to conduct a one-time, national stocktaking to address the stockout crisis head on. UNFPA and USAID/Albania agreed to procure needed contraceptives as an interim measure. The next step was to expand the LMIS nationwide; the creation of a truly national LMIS would enable the MOH to estimate total national requirements. The LMIS was then centrally computerized and located within the MOH's Reproductive Health Unit (RHU).

Contraceptive security is defined as "an adequate supply and choice of quality contraceptives for every person who needs them, in accordance with the International Conference on Population and Development goal of universal access."

A National Contraceptive Security Commission was formed, chaired by the Deputy Minister of Health and with JSI/TASC I serving as the secretariat. Commission members included representatives from the Institute of Public Health (IPH); HII; UNFPA; USAID; the then-named AFPA (now ACPD), the two social marketing programs, NESMARK and ASMA/PSI; and Schering from the commercial for profit sector. The NCSC was expected to monitor the adequacy of national contraceptive supplies, review contraceptive forecasts, assess method mix and sector mix, and look at family planning coverage by District. As a very crucial and important first step, the NCSC recommended that the Government of Albania (GoA) begin budgeting for the procurement of public sector contraceptives, instead of relying on donor-supplied contraceptives.

In early 2003, the NCSC requested JSI/TASC I/Albania assistance in the development of a **National Contraceptive Security Strategy** that was signed by the Minister in July 2003. A key component of the Strategy is the commitment of the GoA to increasingly assume the cost of procuring public-sector contraceptives in a step by step fashion (while the UNFPA share correspondingly decreases). Under this agreement, by 2010, Albania will be completely self-reliant and independent of outside donor support for contraceptives.

Relative Share of Contraceptive Costs Provided by the MOH and UNFPA by Year



By 2005, only two contraceptive donors remained in Albania: UNFPA and KfW. UNFPA was the sole contraceptive supplier for the public sector; USAID continued to provide family planning technical assistance, but not contraceptive commodities. IPPF no longer supplied contraceptives to the IPPF-affiliate, AFPA (now ACPD). KfW was the sole social marketing contraceptive supplier (for NESMARK). It should be noted that UNFPA has been the only source for progestin-only pills in Albania, and NESMARK has been the only source for emergency contraception.

Implementation and Results

AFPP quickly re-established communication with Albania's key contraceptive security stakeholders: MOH, UNFPA, NESMARK and Schering.

National Contraceptive Security Commission

As AFPP was starting up, USAID's Bureau for Europe and Eurasia announced a Reproductive Health Commodity Security Conference in Bucharest, Romania to be held in May 2005, and AFPP was invited to organize an Albanian delegation to participate. A delegation of five attended from Albania, including three representatives from the MOH, one from PRO Shendetit, and the AFPP Project Director. The previously established National Contraceptive Security

Commission had not met since 2003, so AFPP used the necessary pre-Conference preparations to focus key Albanian stakeholders on the contraceptive security situation in Albania, especially progress in implementing the National Contraceptive Security Strategy adopted in 2003. AFPP planned to use the outputs from the Bucharest Conference as inputs for a program to revitalize the NCSC, and thus continue the movement toward contraceptive security in Albania.

Soon after the Bucharest conference, AFPP began to document the current status of contraceptive security in Albania to provide baseline data for AFPP interventions to strengthen national contraceptive security. Using LMIS data and information collected by AFPP staff from the public, private and social marketing sectors, AFPP produced and submitted to the MOH and USAID/Albania a **Contraceptive Security Report 2006** as an update to the 2003 National Contraceptive Security Strategy. In spite of multiple attempts by AFPP to encourage the MOH to reinstitute the NCSC, it was eventually abolished in 2006. This 'downgrading' of contraceptive security was in part due to national elections in 2006 that resulted in a change in government and a change in MOH officials at the most senior level.

In early 2007, the new MOH Vice-Minister indicated that the 2003 National Contraceptive Security Strategy remained the framework for contraceptive security in Albania, and that the functions of the now-abolished NCSC would be merged into a revitalized and reconstituted UNFPA-supported National Reproductive Health Commission. Initially, AFPP thought this new arrangement would, in the long run, get contraceptive security a more prominent place on Albania's national reproductive health agenda. A National Reproductive Health Commission could be better placed to deal with important contraceptive security issues such as improving the method mix and market segmentation. AFPP's position was that it was prepared to assist the Commission to establish a strong Contraceptive Security Subcommittee that met regularly to monitor contraceptive stock levels and enhance overall contraceptive availability.

Ultimately, a National Reproductive Health Commission was formed with four main technical subcommittees :

- Reproductive Health Policy, Strategy and Legislation
- Norms and Standards for Reproductive Health Services
- Reproductive Health Situation Analysis and Indicators
- Social Aspects and Media in Support of Reproductive Health

In theory, the functions of the defunct NCSC were to be part of the Reproductive Health Situation Analysis and Indicators subcommittee, but in practice this did not happen. The Commission did meet and the subcommittees also met several times, but reportedly they are still struggling with exactly how they should function.

Also, as part of the expanded SOW included in Contract Modification #1, AFPP intended to conduct a strategic re-assessment of the family planning situation in Albania, given the low CPR for modern methods. The objective was to assist the MOH in identifying the major barriers to increased contraceptive use and the next steps that might be taken by the GoA to improve the quality of family planning services. Initial interviews were conducted in late 2006 with a wide range of potential stakeholders, both public and private. Subsequently, once the concept of a

National Reproductive Health Commission re-emerged, the MOH concluded the Commission would itself do the strategic re-assessment, and AFPP discontinued its efforts.

Market Segmentation Analysis

In September 2006, a JSI advisor conducted a **market segmentation analysis** in Albania using a total market approach. A **total market approach** looks at the characteristics of existing and likely future markets to define the comparative advantages of commercial, social marketing, and public sector actors in terms of ability and efficiency in delivering a range of products and services to different market segments, including the poorest. Using a total market approach strategy often leads to improved coordination and collaboration among sectors so that more total clients are reached and government subsidies go to those who most need them. The gradual shifting of consumers with sufficient purchasing power out of the public sector and into the commercial sectors allows the private commercial sector to thrive alongside the subsidized sectors.

> 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.

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

- Increased 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 of the population underserved by the private sector: low income and rural groups; and
- Enhanced program sustainability.

Ultimately, market segmentation contributes to long-term contraceptive security. Although Albania has no formal market segmentation strategy for contraceptives, data collected in 2005 showed that de facto market segmentation was occurring; for example, NESMARK supplied 93% of the condoms distributed in the country, leaving the public sector to concentrate on IUDs (98 %) and injectables (80 %). The commercial sector was supplying an estimated 28 % of oral pills in spite of having to compete with the 'free' and subsidized contraceptives being provided by the public sector and NESMARK.

Contraceptive Market Share as Percent of the Total Market, 2005

Sector	Pills	Injectables	IUDs	Condoms
Public Sector (MOH)	**29%**	**80%**	**98%**	**7%**
Social Marketing (NESMARK)	**43%**	**20%**	**0**	**93%**
Private Commercial Sector	**28%**	**0**	**2%**	**0**
	100%	**100%**	**100%**	**100%**

Contraceptive Security Report March 2006

Logistics Management Information System

In addition to policy-level involvement, AFPP quickly began providing technical support to the LMIS, starting with a review of the existing database. Updates were made to the software, and

the software was re-installed where computer systems had crashed or new computer systems had been introduced.

In mid-2005, after discussions within the MOH and with AFPP, the Vice-Minister of Health decided to shift LMIS operations (data entry and report preparation) from the MOH's Reproductive Health Unit in the Primary Health Care Directorate to the IPH's Health and Reproductive Health Indicator Department where there would be more technical and administrative support for the LMIS. IPH manages Albania's vaccine supply system and could offer more information technology capability.

This shift required increased training and technical assistance from AFPP to IPH, but, in the long term, it has the potential to fully institutionalize the LMIS within the government system. In mid-2006, IPH also assumed responsibility for the central-level warehousing and distribution of contraceptives, a function UNFPA had performed previously. Under the new distribution system, the Districts must come to the IPH warehouse in Tirana to pick up their contraceptive supplies. The RHU retains the responsibility and authority for policy decisions regarding the LMIS and MOH contraceptives; only the LMIS operations (warehousing, distribution) and contraceptive logistics have been delegated to the IPH.

For the new SDPs, LMIS training was an integral part of the family planning training curriculum so that SDPs received contraceptive commodities and began reporting quarterly at the same time their providers were trained to provide services.

LMIS reporting nationwide and in the 16 AFPP target Districts has been quite high; in April 2007, 94% of all SDPs nationwide reported and 96 % of the SDPs in the target Districts reported.
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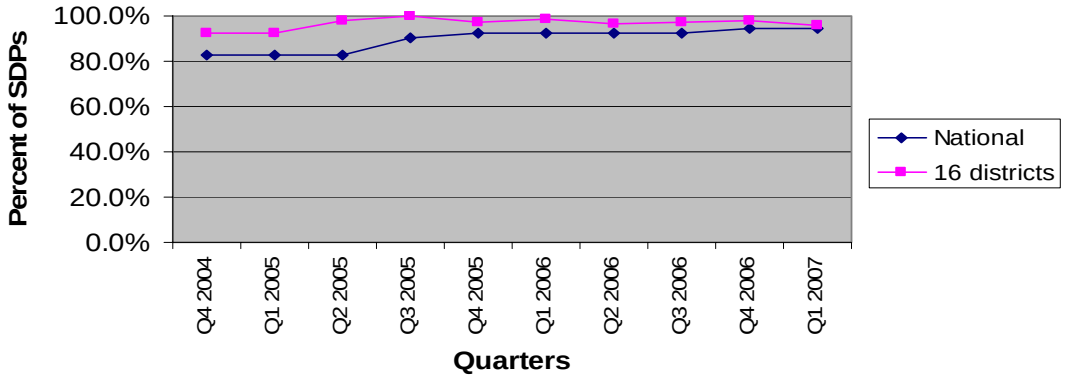
LMIS Reporting Rates: National and AFPP's 16 Target Districts



Timeliness remains an ongoing challenge, however, with reports trickling in over several months. Some Districts must still be contacted directly to request submission.

The level and quality of LMIS reporting had suffered some decline in 2004 and 2005 from the very high levels achieved in 2003. Additionally, it was time to convert the LMIS at the District level to an electronic system. UNFPA provided 36 computers, one for each District, and AFPP provided the needed software and initial orientation to the software.

In late 2006, with UNFPA support, AFPP provided refresher training for LMIS staff in all 36 Districts in three separate workshops, each comprising 12 Districts, to enhance the skills of the MOH personnel responsible for managing the LMIS in each District and to orient the Districts to the IPH's new role. The two trainers were IPH staff, and the training venue was at IPH.
To make the LMIS training more effective, participants were divided into three groups based on their level of LMIS expertise. At AFPP's conclusion, many Districts were ready to begin electronic reporting.

Stockouts
Stockouts are an important indicator of supply chain efficiency, and contraceptive stockouts have been a chronic MOH problem for multiple reasons. Most critical has been a central level failure to order needed stock in time, given the long lead time required when placing contraceptive orders. For example, in 2005 the MOH failed to request additional progestin-only pills (brand name Microval) from UNFPA in a timely fashion, resulting in a national POP stock out that lasted until early 2006.

Laudably, as agreed to in the original 2003 National Contraceptive Security Strategy, the MOH has contributed its increasing percentage of contraceptive commodity costs.

Timetable for Government Contraceptive Procurements

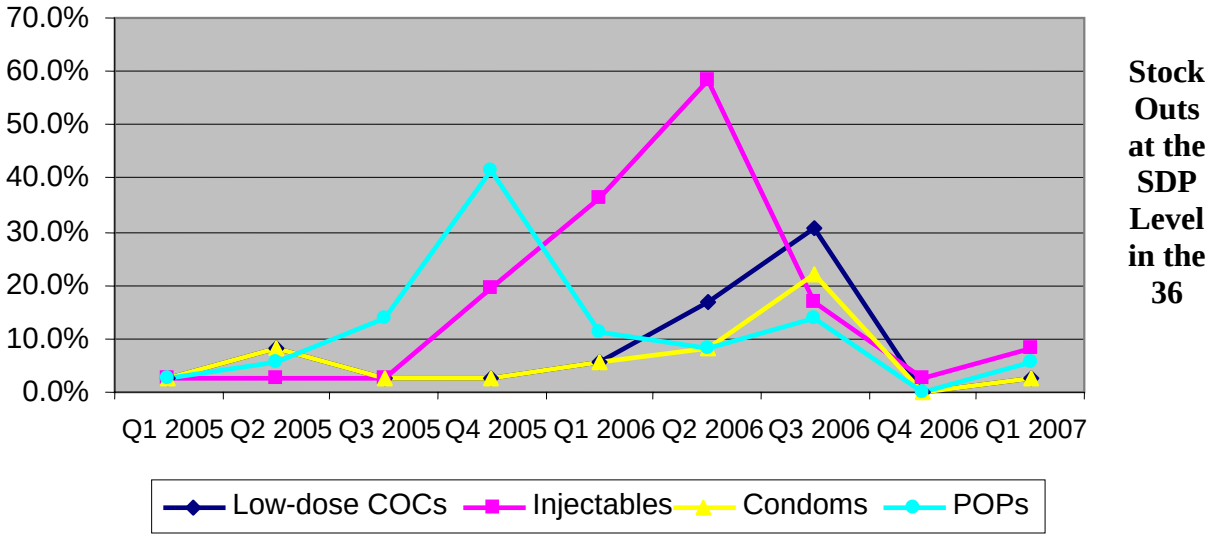
Year	% to be Contributed by Government*	Status	Amount
2005	**10%**	**Achieved**	**$14,043**
2006	**20%**	**Achieved**	**$ 8,991**
2007	**40%**	**Achieved**	**$ 13,966**
2008	**60%**	**Committed**	Dollar amount of government contribution determined each year by the total cost of contraceptives ordered
2009	**80%**	**Committed**	
2010	**100%**	**Committed**	

The MOH procured its first contraceptives (injectables, brand name Depo Provera) through UNFPA in late 2005; approximately three-quarters of injectable users get their injectable from the public sector. Unfortunately, the procurement process was not initiated in time to avoid a central level stockout that lasted until June 2006.

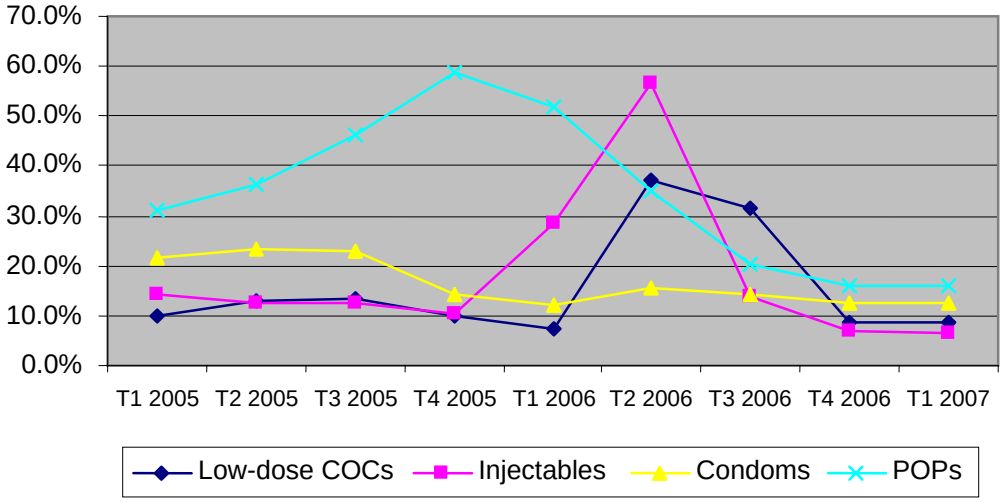
The low-dose combined oral contraceptives (low-dose COCs – brand name Rigevidon) began to stock out in 2006 because the stock remaining in the central warehouse had a June 2006 expiration date. As a result, many district level warehouses stocked out after distributing their supplies to their SDPs. Additional stockouts resulted when District warehouses ran out of stock or when SDPs failed to request contraceptives from their District supplier.

By early 2007, however, stock outs at both district and facility levels (see charts below) were still very low.

Stock outs at the District Warehouse Level in the 36 Districts by Method, January 2005-March 2007



Stock Outs at the SDP Level in the 36 Districts by Method per Quarter



At the consumption levels seen in early 2007, the MOH had the following stock on hand in April 2007.

MOH Stock on Hand, April 2007

Method	Central IPH Level Stock on Hand	District and SDP Level Stock on Hand	Total Stock on Hand	Q1 2007 Consumption (actual)	Estimated Quarters of Stock Remaining
IUDs	**3,758**	**2,134**	**5,892**	**649**	**9.1**
Injectables (Depo-Provera)	**27,435**	**10,790**	**38,225**	**4,389**	**8.7**
Low-dose COCs (LoFemenal)	**93,000**	**41,190**	**134,190**	**18,091**	**7.4**
POPs (Microval)	**2,014**	**12,251**	**14,265**	**3,423**	**4.2**
Condoms	**292,176**	**209,228**	**501,404**	**107,662**	**4.7**

Although it may appear that the MOH has a "cushion," the remaining stocks are very low given the time required for a contraceptive procurement; up to 12 months may be needed to develop an order, place it, and have the commodities arrive in country.

Regularly updated forecasts and timely procurements are the keys to reducing and avoiding contraceptive stockouts. In 2006, AFPP used JSI/DELIVER's PipeLine Software and 2005 consumption levels to prepare a contraceptive forecast for the years 2006 and 2007,and the MOH prepared and submitted to UNFPA a request for contraceptives needed. However, in December 2006, due to higher than expected consumption, UNFPA placed and funded an additional emergency order for oral pills – both POPs and low-dose COCs – and condoms on the MOH's behalf. In large part, this higher than expected consumption was attributed to the NESMARK social marketing products (low-dose COCs and condoms) being off the market for more than a year due to a NESMARK pricing disagreement with the MOH. This situation led to Albanians turning more to the public sector for supplies and to POPs being used when low-dose COC supplies were temporarily depleted.

In May 2007, AFPP conducted a contraceptive forecasting workshop using the JSI/DELIVER PipeLine Software where staff from IPH and PRO Shendetit learned forecasting skills. As AFPP was closing, assistance was focused on alerting the MOH and UNFPA to the need for an immediate procurement if a serious contraceptive stockout is to be avoided. In July 2007, AFPP helped the government prepare an updated contraceptive forecast for the MOH to use as the basis for requesting UNFPA to place an immediate contraceptive order. **The MOH needs to place an order now (August 2007**) for the quantities in the updated contraceptive forecast shown below and in Appendix A to avoid a contraceptive stockout in 2008.

Contraceptive Forecast To Cover MOH Needs Until December 2008

Methods	Quantity	Cost/Unit	Estimated Cost
Low-dose COCs: Rigevidon (cycles)	**105,224**	**$ 0.338**	**$ 35,566**
Progestin-only pills: Micorval (cycles)	**14,668**	**$ 0.595**	**$ 8,727**
Injectables: Depo-Provera (vials)	**30,561**	**$ 0.85**	**$ 25,977**
IUDs (pieces)	**3,712**	**$ 0.30**	**$ 1,114**
Condoms pieces)	**403,874**	**$ 0.025**	**$ 10,097**
Total Cost			**$ 81,480**

D. Behavior Change Communication

For maximum utilization of services, it is as important to focus on the demand for services as well as on their supply; the attention given to creating accessible, quality reproductive health services should be constantly balanced by efforts to increase clients' knowledge and their capacity to make well-informed choices.

Background and Mandate

Early in JSI/SEATS II/Albania , a national family planning logo was designed and field-tested with service providers and clients. The logo was designed to serve as the national symbol for the availability of quality reproductive health services. Quality services were defined by three criteria: 1) the presence of trained health providers; 2) the availability of a choice of modern methods of contraception; and 3) the availability of informational/ educational materials for clients. Materials produced to support logo recognition included a family planning logo promotion poster; plastic logo signs for SDPs that met the logo criteria, and logo stickers of various sizes.

The training provided to health professions strongly emphasized a client-centered approach to service provision and the development of appropriate counseling and communication skills. Laminated cue cards for counseling were produced to support the training received by physicians, nurses, midwives and pharmacists. The cards covered 10 methods: IUDs, injectables, combined orals, progestin-only orals; condoms, emergency contraception, spermicides, lactational amenorrhea method (LAM), male (vasectomy) and female (tubal ligation) voluntary surgical contraception.

Considerable attention was also given to the development of client materials to increase client knowledge and stimulate demand for services. Ten brochures, one for each method covered in the set of cue cards, were produced for urban clients. An additional brochure covering all 10 methods was also produced, primarily for rural audiences. A cloth hanging display panel with pockets for the brochures was also designed and produced.

Finally, a mass media campaign was developed with expatriate technical assistance that utilized TV and radio spots; bus-side advertisements (a first for Albania!); magazine and newspaper ads; posters; billboards and street banners. The first campaign targeted the first four JSI/SEATS II/Albania Districts: Tirane, Durres, Kavaje and Kruje(although the TV and radio spots had nationwide reach to a large extent). Three television spots were produced. The first TV spot, the "Market Lady" spot, showed Albania's well-known and popular comedy actress, Mariana Kondi, playing Bakushe, a market vendor. The second spot showed a more middle class couple discussing family planning while the third spot showed university students talking about the importance of using condoms. The post-campaign evaluation showed the campaign in general to have been a big success with the "Market Lady" spot being remarkably successful with both rural and urban audiences. The radio spots were especially successful at reaching males. The bus-side ads were also well received. The second and third TV spots were less successful. All materials (posters, calendars, and client materials) developed after the mass media campaign featured the "Market Lady" as well as the national logo.

As part of JSI/TASC I/Albania, the print materials developed under JSI/SEATS II/Albania were reproduced and/ or reprinted as needed: the 10 individual brochures for clients on specific contraceptive methods, the "rural-oriented" family planning brochure covering all methods; the family planning cue cards; the family planning logo promotion poster; the plastic logo sign and large and small logo stickers. Tasked initially with distributing 30,000 sets of family planning brochures over three years, the Project distributed 120,000 sets over four years. Ultimately 588 service points - 244 MOH service delivery points and 344 pharmacies - in 20 Districts were continuously re-supplied with these IEC materials..

JSI/TASC I/Albania also sponsored a nationwide "modern methods for modern families: family planning offers choices" mass media campaign using the "Market Lady" television and radio spots and bus-side advertisements that had proven so successful in the SEATS II mass media campaign in the initial four Districts. The TV spot visuals were kept exactly as they were, but the message was changed somewhat to help audiences better understand the meaning of family planning and the benefit of family planning services. Central to the campaign was the promotion of the MOH family planning logo.

A mid-campaign assessment, conducted with expatriate technical assistance, found the campaign had essentially already achieved its objectives: almost every respondent had heard the TV and/or radio spots, could connect them to the national family planning logo, and had an idea of what they could find at places displaying the logo. The campaign ran for six months through July 2003

Implementation and Results

Formative Research and Strategy Development

AFPP immediately began assembling the research base needed to inform their BCC strategy by conducting a literature review to understand the demographic issues and their surrounding context learn of others' experience and products, and identify important gaps in knowledge. The next step was to conduct innovative ethnographic and cognitive research to fill the gaps in knowledge and identify potentially feasible behaviors that Albanian married couples could practice to enable them to reach their fertility goals more effectively by using modern contraception, if they so desired.

AFPP designed a qualitative study to provide information for strategy development and trained four researchers to conduct the required in-depth interviews and focus groups in three representative Districts (Devoll, Diber, and Fier). These three Districts were selected because they represent the geographical center, north and south of Albania. A Trials of Improved Practices (TIPs) study was then conducted with a small sample of married couples in Fier.

The resulting findings, conclusions and recommendations included:

- Albanian couples need information on contraceptive methods.
- Mass media should depict the married couple's closeness and link modern methods with the intimacy and affection of husband and wife. Since many couples are already discussing family planning, they should be encouraged to discuss the topic, but with more accurate and complete knowledge of modern family planning methods.
- Promotion of modern family planning methods should hint subtly at the pleasure and lack of restraint within the married couple's relationship to be derived through relying on an effective modern method.
- The doctor and/or midwife have the potential to become a more widely trusted source of contraceptive information. Linking trained MOH providers with the family planning logo will help to reinforce their expertise and the availability of contraceptive methods at health care facilities.
- "Community mobilization" should take the form of face-to-face outreach communication from a healthcare professional rather than via community events.
- The role of modern contraceptive methods in avoiding abortion should be promoted indirectly rather than directly, because couples who have not experienced abortion do not necessarily associate abortion with negative sentiments or a failure of their family planning method.
- Suggested TIPs behaviors to test were: 1) read information provided on contraceptive methods and discuss with spouse; 2) go with spouse to the health facility or midwife for family planning counseling; and 3) choose a modern contraceptive method.

In July 2005, during an AFPP BCC Strategy Development Workshop, a broad range of stakeholders from the MOH, IPH, PRO Shendetit, ACSP, NESMARK, UNICEF, USAID/ Albania, and AFPP discussed in detail the AFPP field research, the TIPS results, and PRO Shendetit's previous research.. AFPP then developed its final BCC strategy and a media plan based on the strategy. The BCC and media interventions envisioned included:

- Three TV spots
  - Urban Couple
  - Rural Couple
  - Testimonial by Satisfied Users

- Two TV programs
- Pilot face-to-face communication initiative using Outreach Negotiation Counseling

Performance Monitoring

To measure the effects of its media strategy, particularly the mass media component, AFPP carried out national sample **baseline** and **end line** surveys. The baseline survey was conducted in November 2005 in 21 of Albania's 36 Districts, and the end line survey was conducted 18 months later in May 2007. The baseline survey sampled 600 married women of reproductive age (MWRA), i.e., women aged 15-45, interviewed at rural and urban SDPs; the end line survey sampled a similar cohort of 601 MWRA. Both surveys used cluster sampling to select the SDPs and then interviewed the first 20 clients encountered at the SDP who fit the sample criteria.

The survey questionnaire was pre-tested in rural and urban areas of Tirane. The questionnaire consisted of 20 open-ended questions with fixed-choice response categories in which the interviewers recorded the respondents' answers. (The choices were not read to the respondents.) AFPP selected four women to conduct the interviews. All had previous training and experience with survey protocols and questionnaires and had served as interviewers for the 2002 RHS. AFPP provided two days of training on this specific instrument, including a supervised practicum day. The interviewers were organized into two teams, with each team accompanied and supervised by a team leader.

The baseline and end line surveys used the same questionnaire. The baseline instrument, however, contained an additional section media viewing and listening habits to help AFPP with broadcasting decisions during the actual media campaigns. It also asked about exposure to family planning print materials family planning information on the radio.

Mass Media: TV Spots and TV Programs

AFPP's intent when developing TV spots was to inform the public and address key issues revealed by the formative research – including gender issues – in a way particularly meaningful for Albanian husbands and wives in order to create an enabling environment for behavior change. AFPP developed the scripts and storyboards for the first two TV spots simultaneously, one for urban audiences, one for rural. The main family planning messages were the same for both audiences; however, the setting, dress, speech, and behaviors identified one spot as urban and the other as rural.

AFPP carefully chose well-known, popular Albanian actors to be the "stars" of the initial two spots. In "rough" form, the spots were pre-tested in four districts – Berat, Fier, Lezhe, and Tirane – using specially trained interviewers. Pre-testing consisted of focus group discussions and the completion of individual questionnaires. The majority of participants were from the primary target audience: MWRA and their partners. A subset of focus groups targeted health professionals, an important secondary audience. Based on the pre-test findings, the "rough" cuts were modified as needed before broadcasting began in January 2006.

Shooting the Urban (left) and Rural (right) Spots

By official letter, the Ministry of Health requested that the television channels most preferred by the target audiences provide special rates to AFPP for the spots, given their social benefit. TOP Channel and Vision+ offered AFPP a 50% discount and Klan TV offered 70%. AFPP closely monitored the broadcasting schedule and was pleased to see that Klan TV and Vision+ also aired the spots at additional times without charge.

In addition to the baseline and end line surveys, AFPP conducted media recall surveys to measure coverage and memo ability while the TV spots were being broadcast and immediately after they stopped airing, so that AFPP could fine tune its campaigns. The media recall surveys interviewed both males and females. Three separate media campaigns featured the urban and rural spots, the third campaign funded by UNFPA on behalf of the MOH. In late 2006, work began on a third TV spot that promoted the family planning logo and provided "testimonials" to support the message that the use of modern contraceptives did not harm a woman's health and could enhance her health. This third spot was included in the fourth and final media campaign

Media Campaign Results

Campaign Number and Dates		Saw At Least One Spot and Can Recall At Least One Message	Districts Surveyed
I	**Jan-Mar 2006**	**38 %**	**Delvine, Devoll, Fier, Kolonje, Mirdite, Puke, Shkoder, Skrapar, Tirane**
II	**June-July 2006**	**42 %**	**Has, Kukes , Permet, Tepelene, Tropoje**
III	**Sept-Oct 2006**	**60 %**	**Devoll, Diber, Fier, Kolonje, Lushnje, Tirana**
IV	**May-June 2007**	**No separate media recall survey was done during or after Campaign IV as the Endline Survey covered similar topics, albeit with a somewhat different (all female) sample.**	

The media recall survey results definitely suggest a dosage effect: the more people were exposed to a spot, the more they remembered it and its messages without prompting. Indeed, the end line survey – which targeted MWRA and therefore sampled a somewhat different population – also reinforces this hypothesis.

Endline Survey Results: Number and Percent of MWRA Who Saw At Least One AFPP Spot and Could Spontaneously Say At Least One Message

	Number Yes	Percent Yes	Number No	Percent No	Total
Baseline Survey (N=600)	**0**	**0 %**	**600**	**100 %**	**600 100%**
Endline Survey (N=601)	**472**	**79 %**	**129**	**21 %**	**601 100 %**

AFPP approached the TOP Channel's Top Show, one of the most popular talk shows in Albania, about jointly presenting a program on family planning and contraceptives. MOH experts participated, as well as AFPP and PRO Shendetit staff. The show aired in late 2005. AFPP also contacted Dr. Flamur Topi, the well-known host of a popular and well-regarded health program "*Trupi dhe Shëndeti*" (Body and Health).

TVSH's *Trupi dhe Shendeti*

"*Trupi dhe Shëndeti*" has aired on the national Albanian channel, TVSH, for many years. Dr. Topi agreed to host two recognized Albanian reproductive health experts who explained modern contraceptive methods, discussed family planning issues, and answered questions from the "live" audience. AFPP also prepared some questions in advance based on their qualitative research findings. The 45-minute show aired successfully in mid-2006.

The end line survey looked at overall viewership for all the AFPP media productions.

Endline Survey Results: AFPP Broadcasts Reported Seen by Residence

Specific Spot or Show	Percent of Rural Respondents Who Reported Seeing It (N=401)	Percent of Urban Respondents Who Reported Seeing It (N=200)	Percent of Total Respondents Who Reported Seeing It (N=601)
None at all	**16 %**	**18 %**	**17 %**
Rural spot	**61 %**	**61%**	**61 %**
Urban spot	**51 %**	**57 %**	**53 %**
Testimonial spot	**19 %**	**26 %**	**21 %**
Call-in show	**18 %**	**14%**	**17 %**
Top Show	**10 %**	**10%**	**10 %**

Many people saw more than one AFPP TV program or spot. More people reported seeing the rural spot than the urban spot, which is interesting as both were broadcast with equal frequency. Perhaps the rural spot was more memorable. The third spot, the "testimonial" spot, although it was aired multiple times per day, had only been broadcast for a short time when the end line survey was done, whereas the urban and rural spots aired for many weeks on three previous occasions. This corroborates the finding that the more a spot is broadcast, the more likely it is to be seen and remembered.

The call-in show and "Top Show" programs, although broadcast only once, were seen and remembered by a respectable percentage of respondents

The end line survey results also suggested strongly that considerable behavior change was occurring, in terms of the percent of MWRA who were discussing family planning with their partners.

Percent of MWRA Who Talked to Husband in the Past 2 Weeks about FP, by Residence

Baseline Survey			
Residence	**Percent Who Did Discuss**	**Percent Who Did NOT Discuss**	**Total**
Urban (N=189)	**71 %**	**29 %**	**100 %**
Rural (N= 411)	**56 %**	**44%**	**100 %**
Total (N=600)	**61 %**	**39 %**	**100 %**
Endline Survey (N=601)			
Residence	**Percent Who Did Discuss**	**Percent Who Did NOT Discuss**	**Total**
Urban (N=200)	**81 %**	**19 %**	**100 %**
Rural (N=401)	**70 %**	**30%**	**100 %**
Total (N=601)	**74 %**	**26 %**	**100 %**

Outreach Negotiation Counseling

In mid-2006, based on formative research results as well as the needs suggested by the 2002 RHS, AFPP introduced an innovative approach to community outreach and mobilization called Outreach Negotiation Counseling (ONC) and piloted it in Fier and Diber Districts. The intent of ONC was to increase women's access to information about the benefits of family planning and the modern methods available to help women/couples achieve their reproductive health goals.

This pilot effort utilized community midwives to communicate directly with married women and couples regarding family planning, usually in their home. Diber and Fier were chosen to represent the north and south parts of Albania respectively; both were also considered to be rapidly urbanizing. In addition, ACSP was very active in Diber; they had used the AFPP standard family planning training curriculum to train widely in the District and had a large cadre of health volunteers. Throughout the ONC pilot, they were AFPP's close collaborators.

In preparation for the pilot, AFPP developed an ONC curriculum and laminated cue cards, as well as a fertility history card to be used by the community midwife. Five ONC trainings were offered in Diber; eight in Fier. The community midwives had participated in the standard AFPP family planning training before receiving this additional ONC training. To enhance sustainability, supervisors were also trained.

Number of Staff Trained in Outreach Negotiation Counseling in Diber and Fier, by Cadre

	Doctors	**Nurses/ Midwives**	**Others**	**Total**
Diber	1	96	1	98
Fier	3	131	8	142
Total	4	227	9	240

ONC assumes that there is a continuum of decisions and behaviors that lead to FP adoption and that different individuals and couples are at different points along the continuum at different times. Thus, ONC requires that any one household be visited multiple times.

The Public Health Directorate of each pilot District formed an ONC supervisory team composed of the Deputy Director, health promotion staff, and LMIS staff. While the health promotion staff ensured that the community midwives were carrying out the negotiation process correctly, the LMIS staff ensured that contraceptives were available in the relevant facilities and that the reporting system followed LMIS protocol instructions. AFPP also developed a supervision tool for the District supervisory staff.

In addition to routine monitoring and supervision visits to check and track ONC recording forms, AFPP conducted several small operations research studies designed to validate and support the accuracy of results. The ONC pilot results were extremely encouraging.

Outcome of Outreach Negotiation Counseling Pilot in Diber and Fier

District	Total Number of Visits	Number of Homes Visited	Average Number of Visits per Home	Number of First Visits Registered	Percent Acceptance of a Modern Method
Diber	804	337	2.4	219	65 % (219/337)
Fier	866	471	1.8	263	56 % (263/471)
Total	1,670	808	2.1	482	60 % (482/808)

National Family Planning Logo

AFPP actively promoted the national family planning logo developed in the mid-1990s by the JSI/SEATS II/Albania project via project documents, clinic signage and mass media. In response to requests from providers, AFPP designed a family planning lapel pin, showing the logo and the phrases: "Want more?" "Ask me..." The hope was that the pin would reinforce the TV spot message that trained providers were available wherever the logo was displayed and would help raise logo recognition even higher. The pin design was pretested with family planning service providers before being produced.

In the end line and baseline surveys, respondents were first shown a picture of the logo alone, without any associated context, and were then shown a picture of the logo on a health facility.

Logo recognition was encouragingly high. At end line, the percentage of respondents able to connect the logo with family planning even without a context had increased considerably.

Percentage of MWRA Who Connect Logo with Family Planning

	Without Context	In Context
Baseline Survey (N=600)	54 %	77 %
Endline Survey (N=601)	77 %	79 %

Logo Recognition

The window of the AFPP office displays the national family planning logo. Shortly after the first two television spots aired, a man knocked on the AFPP door. When an AFPP staff person answered, the man asked for contraceptives and information. He had seen the AFPP spots promoting free contraceptives and trained family planning providers at facilities displaying the family planning logo. He and his wife had recently moved to Tirane from the north and didn't know where to get contraceptives. As he passed by the AFFP building, he'd spotted the logo so had stopped by. Staff were happy to direct him to a nearby source of services..

V. UTILIZATION OF SERVICES AND COUPLE YEARS OF PROTECTION (CYP)

A. First Visits, Total Visits, Revisits and Counseling Visits

First visits and total visits increased markedly over AFPP's lifetime, nationwide and especially in the 16 AFPP target Districts.

First Visits and Total Visits: All 36 Districts (LMIS)

	First Visits	Percent Annual Change	Total Visits	Percent Annual Change
2004	**13,474**		**60,230**	
2005	**15,101**	**+ 12 %**	**65,806**	**+ 9 %**
2006	**24,308**	**+ 61 %**	**93,419**	**+ 42 %**
Life of Project	**52,883**	**+ 80%**	**219,455**	**+ 55 %**

First Visits and Total Visits: 16 AFPP Target Districts (LMIS)

	First Visits	Percent Annual Change	Total Visits	Percent Annual Change
2004	**3,233**		**14,214**	
2005	**4,603**	**+ 42 %**	**17,026**	**+ 20 %**
2006	**8,798**	**+ 91 %**	**31,670**	**+ 86 %**
Life of Project	**16,634**	**+ 171 %**	**62,910**	**+ 123 %**

As AFPP progressed, the 16 AFPP target Districts contributed an increasing percentage of the first visits and total visits.

First Visits: 16 AFPP Target Districts as a Percentage of All First Visits

	First Visits: All 36 Districts	First Visits: 16 AFPP Target Districts	First Visits: 16 AFPP Target Districts as Percentage of All First Visits
2004	13,474	3,233	24 %
2005	15,101	4,603	30 %
2006	24,308	8,798	36 %
Life of Project	52,883	16,634	31 %

Total Visits: 16 AFPP Target Districts as a Percentage of the Total Visits

	Total Visits: All 36 Districts	Total Visits: 16 AFPP Target Districts	Total Visits: 16 AFPP Target Districts as Percentage of Total Visits
2004	60,230	14,214	24 %
2005	65,806	17,026	26 %
2006	93,419	31,670	34 %
Life of Project	219,455	62,910	29 %

Re-visits and counseling visits also increased markedly. When the data is reviewed District by District, however, wide variations are seen in the relative numbers of re-visits compared to counseling visits, suggesting that there is not uniform agreement at the SDP level as to what constitutes a counseling visit and what constitutes a re-visit.

Re-Visits and Counseling Visits: All 36 Districts (LMIS)

	Re-visits	Percent Annual Change	Counseling Visits	Percent Annual Change
2004	25,510		21,246	
2005	25,501	- 2 %	25,704	+ 21 %
2006	35,110	+ 40 %	34,001	+ 32 %
Life of Project	86,121	+ 38 %	80,951	+ 60 %

Re-Visits and Counseling Visits: 16 AFPP Target Districts (LMIS)

	Re-visits	Percent Annual Change	Counseling Visits	Percent Annual Change
2004	5,600		5,187	
2005	6,403	+ 14 %	5,767	+ 11 %
2006	11,833	+ 85 %	12,202	+ 112 %
Life of Project	23,836	+ 111 %	23,156	+ 135 %

Again, as AFPP progressed, the 16 AFPP target Districts contributed an increasing percentage of the re-visits counseling visits.

Re-Visits: 16 AFPP Target Districts as a Percentage of All Re-Visits

	Re-visits: All 36 Districts	Re-visits: 16 AFPP Target Districts	Re-visits: 16 AFPP Target Districts as Percentage of All Re-visits
2004	**25,510**	**5,600**	**22 %**
2005	**25,501**	**6,403**	**25 %**
2006	**35,110**	**11,833**	**34 %**
Life of Project	**86,121**	**23,836**	**28 %**

Counseling Visits: 16 AFPP Target Districts as a Percentage of All Counseling Visits

	Counseling Visits: All 36 Districts	**Counseling Visits: 16 AFPP Target Districts**	**Counseling Visits: 16 AFPP Target Districts as Percentage of All Counseling Visits**
2004	**21,246**	**5,187**	**24 %**
2005	**25,704**	**5,767**	**22 %**
2006	**34,001**	**12,202**	**36 %**
Life of Project	**80,951**	**23,156**	**29 %**

B. Couple Years of Protection

As would be expected from the data on visits, the CYP generated during AFPP's lifetime also increased markedly. Again, the percentage increase was greater in the 16 AFPP target visits.

Couple Years of Protections: All 36 Districts (LMIS)

	Couple Years of Protection	**Percent Annual Change**
2004	**14,999**	
2005	**14,876**	**- 1%**
2006	**20,711**	**+ 39 %**
Life of Project	**50,586**	**+ 38 %**

Couple Years of Protections: 16 AFPP Target Districts (LMIS)

	Couple Years of Protection	**Percent Annual Change**
2004	**3,617**	
2005	**3,749**	**+ 4 %**
2006	**6,053**	**+ 61 %**
Life of Project	**13,419**	**+ 67 %**

Likewise, as AFPP progressed, the 16 AFPP target Districts contributed an increasing percentage of the total CYP.

CYP: 16 AFPP Target Districts as a Percentage of Total CYP

	CYP: All 36 Districts	CYP: 16 AFPP Target Districts	CYP: 16 AFPP Target Districts as Percentage of Total CYP
2004	**14,999**	**3,617**	**24 %**
2005	**14,876**	**3,749**	**25 %**
2006	**20,711**	**6,053**	**29 %**
Life of Project	**50,586**	**13,419**	**27 %**

Couple Years of Protection

What is it?

CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives provided to clients during that period.

How is CYP calculated?

The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYPs for each method are then summed for all methods to obtain a total CYP figure. CYP conversion factors are based on how a method is used, failure rates, wastage and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, like condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or that IUDs and implants may be removed before their life span is realized.

What conversion factors are used by the Albanian LMIS?

Oral Contraceptives	15 cycles per CYP
Condoms	120 units per CYP
Injectables	4 doses (ml) per CYP
IUD	3.5 CYP per IUD inserted

VI. GENDER

AFPP was extremely sensitive to gender equity in all aspects of its work.

Number and Percent of Staff Trained by Cadre and Gender

Number and Percent	Facility-based Providers		Community-based Providers	Others	Total
	Doctors	Nurses/ Midwives	Midwives		
Male	110 (15 %)	1 (< 1 %)	27 (4 %)	7 (1 %)	145 (20 %)
Female	68 (9 %)	312 (43 %)	184 (25 %)	21 (3 %)	585 (80 %)
Total	178 (24 %)	313 (43 %)	211 (29 %)	28 (4 %)	730 (100 %)

Although a vast majority of family planning services are delivered to women, AFPP's BCC component was especially attentive to males, their involvement in joint decision-making, and their equal need for accurate information to make informed decisions about desired fertility.

VII. END OF PROJECT CONFERENCE

In late June 2007, AFPP hosted an End of Project Conference, *Family Planning: Increasing Demand While Improving Access and Quality*, in Tirana. The Conference agenda is included as Appendix B.

The objectives of the Conference were to tell the "story" of AFPP's collaboration with the MOH and IPH, to present and make explicit Albania's progress towards integrating family planning services into primary health care, to look backwards at achievements, and to then look forward to building on this strong base and maintaining momentum. The Conference opened with welcoming speeches by the Vice-Minister of Health and the USAID Mission Director. The Conference presenters then focused on the increased geographic access as well as on the increased qualitative access achieved by strengthening three key components of quality reproductive health services: provider competence, contraceptive security and an informed clientele.

The Conference presenters included staff from IPH, the MOH , and ACSP as well as AFPP. The Project's achievements were reviewed and future challenges presented and acknowledged in closing remarks by the MOH's Director of Primary Health Care and by AFPP's USAID CTO. The CTO also made clear USAID/ Albania's intention to continue as an active partner with the Albanian health sector in the future.

VIII. USAID PERFORMANCE MONITORING PLAN OUTCOMES

With a few exceptions, AFPP met and often considerably exceeded its expected outcomes as outlined in USAID's Performance Monitoring Plan (PMP). SDP-level stockouts of POPs at the end of 2007's first quarter were 1 % higher than the expected 10% threshold. As noted earlier, regarding the number of staff trained by cadre, the initial intent was to train one doctor and two nurses or midwives per facility. However, especially in the more rural Districts, the health centers did not have this level of staffing, and, in response and as requested, AFPP instead trained community-based midwives affiliated with the HCs but not based in the HCs. AFPP also trained additional community-based midwives in anticipation of the Outreach Negotiation Counseling pilot. Ultimately, AFPP trained 212 community midwives in addition to the originally targeted facility-based FP providers.

S.O. 3.2: Improved Selected Health Care Services in Target Areas			
Indicator	**Baseline (source)**	**Expected**	**Actual (Q1 2007 data)**
% of service delivery points providing family planning services in the 16 AFPP target Districts	23 % 42/180 (2004 LMIS)	90 %, increased to 100 % during extension	**100 % 180/180**
% of service delivery points providing family planning services in all 36 Districts	58 % 249/429 (2004 LMIS)	99 %, increased to 100 % during extension	**100 % 429/429**
Couple Years of Protection in the 16 AFPP target Districts	774 per quarter (2004 LMIS)	1,600 per quarter, increased to 1,700 per quarter during extension	**1,746**
Couple Years of Protection in all 36 Districts	3,750 per quarter (2004 LMIS)	5,000 per quarter, increased to 5,500 per quarter during extension	**5,676**
IR.1: Health resources efficiently managed **Sub IR.1.2 Health information systems improved**			
Indicator	**Baseline (source)**	**Expected**	**Actual (Q1 2007 data)**
% of service delivery points stocked out of **condoms** in the 16 AFPP target Districts	28 % (2004 LMIS)	10 %	**8.3 %**

% of service delivery points stocked out of **progestin-only pills** in the 16 AFPP target Districts	64 % (2004 LMIS)	10 %	**11.0 %**
% of service delivery points stocked out of **low-dose combined oral contraceptives** in the 16 AFPP target Districts	22 % (2004 LMIS)	10 %	**7.7 %**
% of service delivery points stocked out of **injectables** in the 16 AFPP target Districts	14 % (2004 LMIS)	10 %	**3.9 %**
IR 2: Quality of PHC services improved **Sub IR 2.2: Skills of PHC providers enhanced**			
Indicator	**Baseline (source)**	**Expected**	**Actual (Q1 2007 data)**
% of service delivery points in the 16 AFPP target Districts with staff trained using the national family planning curriculum	0% (0/180)	90 %	**100 % 180/180**
% of service delivery points in the 16 AFPP target Districts with staff trained using the national family planning curriculum by type of SDP: **maternity**	0% (0/16)	90 %, increased to 100% during extension	**100 % (16/16)**
% of service delivery points in the 16 AFPP target Districts with staff trained using the national family planning curriculum by type of SDP: **women's consultation room**	0% (0/21)	90 %, increased to 100% during extension	**100 % (21/21)**
% of service delivery points in the 16 AFPP target Districts with staff trained using the national family planning curriculum by type of SDP: **health center**	0% (0/143)	90 %, increased to 100% during extension	**100 % (143/143)**
% of service delivery points in the 16 AFPP target Districts with staff trained using the national family planning curriculum by cadre: **doctors**	0% (0/180 – intent was to reach one doctor per facility)	90%, increased to 100% during extension	**99 % (178/180)**
% of service delivery points in	0%	90 %,	**87 %**

the 16 AFPP target Districts with staff trained using the national family planning curriculum by cadre: **nurses/ midwives**	(0/360 – intent was to reach two nurses or midwives per facility)	increased to 100 % during extension	**(313/360)**
IR 3: Use of PHC services increased **Sub IR 3.1: Access to PHC services increased**			
Indicator	**Baseline (source)**	**Expected**	**Actual (Q1 2007)**
Number of family planning visits in the 16 AFPP target Districts: **first visits**	750 per quarter (2004 LMIS)	1,500 per quarter, increased to 3,500 per quarter during extension	**2,358**
Number of family planning visits in the 16 AFPP target Districts: **re-visits**	1,339 per quarter (2004 LMIS)	2,680 per quarter, increased to 3,100 per quarter during extension	**3,673**
Number of family planning visits in the 16 AFPP target Districts: **counseling only**	686 per quarter (2004 LMIS)	1,370 per quarter, increased to 4,500 per quarter during extension	**3,613**
Sub IR 3.2 Awareness of PHC services increased			
Indicator	**Baseline (source)**	**Expected**	**Actual (Q1 2007)**
% MWRA attending SDPS who have been exposed to at least one campaign material and who can state at least one message	0% (Baseline and end line surveys)	15 %, increased to 55% during extension	**79 %**
IR 3.3: Community participation in health promotion activities increased			
Indicator	**Baseline (source)**	**Expected**	**Actual (Q1 2007)**
% of villages in the 16 AFPP target Districts that have family planning services provided by at least one community midwife	0% 0/1328	18%, increased to 32 % during extension	**27 % (361/ 1328)**

IX. COLLABORATION

UNFPA, ACSP, and PRO Shendetit were close and valuable partners throughout AFPP as the Project worked to institutionalize its activities within IPH and the MOH.

UNFPA acted as the procurement agent for the MOH's contraceptive purchases and provided other contraceptive commodities outright. UNFPA is committed to supplying contraceptives to the MOH until 2010, with the expectation that the MOH will procure more and more of its own contraceptives until reaching 'contraceptive independence' in 2010.

Until mid-2006, when IPH assumed these functions, UNFPA also paid to warehouse the MOH contraceptives as the MOH had no central warehouse space. UNFPA also distributed the MOH contraceptives quarterly to the District Primary Health Care Directorates, based on stock levels provided by the LMIS and communicated to UNFPA by the MOH Reproductive Health Unit. Although still a work in progress, UNFPA is also supporting the change over at the District level from a paper LMIS to an electronic LMIS and funded the LMIS refresher training AFPP conducted for all 36 Districts. UNFPA also funded the third round of the mass media campaign, giving the AFPP TV spots an important increase in airtime.

To promote synergy with other USAID-funded projects, AFPP's training strategy deliberately focused first on their target Districts that were also target Districts for PRO Shendetit and ACSP. PRO Shendetit participated actively in AFPP's BCC work, especially with regard to development of its media strategy and TV spots. PRO Shendetit also produced the all-methods family planning brochure used by AFPP.

When AFPP began, ACSP was already using the JSI/TASC I-produced family planning curriculum to train health providers in their target Districts (Diber, Has, Kukes). Building on this base of previously-trained personnel and ACSP's keen interest in collaboration, AFPP chose Diber District as the northern District for the Outreach Negotiation Counseling pilot.

X. PROJECT MANAGEMENT

Having been actively working in Albania since 1995, JSI was able to quickly set up AFPP by re-establishing old contacts, identifying and hiring project staff, finding office space and assessing the situation with regard to family planning in general and training and contraceptive security specifically. JSI re-opened previous bank accounts and re-established official relationships with the Ministry of Finance. AFPP subleased a free-standing annex from the USAID-funded PRO Shendetit Project, a particularly desirable arrangement given AFPP's intention to collaborate closely with PRO Shendetit. Another USAID-funded project, Partners for Health Reform*plus*, provided furniture, equipment and a vehicle in early 2005, as they were closing out.

In early 2005, the entire AFPP team – resident staff plus international advisors – gathered in Tirana for an intensive period of strategic planning and teambuilding. The outputs were 1) a cohesive project team with clearly defined roles and responsibilities; 2) an AFPP Strategic Framework document that outlined the Project's strategic approach; 3) a two-year work plan;

and 4) explicit PMP indicators to measure progress. Both the workplan and the PMP indicators were revised accordingly in August 2006 when the Task Order Modification #1 increased the funding ceiling, expanded the SOW, and extended AFPP's completion date to June 30, 2007. (A February 2007 two-week Administrative Extension gave AFPP a final completion date of July 15, 2007.)

In late 2006, USAID/ Albania indicated its intention that PRO Shendetit provide any needed support and oversight to the AFPP components – training, BCC, contraceptive security – when AFPP ended. Therefore, in January 2007, AFPP and PRO Shendetit began planning for an effective transition and identifying activities that needed to take place to ensure the continuing impact of AFPP's work and USAID investment in family planning. As a result, AFPP technical staff met with their PRO Shendetit counterparts for training, BCC, and LMIS to discuss transfer of information, resources, contact people and knowledge about current AFPP programmatic activities. At AFPP's conclusion, AFPP and PRO Shendetit provided USAID/Albania with a joint memo outlining the transition process.

XI. CONCLUSIONS AND LESSONS LEARNED

Implementation of the USAID-funded Albania Family Planning Activity (known throughout implementation as the Albania Family Planning Project – AFPP) has truly been a collaborative effort between the MOH, IPH, JSI and USAID. AFPP simultaneously implemented **three major components** to improve the quantity and quality of family planning services available in the public sector and to increase the public demand for these improved services: **family planning training, contraceptive security, and behavior change communication.** These three related components were designed to complement each other, and they functioned synergistically as the Project was implemented. Working at both the District and national levels, AFPP placed an emphasis on public sector capacity building to increase the likelihood of sustainability.

Building on the work initiated by the previous USAID-funded JSI/SEATS II and JSI/TASC I projects, AFPP **completed the integration of family planning services into primary health care down to the commune level** nationwide into all of Albania's 36 Districts. In April 2007, **429 SDPs** reported providing FP services. To achieve this, AFPP trained **730 physicians, nurses and midwives**. AFPP updated and revised a now MOH-adopted three-day **family planning curriculum,** developed a cadre of **trainers,** and refined a **monitoring and evaluation follow-up system.**

Contraceptive security received major attention. Although the MOH did not revive the National Contraceptive Security Commission as hoped, the MOH still views the 2003 *National Contraceptive Security Strategy* **as** the MOH's framework for contraceptive security in Albania. As agreed to in the *2003 Strategy*, the MOH has begun to procure an increasing percentage of its needed contraceptives. AFPP produced a ***Contraceptive Security Report 2006*** as an update to the *2003 Strategy* for use by the MOH and USAID. AFPP also carried out an innovative **market segmentation analysis** for Albania using a total market approach. Unfortunately, there is still no National Reproductive Health Policy or National Family Planning Policy to serve as a framework for contraceptive security.

Quality Family Planning Services Available Here!

Early in AFPP, the MOH decided to shift the existing LMIS operations from the MOH's Reproductive Health Unit to the Institute of Public Health, where there would be more technical and administrative support for LMIS. The move has worked well, and the **LMIS** appears to be **well-institutionalized at IPH**. At various points, there's been discussion of merging or synchronizing the LMIS with PRO Shendetit's HMIS, but this has yet to happen. Some logistics data is time-sensitive, so it may never make sense to completely merge LMIS and HMIS, but they should be seen as vital parts of an overall MOH health information system.

AFPP's BCC component was especially strong and successful, utilizing **innovative formative research** to inform its media strategy and national sample **baseline and end line surveys** to measure results. The three AFPP TV spots were well received and quite memorable. The ONC pilot results were extremely promising. To achieve this, AFPP developed an **ONC curriculum** and supporting **cue cards** and trained a small group of **trainers**. The MOH and IPH both showed considerable interest in this innovative approach to community outreach.

√ ***Lesson Learned:*** The national family planning logo has been a major success. Recognition is high and positive. Albania has a solid platform from which to launch successive improvements in quality and access.

- √ ***Lesson Learned***: Technical assistance is often considered USAID's comparative advantage among international donors, especially in the reproductive health field. Many multilaterals are capable of providing significant amounts of funding, but then tend to be weak at providing needed technical assistance during the implementation phase. Consequently, funds are not put to optimal use. Targeted expatriate technical assistance can bring true added value and help introduce international standard approaches and practices. Especially in a country like Albania – where the majority of local counterparts are bright, energetic, educated and open to new approaches – the value added can be considerable. For example, the market segmentation analysis and the strong evidence-based approach to BCC programming are both international standard best practices. In Albania, their introduction was also innovative, and both approaches were extremely well received.

- √ ***Lesson Learned*:** Regardless of how well-intentioned both parties were, having an independent entity (PRO Shendetit) essentially responsible for AFPP's client IEC materials did not work well. The PRO Shendetit all methods brochure was not available in sufficient quantities until midway through the Project. Needed method-specific brochures were never available, and AFPP lacked the resources to produce them independently. Collaboration is certainly valuable (and was extremely productive in other areas) but, for maximum impact and efficiency, a project needs to be in control of its key components.

- √ ***Lesson Learned:*** After any type of training, supportive supervision and "hands-on" follow-up is of paramount importance to ensure the successful integration and mastery of new knowledge, approaches, processes, and skills. AFPP was especially attentive to this need in regard to provider training, ONC training, and LMIS training. It is important to plan and budget adequate resources (staff time, materials, transportation, etc.) to do this effectively.

A successful End of Project Conference highlighted the above accomplishments, outputs and results, all strong indications that the capacity of the MOH to offer quality reproductive health services to the Albanian people has been enhanced.

Certainly many domestic indicators – economic development, urbanization, high literacy and education levels, low fertility preferences – coupled with the social changes underway in Albania, as Albania seeks to more fully integrate itself into the European community, suggest that the use of modern contraceptive methods will take off rapidly, and the AFPP experience suggests this process is underway.

The MOH appears to have a heightened appreciation of the need for and importance of quality reproductive health services. It must be noted, however, that – compared to many other countries – the community of people committed to providing Albanian families with access to quality family planning services is neither sizeable nor strong. For example, a major stumbling block to contraceptive security in Albania has been the lack of a "contraceptive security champion" – someone who is willing and able to keep contraceptive security on the national health agenda. At the end of the JSI/TASC I project in 2003, the MOH also had a functioning LMIS, a cadre of

trainers, a set of curricula and cue cards, and a range of IEC materials and TV spots. In the approximately one year hiatus between the end of the JSI/TASC I project and the start up of AFPP, the MOH did not enhance family planning services, and in many respects, service quality and contraceptive availability declined. Lack of political commitment has got to be listed as a current family planning weakness in Albania.

XII. NEEDED NEXT STEPS

More than five years have passed since the 2002 Reproductive Health Survey was conducted. Reportedly, major donors, including USAID/Albania, are negotiating with the Government of Albania and each other to plan and fund a Demographic and Health Survey (DHS). A DHS would be extremely informative and useful for Albania. In the meantime, however, there is much that the GoA can do.

Integrating Family Planning into Primary Health Care

Although family planning services are now available nationwide at the commune level, many more health care providers would benefit from training and/ or refresher training. Generally, only a few providers have been trained at each site, and some were initially trained more than a decade ago. Training community midwives at the ambulanca level – as was done during JSI/SEATS II/Albania and again during AFPP – would help bring services and information even closer to Albanian families.

The MOH and IPH have the tools needed to **roll out training** to a larger group of providers, both facility-based and community-based. This rollout can be accomplished at a relatively low cost since the major costs of developing a training program, developing the curricula and training the trainers, have already been incurred for both the standard family planning training for providers and for ONC. The additional costs that the MOH would have to assume would be for per diems, transportation, course set-up and oversight, and follow-up on-site supervision. Should more trainers be needed, the MOH now has a small group of master trainers able to independently conduct a TOT. Anecdotally, there is certainly demand for more training.

> "Governments should strive to ensure that by 2015 all primary health care and family planning facilities are able to provide, directly or thorough referral, the widest available range of safe and effective family planning and contraceptive methods."
> UN General Assembly, July 1999 (International Conference on Population and Development +5)

As well prepared as the MOH is now to institutionalize and expand the current training component, future challenges remain. The MOH does not have the capacity to conduct a needs assessment and design a quality curriculum without outside technical assistance, Overall, the MOH needs a systematic approach for planning and implementing in-service training for all aspects of primary health care.

In addition, considerable more attention needs to be paid to **pre-service education** to assure quality, evidence-based information and practices are built into the basic education of all students of medicine, nursing, midwifery and pharmacy. It should be expected, for example, that

a newly-graduated physician would already be totally familiar with the contraceptive technology and counseling concepts included in the national family planning curriculum; in practice, this reportedly in not the case.

Service quality would improve if reproductive health training included more hands-on **clinical skill development, especially IUD insertion, using the no-touch technique**.

Empowering Potential Users

PRO Shendetit conducted a survey in 2005 in its 3 target prefectures. These 3 prefectures contain 10 Districts and 22 % of Albania's total population. The previous JSI/SEATS I/TASC II projects covered more than 70% of this population; AFPP covered the remainder. This 2005 survey found some improvements in knowledge of methods of contraception compared to the 2002 RHS, especially among men, but, overall, knowledge was still woefully low. Approximately 30% of men and 20% of MWRA had *not* heard of oral pills; 40% of both men and MWRA had not heard of injectables, 65% of men and 60% of MWRA had *not* heard of IUDs; and more than 70% of men and 80% of women had not heard of emergency contraception. Lack of knowledge of permanent methods was likewise high: approximately 55% of men and 45% of women had not heard of female tubal ligation while 70% of men and 80% of women had not heard of male vasectomy.

A **sustained IEC/BCC campaign** to greatly increase Albanians' awareness of their contraceptive choices and sources of contraceptive supplies continues to be a high priority for Albania. The majority of sexually active Albanians already contracept using withdrawal and the occasional condom, backed up by legal abortion. Given that various studies have shown that withdrawal is about 80% effective among long term users, this "system" works reasonably well for Albanians, especially since withdrawal is free. However, a case can also be made for modern contraceptive methods, even if they do require commodities, cost money, and have unwanted side effects as well as the occasional serious health consequence. The real issue is that **Albanians should have choice**, and they currently lack the information to make an **informed choice** about modern contraception. They deserve to know there are ways to contracept that are more convenient and offer better protection than withdrawal, and that are considered safe. AFPP's work promoting the national family planning logo, creating TV spots, and piloting ONC provides a firm foundation on which to build.

Extending Services to Those Most in Need

The women most in need of family planning information and services are women who have just delivered a baby or have just had an abortion. Albania has a great need for upgraded/ expanded **standardized postpartum/ post-abortion counseling and services** with a strong link to primary health care services. This is a significant missed opportunity that needs addressing.

Exclusive breastfeeding and **the contraceptive effects of exclusive breastfeeding (LAM**) merit increased attention during both the antenatal and postpartum periods. For innovation, the MOH might **introduce family planning into postnatal and well-baby services**.

Expanding Method Choice

The contraceptive method mix in Albania is **skewed toward re-supply** methods (pills, condoms, injectables). **Permanent and long-term methods** (IUDs, female tubal ligation and male vasectomy) **have not been actively promoted** and are not yet easily available, or available at all. Access to even the re-supply methods is limited: POPs are available only in the public sector; there is no non-hormonal IUD in the commercial for profit sector, only a very expensive hormone-releasing system. **Emergency contraception** is available only through the social marketing sector, when it should be especially available in the public sector. LAM is not well known, nor encouraged; likewise Standard Days. Implants and female condoms are not at all available.

As expected, the 2002 Reproductive Health Survey revealed a considerable "unmet demand" from "limiters", i.e. families who have the family size they desire and who do not want additional pregnancies. This suggests a major need for **increased emphasis** on **long term and permanent methods,** especially **IUD services using the "no-touch" insertion technique.** (It is worth noting that USAID globally has invested considerable resources in extending and improving IUD access and use. The IUD Subcommittee of USAID's Maximizing Access and Quality Initiative has developed a thorough and helpful IUD Toolkit available at http://www.maqweb.org/iudtoolkit).

These health facility-dependent methods should increasingly be the MOH's "niche" as the re-supply methods – pills and condoms – move increasingly to the private sector. For the MOH to concentrate on facility-dependent methods also makes sense economically and in terms of demand on services, as can be seen when the cost per CYP by method is examined, using the contraceptive forecast of contraceptives needed by the MOH to cover needs through December 2008..

Estimated Cost per CYP by Method

Method	Quantity Required	Cost per Unit	Total Cost	CYP Equivalent	Cost per CYP
Low-dose COCs: Rigevidon (cycles)	**105,224**	**$ 0.338**	**$ 35,566**	**10,826**	**$ 3.29**
Progestin-only pills: Micorval (cycles)	**14,668**	**$ 0.595**	**$ 8,727**	**978**	**$ 8.92**
Injectables: Depo-Provera (vials)	**30,561**	**$ 0.85**	**$ 25,977**	**7,640**	**$ 3.40**
IUDs (pieces)	**3,712**	**$ 0.30**	**$ 1,114**	**12,992**	**$ 0.085**
Condoms (pieces)	**403,874**	**$ 0.025**	**$ 12,992**	**3,366**	**$ 3.86**
Total Cost and Total CYPs			**$ 81,480**	**35,802**	
Average Cost per CYP All Methods					**$ 2.28**

For example, the cost of an IUD (30 cents) is less than a cycle of Rigevidon (34 cents), yet an IUD provides protection from unwanted pregnancy for up to 10 years, while a cycle of Rigevidon protects for only one month. In addition, once a woman has an IUD inserted, she need not return to the health facility until she wants it removed or unless she has problems or questions.

Assuring Contraceptive Security

The challenge facing the MOH is to ensure that contraceptive procurements are timely and based on accurate forecasts to avoid a repeat of the stockouts of recent years. Because contraceptive forecasts require regular updating if adequate national contraceptive stocks are to be maintained, the GoA needs its own internal forecasting capacity. AFPP assisted the MOH to begin building this capacity within IPH, but additional external technical assistance will likely be needed.

Efficiency would be greatly improved, and contraceptive security enhanced, if Albania were to implement an effective market segmentation strategy that expanded the range of contraceptive methods available, made these methods more accessible, and supported and encouraged the social marketing and commercial sectors in supplying contraceptives to clients who are able to pay for them. A long term market segmentation strategy could also help shift the contraceptive method mix toward long-term and permanent methods, thereby addressing more effectively the large unmet needs of “limiters”.

This next step toward contraceptive security in Albania requires a genuine public/private partnership in a way that has not been attempted to date in Albania. The key question -- how to segment the contraceptive market among the public, social marketing and commercial sectors – has not yet been seriously addressed, nor how and by whom such a market segmentation policy would be monitored and adjusted. Unfortunately, Albania lacks a tradition of public/private partnership of the type that would facilitate the successful segmentation the contraceptive market: this is an area where the country may wish to seek external technical assistance.

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Appendix A: Contraceptive Forecast

Contraceptive Forecast to Cover MOH Needs Until December 2008

Urgent: To avoid a contraceptive stockout in 2008, the MOH should order these quantities immediately (August 2007).

Methods	Quantity	Cost/Unit	Estimated Cost
Low-dose COCs: Rigevidon (cycles)	**105,224**	**$ 0.338**	**$ 35,566**
Progestin-only pills: Micorval (cycles)	**14,668**	**$ 0.595**	**$ 8,727**
Injectables: Depo-Provera (vials)	**30,561**	**$ 0.85**	**$ 25,977**
IUDs (pieces)	**3,712**	**$ 0.30**	**$ 1,114**
Condoms (pieces)	**403,874**	**$ 0.025**	**$ 10,097**
Total Cost			**$ 81,480**

Appendix B: End of Project Conference Agenda

ALBANIAN FAMILY PLANNING PROJECT (AFPP)
END OF PROJECT CONFERENCE
Tuesday, 19 June, 2007
Tirana International Hotel

08:20 - 09:00	**Registration and Coffee**
09:00 - 09:20	**Welcoming Remarks** Mr. Edward Landau, USAID Mission Director Dr. Arben Ivanaj, Vice Minister of Health
09:20 - 09:45	**Albania Family Planning Project: Goals, Strategy and Coverage** Dr. Laurie Cappa, John Snow Inc. Mrs. Manuela Murthi, AFPP Dr. Agim Shehi, Ministry of Health
09:45 – 10.15	**Coffee Break**
10:15 - 10:55	**Training and Follow up** Dr. Gazmend Koduzi, AFPP Dr. Lindita Myzyri, Policlinic No.3, Tirane Dr. Anila Moci, Public Health Directorate, Fier Dr. Halil Stana Public Health Directorate, Tirane
10:55 – 11:05	Questions, Discussion
11:05 - 12:00	**Behavior Change Communication** Ms. Altina Peshkatari, AFPP Mrs. Eda Pellumbi, Ministry of Health Dr. Engjell Mihali, Institute of Public Health Mrs. Luljeta Maniani, Public Health Directorate, Diber Ms. Brunilda Bocova, Public Health Directorate, Fier
12:00 – 12:10	Questions, Discussion
12:10 – 12:40	**Coffee Break**
12:40 - 13:35	**Contraceptive Security and LMIS** Dr. Elizana Petrela, Institute of Public Health Dr. Gazmend Bejtja, Institute of Public Health Dr. Miranda Hajdini, Institute of Public Health Mr. Agim Kasaj, AFPP

13:35 – 13:45	Questions, Discussion
13.45 – 13.55	**Family Planning in Albania: The Way Forward** Dr. Nedime Ceka, Ministry of Health
13:55 – 14:00	**Closing Remarks** Mrs. Manuela Murthi, AFPP Dr. Zhaneta Shatri, USAID Dr. Agim Shehi, Ministry of Health
14:00 - 15:00	**Lunch**

Djibouti

Expanded Coverage of Essential Health Services in Djibouti

Annual Report

Project Year 3: May 1st 2006 - April 30th, 2007

During the third project year, all the health posts assisted by the Project are providing essential health care with trained nurses

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

May 2007

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.

John Snow, Inc.
B.P. 86
Djiboutiville, Djibouti

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

Each health post has community health workers trained by the Project to develop a regular three month work plan

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ANNEXES

I Project indicators status

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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
HIV	Human Immuno-deficiency virus
HMIS	Health Management and Information System
HP	Health Post
IEC	Information, Education and 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 Project)
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
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

During the third project year (PY 3) of the Expanded Coverage of Essential Health Services in Djibouti Project (PECSE), activities have continued at a rapid pace at all levels, and have expanded in some areas.

During the 3rd quarter of PY 3, JSI was asked to produce a draft Work Plan and budget for a possible 12 month no-cost extension, which was eventually extended to 15 months. The contract modification was approved by USAID in April 2007; PECSE is now extended until July 2008.

The 2006 Djibouti Multiple Indicator Cluster Survey (MICS) shows some promising trends in a number of key statistics, when compared with the Djibouti Family Health Survey of 2002. Child mortality fell from 121/1000 to 94/1000 and infant mortality fell from 103/1000 to 67/1000 in 2006. There was also an impressive increase in the contraceptive prevalence rate, rising from 12% in 2002 to 18% in 2006. PECSE played some role in these achievements, but it is not possible to precisely quantify its impact.

Major Achievements of PECSE include:

Seventeen health structures have been rehabilitated, including 16 in rural areas and one in Djiboutiville that was damaged in the floods of 2004. All the rehabilitated health posts have been provided with water reservoirs to supply continuous water, but certain villages lack a permanent water supply. PECSE continues to work with the US Military to coordinate and finance drilling of new wells in sites where there is no water supply and new wells are technically feasible.

Distribution of new medical equipment and furniture for all renovated health facilities and some items for district hospitals was completed, and training in the use and maintenance of equipment was completed as required. Equally important was the training of providers in infection prevention, which was also completed during PY 3 for all five districts. For the first time, the health providers have the means to sterilize their medical instruments, and in this way comply with international norms in this area.

The PECSE Project attained complete coverage of all the villages having health posts with social mobilisation activities. All of the 23 health posts have Health Committees consisting of men and women, as well as having four or five trained community health workers including at least two per site that are women.

A far-reaching impact of the project's community mobilization work has been the change in law to reflect the legal existence and recruitment by the Ministry of Health of the Community Health Workers. The Ministry's appropriation of community mobilization as a key component of health improvement has been rapid and is now codified.

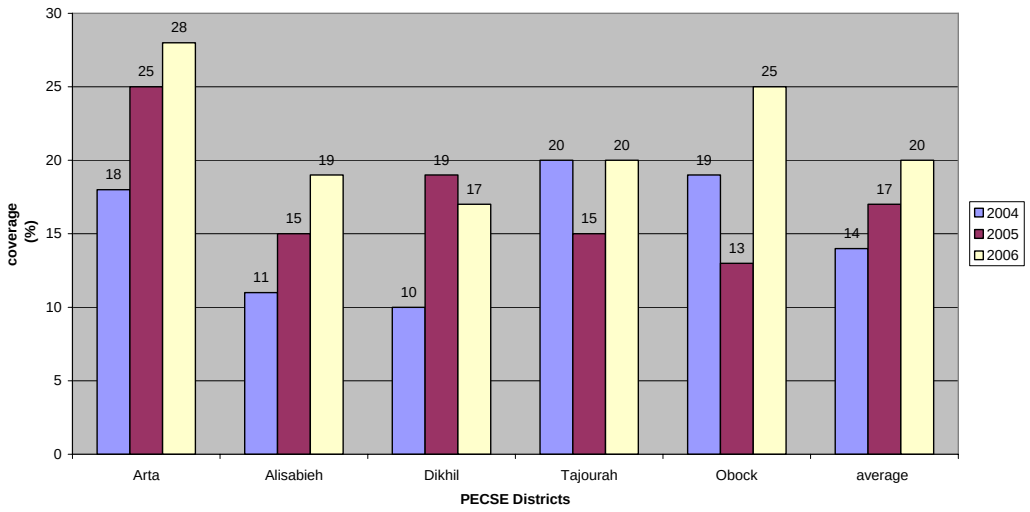
Supprimé :

Progress towards a functional national health information system (HMIS) continues. Training in use of the new database software and distribution of the new computers for each district was completed. Data entry for 2006 was completed for each district, and most districts are up to date for 2007. For the first time, monthly reports arrive in Djiboutiville on time and include data from the majority of health posts.

Supervision at PECSE Project health posts was universal during PY 3, jointly conducted by the MOH and PECSE. Along with providers training, supervision emphasizes quality of care and allows for joint problem-solving. Clinical training in STI management and HIV/STI prevention and child nutrition took place during PY 3.

PECSE, with key partners UNICEF and WHO, implement the Joint EPI Plan with the MOH. UNICEF and PECSE continued to have exceptional coordination in support of the MOH. During PY 3, PECSE funded a number of technical assistance visits to support MOH activities, including polio eradication, EPI policy, data collection and analysis, surveillance, and improving routine EPI. In addition, PECSE coordinated efforts for an improved national health information system including all important components of EPI.

DPT3 coverage in PECSE intervention districts , 2004-2006



Unexpected health crises required PECSE intervention. With both human and avian H5N1 bird influenza cases reported and a deadly cholera epidemic in Djibouti, the Project was involved in several actions of the MOH to better curb and control these diseases. In addition, PECSE assisted communities and rural health post staff in preparedness for avian influenza.

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

In summary, the original project objectives for equipped and renovated health posts, trained providers, increased community mobilization and participation, improved health sector coordination and establishment of a HMIS have been met or surpassed in all cases.

Distinguished Guests visited the project sites during the third implementation year:

- Left : the discovery channel team with the Gallamo Community and
- Below: a US Congress staff member (Michael Phelan) visiting the Mouloud health post rehabilitated and equipped jointly by the Project and the US Military

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 1st 2006 until May 31st 2007, or Project Year 3 (PY 3).

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 was revised in early 2006 after the visit of Dr. Vathani from USAID's regional office and according to additional comments by Mr. Tom Hall, CTO.

In early 2006, USAID informed JSI 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[1]

In the fall of 2006, after USAID formalized their new system of Operational Plans and published books of indicators, PECSE worked with USAID/Djibouti to select three indicators from the options indicated for "investing in people". These indicators will be analyzed each year, and supersede those included in the PMP for the purposes of USAID reporting.

[1] USAID has noted that they will use Ministry of Health data for this indicator.

Indicators	Activities/ Mode of calculation of the indicator	Source of the data / Base line / Target	Annual Targets	
			2007	2008
Indicator 1 : Number of child diarrhea cases treated	Number of under-five child diarrhea cases treated in the Project sites.	Routine Data Base line: 1600 target: 10 -15% annual decrease N= 23 health posts	1400	1600
Indicator 2 : Number of antenatal visits by a skilled attendant	Number of women seen at least once during their pregnancy by skilled attendants in the Project sites	***Routine Data*** Base line : 1500 Target: 5% annual increase N= 23 health posts	1500	1700
Indicator 3 : Number of people trained in child health and nutrition	Number of trained health workers (including community health workers and community health committee members) in child health and nutrition conducted by the Project	Routine data Base line = 131 Target:25% by year	150	200

Highlights of PY3 include:

- Total of 17 facilities refurbished and the technical plans for 5 remaining facilities requiring renovation were completed; equipping of all health posts completed;
- Flip charts and posters covering nine key subjects were designed, pre-tested and finalized;
- Health Committees linked to health facilities with trained male and female community health volunteers extended to all the 23 project sites;
- Launch of Health Information System for the districts including new data base and district level computerization;
- Implementation of the Joint Program Plan for EPI developed in collaboration with WHO, UNICEF and the Ministry of Health.

To ensure quality of services in the rural health posts, the project provided gas steam sterilizers and trained the nurses for the utilization and maintenance of the materials

2. CONTEXT

Estimates of Djibouti's population range from 500,000 to 700,000 (for political reasons, a national census has not been conducted in decades). It is estimated that 80 per cent of the total population of Djibouti live in or just outside of the capital city. Overall, 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 and normal temperatures from May to September are over 40 degrees Celsius. In addition, there is significant population movement out of Djiboutiville and some secondary cities during this annual hot season, 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 Djiboutiville, 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.

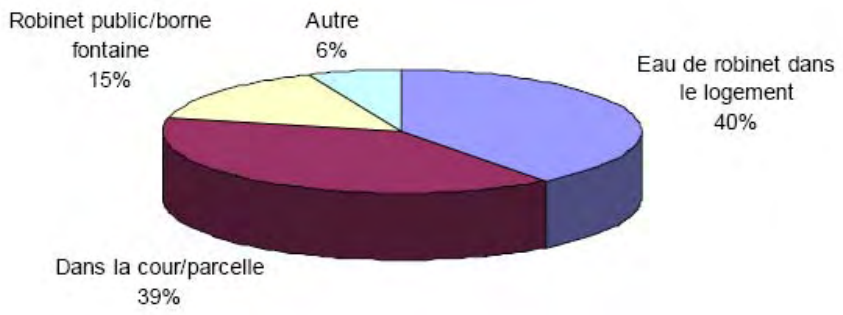
Administratively, Djibouti divides the country into health management zones of Djiboutiville, and five health districts of Arta, Ali Sabieh, Dikhil, Obock and Tadjoura. Four of the five districts have district hospitals; Arta, closest to Djiboutiville, does not have a district hospital. At this time, each district has one physician based in the district capital, and often times one contract expatriate physician (usually a Cuban) who works primarily in the mobile clinic. Each district has several health posts, and most have a mobile clinic. 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, poverty, regular population movement and multiple languages make improving basic health knowledge a major challenge.

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 Djiboutiville, 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. Success in assigning newly graduated nurses to rural areas, and implementation of strategies to train more health professionals ready to return to rural areas, show recent commitment to improving health throughout the country.

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 for more than a decade.

The 2006 Djibouti Multiple Indicator Cluster Survey (MICS) shows some promising trends in a number of key statistics, when compared with the Djibouti Family Health Survey of 2002. Child mortality fell from 121/1000 to 94/1000 and infant mortality fell from 103/1000 to 67/1000 in 2006. There was also an impressive increase in the contraceptive prevalence rate, rising from 12% in 2002 to 18% in 2006.



Water supply sources for the families in Djibouti. MISC survey (EDIM) – page 12 Figure 2

3. COMPLETED ACTIVITIES: PROJECT YEAR THREE

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 updated in PY 2. The adjustment harmonised PECSE project indicators and the finalized USAID annual report indicators. In late 2006, PECSE worked with USAID/Djibouti to select three key indicators to report on from the new Operational Plan indicator lists, as discussed above.

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.

<u>IR 1: Increased Supply of Essential Health Services</u>

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 essential health package identified by PECSE in collaboration with USAID and the MOH 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.

Achievements this year include:

- Increased immunization coverage, documented by the new MOH Health Information System (HIS) as well as by a 2006 Multiple Indicator Cluster Survey (MICS). PECSE continued to work closely with WHO and UNICEF to implement a joint program of support for routine immunization, including the provision of expert technical support from USAID-financed IMMUNIZATIONBasics (also implemented by JSI);

- 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 was completed at 16 rural sites and one urban site damaged by flooding (Djibouti District) over the past three years. The rehabilitation of health posts was almost completed, when an additional five were identified for work by the Ministry of Health and accepted by USAID. The technical specifications of this work has already been completed, requests for proposals launched and the technical review of the proposals is underway. The work at these five additional structures should be completed by the second quarter of PY4.

- All the rehabilitated health posts have been provided with water reservoirs to supply continuous water to the health facilities, but in certain villages, the access to running water is not yet operational because of a lack of a permanent water supply. In addition, some health posts need additional engineering work to link existing water sources to the health posts to provide permanent water supply. This work is underway for some sites, pending technical specification work for others, and will be completed in PY4.

- The PECSE Project continues to work with the US Military to coordinate and finance drilling of new wells in some sites where there is no safe water supply and new wells are technically feasible. Current plans call for at least three new wells, and two more upgraded, with the technical support of the US Joint Armed Forces based in Djibouti.

- Distribution of new medical materials and equipment for all renovated health facilities and some items for district hospitals was completed, and training in the use and maintenance of equipment completed for Ministry of Health personnel as required.

- PECSE supported the initiatives of the MOH, including annual national health days and a major East Africa regional health conference hosted by Djibouti.

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 continued, primarily on themes of maternal and child health and broader health concerns including infection prevention and use of new sterilization equipment.

- STI management and HIV/AIDS prevention trainings were also launched in PY 3. The Project developed the STI management and HIV/AIDS prevention modules in collaboration with the WHO, the National Program for AIDS Prevention and the heads of concerned MOH departments.

- The PECSE Project team assisted the Head Physician (Medical Director) of each district to supervise personnel in the Health Posts in their districts. In some districts, the District Health Management Teams has taken ownership of supervision activities, which will add to the sustainability of services.

- A medical services handbook was drafted, covering key themes and providing descriptions and treatment algorithms. Clinicians had asked for such a tool, to assist them in improving or maintaining high quality of care.

With both human and avian H5N1 bird flu cases reported and a deadly cholera epidemic in Djibouti, the Project was involved in all actions of the MOH to better curb and control these diseases. Key activities include:

- Due to a USAID request, the Project is going to procure laboratory freezers for the conservation of H5N1 samples, and will participate in the organisation of a national workshop on this issue. With the development of social mobilisation activities in the villages, the Project is ready to participate in an effective way in activities for the fight against the Avian Influenza (H5N1) epidemic, and basic training for the community health mobilizers has been completed. PECSE's rented warehouse holds a stock of materials belonging to USAID for use in the case of an epidemic. The freezers being procured are for the MOH and Minister of Agriculture to reinforce local laboratory capacity in avian influenza management.

- The PECSE Project was also involved in cholera outbreak mitigation activities in Djibouti beginning in December 2006. The PESCE COP was a member of the MOH technical team put in place for the coordination of activities, and the PECSE Project contributed to the social mobilization activities in affected areas and the training of district nurses.

Cholera outbreak management:
- Right: MOH team meeting hold in the project office
- Below: cholera camp in rural area

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.

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.

The PECSE Project attained complete coverage of all the villages having health posts with social mobilisation activities during PY 3. All of the 23 health posts have Health Committees consisting of men and women, as well as having four or five trained community health workers including at least two per site that are women. Based on this experience, the MOH requested that the PECSE Project put in place management committees for the cost recovery system in the health facilities of Djibouti City. Following USAID request, the PECSE Project extended social mobilisation activities into the sub-urban and selected urban areas in collaboration with WHO and the MOH Social Mobilization Unit.

Community members, especially those on Health Committees, were trained in social mobilization techniques. This training covered all Health Committees in health posts during PY 3, and support has been provided as needed to the Health Committees. Regional Health Committees were also supported as needed.

Seven radio spots were produced and broadcast, in three different languages.

Flipcharts for use in the community by animators, teachers and by providers, representing all key PECSE themes, were pre-tested in the field, modified as needed, and duplicated.

Voluntary community workers continue to develop monthly Activity Plans for outreach and community education.

The PECSE Project has started Champion Community strategy implementation in selected sites, with use of an experienced outside consultant and multiple field visits.

4. PROGRESS TO DATE: ON-GOING ACTIVITIES

A few key activities are on-going, due for completion in most cases in early PY 4.

Procurement:

Some procurement still remains in the pipeline, although much of the work has been completed. Remaining deliveries include solar lighting and fans for health posts, solar pumps and related items for new wells and wells being upgraded from diesel pumps, additional computers for the central levels for HIS and freezers for the avian influenza preparedness program. This procurement was seriously delayed by the length of time it took for the contract extension for PECSE to be approved by USAID. (No procurement orders can be placed less than 6 months before the end of a contract.) In addition, a change in the contract added to the extension amendment changed the geographic origins and sources allowable under the contract, rendering some of the prior research obsolete and requiring USAID waivers for a number of procurements.

In PY 3, a new request for a radio communication system to link health posts to their district hospitals and ambulances was received. PECSE benefited from the technical expertise of US Military personnel during the planning for this communication network, and procurement and installation of this new system will take place during PY4.

Collaboration with the Education Sector:

Development of posters with key messages for the promotion of the health is complete and materials printed and ready for distribution. A new Chief of Party for the AIDE Education sector project has arrived so further collaboration is possible.

Health Management Information System:

The launch of the new HMIS in the five districts led to additional requests for assistance - both material and technical - from the central level MOH. PECSE is working closely with the MOH to ensure the nationwide functioning of the HMIS. Additional hardware and software is being procured, and more technical support is planned for PY 4.

Rehabilitation of Health Posts:

Seventeen health structures have been rehabilitated by PECSE, and an additional five were identified for work and accepted by USAID late in PY3. The technical specifications of this work have already been completed, requests for proposals launched and the technical review of the proposals is underway with the MOH. The work at these five additional structures should be completed by the second quarter of PY4.

Urban Community Mobilization:

Peri-urban and district capital sites were selected for mobilization activities, and visits to some sites with MOH staff were completed. A different strategy for peri-urban sites has been developed, based upon the community and social structures, MOH guidelines and health site staff in the town. In the District Capitals, the Regional Health Committees already put in place for the HIV/AIDS activites, have been trained for the enlargement of their activities to the social mobilisation and community participation activities. In Djibouti City, the local NGOs have been involved in the social mobilisation activities.

5. PERFORMANCE INDICATOR ACHIEVEMENT SUMMARY

5.1 Strategic Objective Indicators (Annually Recorded)

Indicator 1: DPT 3 Coverage

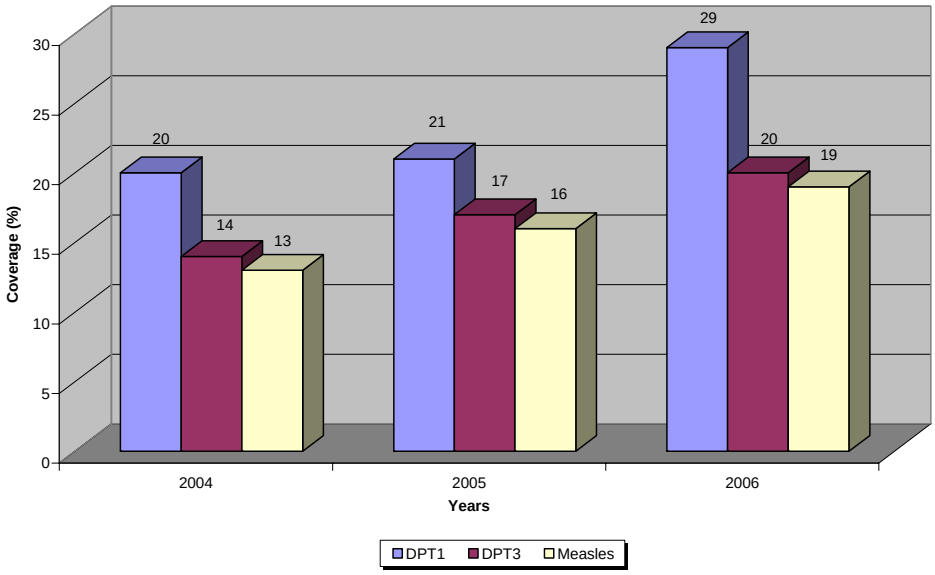
While donors used national data in prior years that show high coverage rates, PECSE based its rates on existing health post data in target zones, and on data from "Djibouti Strategic Framework against Poverty" (2004) . The PECSE Project team has estimated that the basic rate was 11% in rural zones in 2004.

The current DPT3 coverage rate in the districts is 20%, a major improvement over the lifetime of PECSE but still significantly below an acceptable level. See the chart below showing DPT 3 coverage rates for the past three years. The PY3 target for this indicator was 15%, which was achieved. PECSE, in collaboration with UNICEF, hopes to assist health posts achieve rates closer to the national level.

The "Djibouti Multiple Indicator Cluster Survey" 2006 (EDIM 2006)[2], Preliminary Report of April 2007, showed a national DPT3 rate of 56%. Sub-analysis of geographic areas is not yet available, therefore the results for rural areas and districts cities are not yet known.

[2] Enquete Djiboutienne a Indicateurs Multiples, Rapport Preliminaire Avril 2007. Ministere de la Sante et Ministere des Finances, de l'Economie et de la Planification.< Republique de Djibouti..

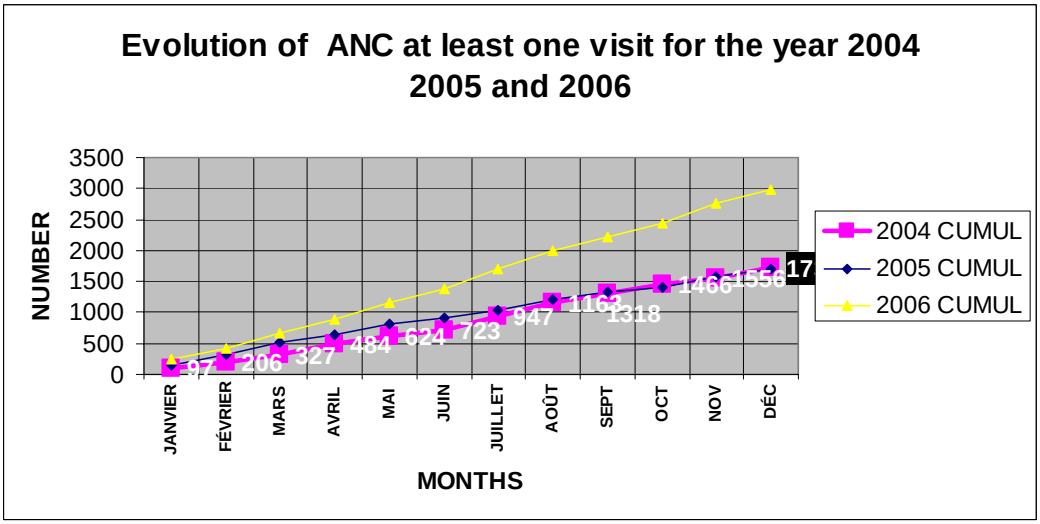
Vaccination coverage trends by antigen and by year, PECSE Intervention Districts, 2004-2006



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

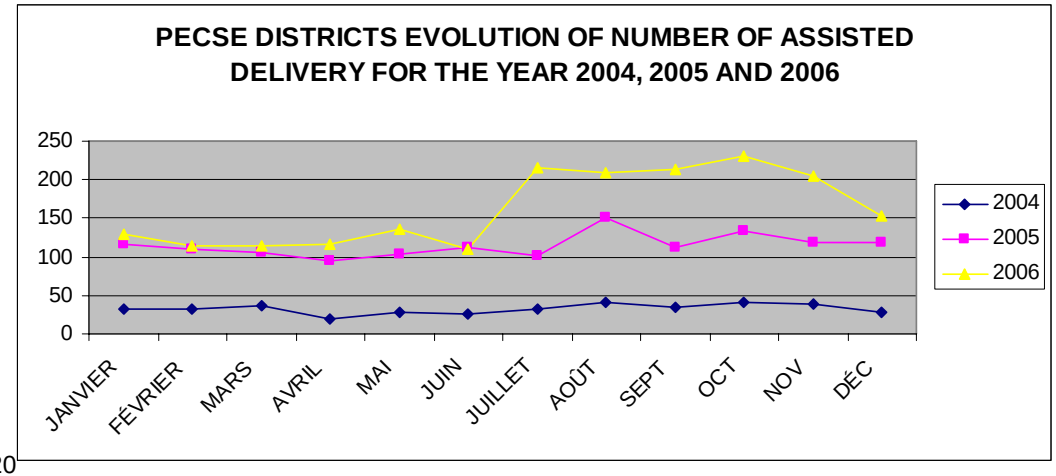
The basic package of services include: Immunization, growth monitoring, breastfeeding promotion, antenatal services, assisted deliveries and /or family planning. The current numbers of facilities which have been rehabilitated by PECSE are 17 of 23 and completely equipped are 23 of the 23. Training of providers has been completed, including some technical updates in areas beyond the basic package of services.

With the vast improvement in physical infrastructure, equipment, provider training and community outreach, use of most facilities has increased significantly. For antenatal care, for example, visits have almost doubled in the districts by the end of 2006.



The target for PY3 was 19 health facilities equipped and providing the basic package of services. The overall number of facilities that were targeted by PECSE is 23, and therefore 100% achievement for this indicator has been reached.

The one area beyond the control of PECSE that remains a barrier to high quality of care is the lack of trained midwives in many of the health posts. Overall lack of midwives and the refusal of some to be transferred to very rural postings with no lodging provided has led to this difficulty. The strategy undertaken by the MOH to recruit midwifery trainees from the communities where they will work afterwards has led to the hope that many of these positions will be filled when the next class of midwives graduates in 2008.



In spite of the lack of trained midwives in most sites, the use of the health post for deliveries has tripled in most months between 2004 and 2006.

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

The PECSE Project performed above the level of the project year three annual objectives by reaching all 23 health posts, and continues to support the health committees. The objective was to reach 14 health posts by the end of PY 3.

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

The PECSE Project trained two or three community health workers for each of the 23 health post communities, attaining 100% coverage during PY3. The target for PY 3 was to reach 20 health post communities, or 87%.

Currently, the MOH has approved a new policy recognizing the work of community health animators, and plans to hire formal community health workers as MOH staff to serve near each health post. Some of those hired are likely to be current volunteer staff; the evolution of the system will determine whether PECSE needs to train more volunteers if the current ones become staff.

5.2 Indicators by Expected Results: These indicators are recorded quarterly.

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 be 47%. (Catchments area population need to be estimated) The objective for coverage rate for the end of PY 3 is 40%.

- IR-1.5 Number/Percentage of health posts rehabilitated, including a water system storage, by PECSE. The following chart provides a summary of status of rehabilitation and water supply.

WATER SUPPLY SITUATION

Health Districts	Site	Type of Facility	Water resources
ALI-SABIEH	**ALI-SABIEH**	**District Hospital**	**24h tab water availibility**
	Holl Holl	Health Post	**There is a well very far from the village (6 km) in a very lower altitude than the village. The PECSE Project connected the health post tank to the village water system.**
	Dasbyo	Health Post	**There is a water source 8km farther from the village with a tank on a hill to supply water to the village. The Project connected the health post tanks to the village water system**
	Ali-Adde	Health Post	**The refugee camp in Ali-Adde has its own well drilled by WFP and a village water tank on a hill. The Ptroject connected the health post tanks to the village water system**
	Assamo	Health Post	**There is traditional well. The US Military team will drill a new well and the Project will provide all the necessary materials including solar pump and piping to connect to the health post water tanks**
	Goubetto	Health Post	**New well drilled and equiped with solar pump, connected to the village water tanks. The project connected the water tank to the health post**
ARTA	Arta	Health Post	**24h tab water availibility**
	Wea	Health Post	**24h tab water availibility**
	Damerjog	Health Post	**24h tab water availibility**
DIKHIL	**DIKHIL**	**District Hospital**	**24h tab water availibility**
	Gourabouss	Health Post	**There is a well in very low altitude and one km far from the village. Even though there is water once a week. The project connected the health post tanks to the village water system**
	Gallamo	Health Post	**The Health Post water tank is connected to the village water system filled by solar pump**
	As-Eyla	Health Post	**The Health Post water tank is connected to the village water system by US Army**
	Yoboki	Health Post	**The Health Post water tank is connected to the village water system by US Army. The tank is filled once every three days**
	Mouloud	Health Post	**24h tab water availibility**
OBOCK	**OBOCK**	**District Hospital**	**24h tab water availibility**

Health Districts	Site	Type of Facility	Water resources
	Medeho	Health Post	**Since the US Military well-driling rig can not reach this village, the traditionnal village well will be deepened by the Project and equiped with solar pump to provide water to the health post water tanks.**
	Alaili-Dada	Health Post	**There is unsafe water source in a very lower altitude and far from the health post. . The US Military team will drill a new well and the Project will provide all the necessary materials including solar pump and piping to connect to the health post water tanks**
	Waddi	Health Post	**A new well is drilled by GORD in the village, and equiped with electric solar pump to fill the village tank. The Project connected the health post tanks to the village water system**
	Daley af	Health Post	**The village water system is equiped by the community with solar pump. The Project connected the health post tanks to the village water system**
TADJOURAH	**TADJOURA**	**District Hospital**	**24h tab water availibility**
	Adaylou	Health Post	**There is an unsafe water source in the village. It's necessary to protect the water source and procure an electric water pump to fill the tank.**
	Day	Health Post	**A new well has been drilled by the GORD and the Project connected the health posts tank to the water system**
	Sagallou	Health Post	**A well has been recently drilled by GORD in the village and connected to an electric pump to fill the village tank. The Project connected the health post tanks to the village water system**
	Randa	Health Post	**The HP water tank is connected to the village water system**
	Dorra	Health Post	**The project is procuring a solar pump to replace the electric one providing water once a week to the village.**
	Assagueyla	Health Post	**. The US Military team will drill a new well and the Project will provide all the necessary materials including solar pump and piping to connect to the health post water tanks**

IR 2: Improved Quality of Services

- IR 1.2 Number of training modules implemented: The target for the third year was 18 training modules implemented and PECSE reached its target by implementing 18 modules.

- IR: 1.3 Number/Percentage 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 383 health workers (not including community health volunteers) trained. In addition, another 183 health committee members were trained in PY 3 and 143 health volunteers trained in STI management, infection prevention and nutrition.

- IR1.4 Percentage of health posts supervised according to MOH guidelines for supervision and management. The target of the third year is 45% (11 health posts). All the health posts (100%) were supervised.

IR 3: Enhanced Local Capacity to Sustain Health Services

- Number/percentage of health facilities linked to community health committees with both male and female representation (see SO Indicator 3).

- Number/percentage of communities with trained community health workers (see SO Indicator 4).

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

The next Annual Report, for PY 4-5, will cover the period from May 1st 2007 to July 30th, 2008. The following main activities have been planned for the fifteen month 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 additional five health posts (by quarter 2)
- Equipping of any additional health posts as needed

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 health providers in health posts in MCH modules
- 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 posters, and provision of any needed technical support for their use
- Implementation of flip charts especially for the community health workers, nurses and aides in health posts and centers, and teachers in schools
- Extend social mobilisation activities around the health posts, into district capitals and peri-urban areas of Djiboutiville
- Organise meetings on HMIS development, routine immunization program support and development of social mobilisation strategy.

For more detailed information about planned activities, please see the revised PECSE Work Plan for 2007-2008.

7. Management, US Agency Coordination 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. During PY 2, USAID requested a budget and Work Plan for use of the remaining funds in the project pipeline, and a 15 month extension was granted. Cost control measures will continue to be highlighted, especially for remaining procurement.

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's Regional Office in Nairobi. During 2006-2007, USAID's long-term Senior Health Advisor (Davis) visited Djibouti and provided hands-on support to PECSE.

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 Army and will be equipping the health posts that they have refurbished. A change in leadership in the military led to several weeks of reorientation, during which plans were shared and reconfirmed for well drilling and sharing of costs. The well drilling rig is currently not operational, and plans for the drilling are awaiting its repair or the arrival of a new rig.

Cost Control and Costs 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 the three years of PECSE, a number of actions have been 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 ImmunizationBASICS were co funded by 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. Identifying Best Local Technical Support: While there are limited numbers of trained technicians in Djibouti, PECSE has gone beyond the usual channels to find qualified people to perform technical oversight on renovations and other tasks. This usually has led to significant cost savings when compared to the responses to local requests for quotes on work. In one case, the resulting costs were less than one-half of what the lowest bidder has quoted.

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 often obtaining better products at a lower price.

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, reducing costs, increasing MOH ownership of the activities and increasing internal expertise within the MOH.

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 that 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. The Economic and Social Impact of Rural Health Post Rehabilitation Work

In Djibouti, the service sector is vital to the health of the national economy, especially services like insurance, banking, and port-related services. These services are essentially regrouped in the Djibouti City, creating an enormous disparity between the interior of the country and the capital city. This disparity also existed in the availability of health services, leading to an emphasis for PECSE on improving access to quality care in the districts. Rehabilitations of health posts, and the addition of incinerators, external toilets and other minor structures, were a major part of PECSE work during PY 3 and PY 2.

This work was generally done by either local companies or companies with owners originally from the concerned communities. Many workers were local hires, and the contracts created employment and helped support existing or new activities that generated revenue.

The following table presents a summary of the overall monetary impact of these contracts in two sites: in the south, Daasbyo, and in the north, Assagueyla.

Health Post	Overall Contract Value	Number of Workers and their Salaries	Additional Activities	Length of work
Assagueyla.	22,502,494 DJF	9 employees with an average salary of 60, 000 DJF/month.	Meals = 810,000 DJF Transport of materials = 1,620,000 DJF	60 Work
Daasbyo.	24,781,150 DJF	11 employees with an average salary of 60, 000 DJF/month.	Meals = 990,000 DJF Transport of materials = 1,980,000 DJF	60 Work

While it is likely that this activity did not lead to a long-term change in economic activity for everyone involved, this kind of impact over the course of at least 6 months in each of 17 rural communities did something to alleviate poverty and food insecurity during that year. No government data or analysis was available to supplement these findings.

9. CHALLENGES AND LESSONS LEARNED

There were many challenges for the PECSE Project during the three years of implementation, many of them stemming directly from overall human resource limitations in Djibouti. In addition, political issues including regional and Presidential elections and changes in key MOH personnel 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 at least twice, 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. In addition, new graduates of the midwifery program should be ready to be placed in 2008.

Collaboration with the Ministry of Health:

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.

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.)
However, assistance to the National Health Information System through the JSI Measure/Evaluation Program was provided for the development of a database for the computer data collection and analysis of statistical indicators. With Project support, all the providers, not only those in rural areas, but also in the urban areas, have been trained in data entry and analysis and also equipped with computers, printers, photocopier, etc. The smooth running of this system is one of the success stories of the Project, and USAID has approved the procurement of computer package for the health centres in Djibouti City.

Strong support for PECSE within the MOH led the Minister of Health to assign a new head manager for HMIS during PY 3 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.

Food Security:

The continued food security situation in parts of Djibouti, including a number of PECSE Project zones, has made efforts at community mobilization flawed. 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 aide.

Access to Safe Water:

Resolving the potable water issues at health posts is 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; it a few cases, it will be prohibitively expensive. In others (see Annex III), potable water has already become available and a few sites are receiving either new wells or new solar pumps to ensure sustainability of access to potable water.

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, who are both male and female.

Environment:

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

Supprimé : in the

The project initiated this kind of incinerators in the rural health post which did not exist before

10. A PECSE Project Story

A New Breed of Community Organizer: Saida of Daley Af Obock District, Republic of Djibouti

> "Sometimes I walk a long way to visit with women in their camps, but they don't always want to listen and sometimes they don't have time to talk. But I keep going- now we know things we didn't know before and we can be healthier."
>
> Saida, January 2006

Selected by her community to help prevent common illnesses and increase the use of health services, Saida works with a community of several hundred people, including several scattered encampments of traditionally nomadic families. For the first time, community mobilization is taking place in rural districts of Djibouti, as a result of the USAID funded initiative "The Expanded Coverage of Essential Health Services Project." For outreach workers like Saida, this is an opportunity to be a community resource—in addition to improving their own knowledge and health practices, they assist clinic-based nurses in linking those in need with available services.

Women rarely play visible public roles in rural Djiboutian society, and are virtually absent from the health care system. Consequently, the predominantly male cadre of nurses working in the countryside is often unable to be an effective resource for communities since women do not feel comfortable speaking with men about health issues. Female outreach workers such as Saida are helping women access health services and prevent illness, as well as overcome traditional beliefs about both sickness and prevention and women's role in civil society.

The Expanded Coverage of Essential Health Services Project, implemented by John Snow, Inc., aims to provide populations in rural districts with better access quality health services. Its objective is to reduce morbidity and mortality rates among women and children, and promote full community participation in health service delivery. In rural areas, the Project is working with communities to organize and train village health committees, select and train health workers like Saida and renovate, equip and update training for nurses. JSI provides materials, supplies and support to community workers, reinforces linkages between village health workers, the health committee and clinic health providers and provides support for the three parts of the local system.

Saida speaks with confidence about her role as an educator and motivator in a recent polio eradication campaign, and how it enabled her and other community organizers to feel self-assured about their community assessment skills. They now know where children and women in high-risk groups live, even among scattered camps in a radius of several kilometers. Saida worries about the high level of anemia in women, which she

"Saida listens as people in the community talk about their health needs."

can now recognize from physical symptoms, and the commonness of diarrhea among young children, and hopes to help change things. She refers potentially anemic women to the clinic, encourages pre-natal visits and teaches mothers how to rehydrate their children at home and when it is serious enough to seek help from the clinic.

“Before I was an animator, I wasn’t sure what to do,” Saida says. “Now I know—even though the work is hard sometimes, I like it and will keep doing it.”

ANNEXES

ANNEXE I

PECSE PROJECT INDICATORS STATUS UPDATE
April 2007

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	
SPECIFIC OBJECTIVE (SO) 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							
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% **16%**	15% **20%**	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% **15**	14 61% **25 > 100%**	- year 1: 5 - year 2: 6 - year 3: 3 More than 23 Health Post are linked to health committees
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 % **10**	16 100% **16**	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 **15**	18 **17**	- year 1: 10 - year 2: 5 - year 3: 3

IR 1. INCREASED SUPPLY OF ESSENTIAL HEALTH SERVICES							
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 % **38%**	40 % **47%**	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 **0**	19 **19**	- Year 1: 3 - Year 2: 7 - Year 3: 9 Rehabilitation & equipment of 19 Health posts completed
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	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	**150** **50 %**	**250** **83%** **259**	**300** **100%** **574**	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% **20%**	45% **100%**	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% **24%**	28% **43%**	N.B.: numbers expected pregnancies ≅ total expected birth The new maternity in the rehabilitated health posts don't have enough staff for these activities

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% **23%**	26% **28%**	The base line of this indicator was estimated based on PAPFAM 2002 page 146 Lack of qualify staff in the health posts
IR3. ENHANCED LOCAL CAPACITY TO SUSTAIN HEALTH SERVICES							
IR-3.1 Number of radio spots developed and broadcasted	Number of radio spots developed and broadcasted	Project Document	Annual	2	5 **7**	7 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 % **5**	20 87% **25 > 100%**	- year 1: 0 - year 2: 5 - year 3: 15

In red: updated situation as of April' 2007

ANNEXE II: SUMMARY TABLE OF PECSE TRAININGS (APRIL 2007)

DISTRICTS	Number of trainers trained 19-24 Mars 2005	Number of health providers trained 1st round	Number of health providers trained 2nd round	Number District Health Management Team (DHMT) members trained	Number of DHMT members who trained the health providers	Number of the training centre members who supervised the DHMT training	Number of trainers trained in social mobilization and BCC	Number of health committee members and community volunteers trained	Number of health providers trained in HMIS	TOTAL OF TRAINED HEALTH WORKERS
Ali-Sabieh	4	**10** 24-27/04	**17** 13-15/10	**6** 18-21/11	4	4	11	32	**(16) + 7**	**70**
Dikhil	4	**14** 17-19/05	**13** 12-14/10	**3** 18-21/11	6	4	6	68	**(3) + 17**	**98**
Arta et Périphérie	4	**16** 05-07/07	**14** 01/02/06	**3** 18-21/11	1	4	3	38	**(13)**	**64**
Obock	4	**11** 11-13/07	**15** 20-22/10	**4** 12-15/11	6	4	9	55	**(3) + 15**	**86**
Tadjourah	4	**12** 18-20/07	**16** 20-22/11	**5** 12-15/11	6	4	11	81	**(17) + 3**	**116**
Ville de Djibouti	10 + 3	-	-	**40**	2	-	5+3	-	**(61) + 79**	**140**
TOTAL	**33**	**63**	**61**	**61**	**23**	**18**	**48**	**274**	**235**	

NB : The yellow columns were not included in the totals
The numbers between parentheses are not included in the total of trained Health Workers

In total, 574 persons were trained by PECSE, consisting of health providers (252) and community health workers (322).

ANNEXE III: SUMMARY TABLE OF HEALTH FACILITIES REHABILITATIONS (April 2007)

Region	Health Facility	Kind	Rehabilitation status
ALI-SABIEH	**ALI-SABIEH**	**CMH**	**NA**
	1. Holl Holl	Health Post	**Completed by PECSE**
	2. Dasbyo	Health Post	**Completed by PECSE**
	3. Ali-Addé	Health Post	**Completed by PECSE**
	4. Assamo	Health Post	**Completed by PECSE**
	5. Goubetto	Health Post	**Completed by PECSE**
ARTA	**6. Arta**	**Health Post**	Will be rehabilitated by PECSE and equipement provided by the Project available
	7. Wea	Health Post	Will be rehabilitated by PECSE and equipement provided by the Project available
	8. Damerjog	Health Post	Will be rehabilitated by PECSE and equipement provided by the Project available
	PK 20	Health Post	Will be done with World Bank and African Bank funds
DIKHIL	**DIKHIL**	**CMH**	**NA**
	9. Gorabouss	Health Post	**Completed by PECSE**
	10. Gallamo	Health Post	**Completed by PECSE**
	11. As-Eyla	Health Post	Will be rehabilitated by PECSE and equipement provided by the Project available
	12. Yoboki	Health Post	Will be rehabilitated by PECSE and equipement provided by the Project available
	13. Mouloud	Health Post	**Completed by Partner US Military**
DJIBOUTI	**PK 12**	**Health Post**	**Partner French Coop (AFD)**
	CSC Ambouli	**Health Post**	**Completed by PECSE and World Bank**
OBOCK	**OBOCK**	**CMH**	**NA**
	14. Medeho	Health Post	**Completed by PECSE**
	15. Alaili-Dada	Health Post	**Completed by PECSE**
	16. Waddi	Health Post	**Completed by PECSE**
	17. Daley Aff	Health Post	**Completed by PECSE**
	Assassan	**Health Post**	**Done by WHO and equiped by the PECSE Project**
	TADJOURAH	CMH	**NA**
	18. Adaylou	Health Post	**Completed by PECSE**
	19. Day	Health Post	**Completed by PECSE**

Region	Health Facility	Kind	Rehabilitation status
TADJOURAH	20. Sagallou	Health Post	**Completed by PECSE**
	21. Randa	Health Post	**Done by Partners.** PECSE equipement available
	22. Dorra	Health Post	**Completed by PECSE**
	23. Assagueyla	Health Post	**Completed by PECSE**
	Guirori	**Health Post**	**Done by WHO and equiped by the PECSE Project**

- *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 sites in blue will be rehabilitated by the PECSE Project during the extension period*
- *Equipment of all the sites completed including Ambouli (Djibouti), Guirori, Assassan, Mouloud.*

RADIO SPOTS DEVELOPED ON THE FOLLOWING THEMES

- Pregnancy risk prevention
- Diarrhea management and dehydratation prevention
- STI/HIV prevention
- Malaria-in-Pregnancy prevention
- Acute Respiratory Infections management
- Child immunization
- Breast feeding
- Tetanus prevention in pregnanct women
- Nutrition and child growth monitoring

ANNEX IV TABLEAU RECAPITULATIF DES MODULES DE FORMATION ELABORES PAR LE PROJET PECSE POUR LES FORMATEURS, LES EQUIPES CADRES DE DISTRICT ET LES PRESTATAIRES

DOMAINE	MODULES	POPULATION CIBLE
Approche à la Formation	**1. Techniques de formation :** - Formation en Andragogie - Elaboration d'un module de formation	Formateurs du CFPS et des districts
Gestion Des ressources de vaccination	2. **Gestion des vaccins** et autres intrants du PEV	Equipe cadre de district et responsables de la vaccination du niveau central et des districts
Gestion et Supervision des activités	**3. Techniques de Planification/ programmation, Gestion**	Equipe cadre des District et responsables urbains
	4. **Supervision formative**, Suivi-Evaluation et Recherche opérationnelle	
Nutrition	**5. Guide de Nutrition :** - Allaitement maternel - Surveillance de la croissance - Nutrition intégrée	Formateurs du CFPS, des districts et service formation du Ministère de la Santé
Mobilisation Sociale	6. **Guide de mobilisation sociale** et participation communautaire	Formateurs des districts, animateurs communautaires et membres des comités de santé

Prévention des Infections	7. **Prévention des Infections** : Notions de précautions universelles, et élimination des déchets	Formateurs, ECD et Prestataires des postes de santé
Maladies de l'enfant	**8. Paludisme**	Prestataires des postes de santé
	9. Infections respiratoires aigues	
	10. Diarrhée- prévention déshydratation	
	11. Tuberculose	
Prévention des risques de la grossesse	**12. Consultation prénatale**	Prestataires des postes de santé
	13. Consultation Post natale	
	14. **Risques de la grossesse** (anémie hémorragie obstétricale, hypertension artérielle, prévention du tétanos)	
Contraception	**15. Méthodes contraceptives** - CIP/Counseling en planning familial - MAMA - Gestion des services SR	Prestataires des postes de santé
IST/SIDA	16. **Prise en charge syndromique** des IST et Prévention du SIDA	Formateurs et Prestataires des postes de santé des districts
SNIS	17. **Recueil des données** et remplissage manuel des supports du SIS	Tous les Prestataires des niveaux urbain et rural
	18. Saisie informatique et analyse sur Dj-SIS	Responsables du Minsan et Points focaux des districts
Utilisation et maintenance des stérilisateurs	19. **Utilisation des stérilisateurs** et Maintenance préventive	Equipe de maintenance HGP, des districts et Prestataires des postes de santé

Making Medical Injections Safer

ANNUAL PERFORMANCE MONITORING REPORT FOR MAKING MEDICAL INJECTIONS SAFER/JOHN SNOW, INC.

ACTIVITIES FROM OCTOBER 1, 2006 – SEPTEMBER 30, 2007

SUBMITTED TO USAID ON OCTOBER 22, 2007

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The authors' views expressed in this publication do not necessarily reflect the views of the OGAC, United States Agency for International Development, or the United States Government.

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EXECUTIVE SUMMARY

The World Health Organization (WHO) has estimated that unsafe medical injections may account for over 5 percent of new HIV infections each year.[1] Based on this evidence, prevention of medical transmission of HIV has been an integral part of the President's Emergency Plan for AIDS Relief's (PEPFAR) comprehensive HIV prevention strategy since its inception in 2004. Given the large numbers of HIV-infected patients in many countries, other patients and frontline health workers who provide care are at increased risk of HIV infection through reuse of contaminated needles and syringes and through needlestick injuries. PEPFAR's efforts to improve health worker safety protect one of the most precious resources in the struggle against the pandemic. John Snow Inc. (JSI) was contracted by the United States Agency for International Development's (USAID) PEPFAR-funding mechanism to address the problem of HIV transmission in health care settings by implementing a project known as Making Medical Injections Safer (MMIS). The current contract runs through September 30, 2009.

Through PEPFAR, the U.S. Government has established itself as a global leader in the prevention of medical transmission of HIV through unsafe injection practices. Collaboration among project partners—including JSI, the Program for Appropriate Technology in Health (PATH), and the Academy for Educational Development (AED)—has enabled MMIS to bring together top experts in each of the technical areas that comprise WHO's three-part strategy to reduce harm caused by unsafe injections. This cutting edge work marks the first time that HIV transmission through curative care injections (which comprise 90% of all medical injections) has been addressed in a systematic fashion. In addition to the project's accomplishments at the country level, MMIS contributes to the global body of knowledge and experience in reducing medical transmission of HIV. The international community, including the Safe Injection Global Network (SIGN), relies on the results and experiences of MMIS to inform the design and implementation of injection safety interventions and approaches around the world. With support from MMIS in July 2007, the 44th Annual East, Central and Southern African Community Health Ministers Conference (ECSA) passed a resolution among member states to recognize injection safety as an important element in scaling up cost effective health interventions.

The PEPFAR/MMIS strategy to reduce medical transmission of HIV and improve health worker safety through safer injection practices hinges on a multi-faceted technical approach that builds in-country capacity for sustained improvements in safer injection practices that will last well beyond the five-year project and amplify MMIS's reach. Examples of the project's approach and major project achievements are summarized below:

- **Commodity Procurement & Management:** The MMIS commodity strategy focuses on eliminating re-use of syringes by introducing safety syringes, providing sufficient quantities of safe injection equipment and providing technical assistance in logistics management. Across the 4 countries, MMIS has ensured adequate supply levels of syringes and safety boxes in 29 districts, 6 states (including districts), and over 100 special intervention facilities, protecting an estimated 54 million people from the medical transmission of HIV. The addition of MMIS commodities to existing in-country resources is improving the safety of over 80 million injections per year.[2]

---

[1] Hauri, AM,, GL Armstrong, and YJF Hutin. "The global burden of disease attributable to contaminated injections given in health care settings." International Journal of STD & AIDS, 2004, 15:7-16.

[2] WHO estimates an average of 1.5 injections per person per year.

The commodity strategy has served as a catalyst to increasing host country government commitment to making safety syringes available and affordable in MMIS countries. The base that was built through MMIS was an important support for Uganda in its implementation of a national safety syringe policy and its first local procurement. Nigeria drafted a similar policy in 2007 and also responded by opening a local production facility to produce safety syringes, with a second plant under construction. In keeping with the goals of USAID, and to help countries achieve their Millennium Development Goals (MDG), MMIS has been working to strengthen in-country capacity to plan for procurement, improve forecasting, logistics management and improve quality standards. While continuing to provide necessary technical assistance to ensure continued progress through the life of the project, MMIS will gradually phase out procurement in the next two years of the project as planned.

- **Training and Capacity Building:** Health worker training and capacity building in injection safety, health care waste management and infection prevention is critical for improving injection practices. MMIS trainings have strengthened the effectiveness of other PEPFAR prevention, care and treatment programs by reinforcing safe injection practices and proper sharps waste management. To date, MMIS has trained over 52,000 public sector health workers in injection safety, increasingly using active learning approaches that enhance the effectiveness of training and lead to lasting improvements in health worker practices.

  Pre-service training, another critical component of the MMIS project, ensures that improved injection safety practices will be sustained. MMIS has worked closely with in-country training institutions to incorporate injection safety content into pre-service training programs for health professionals. For example, Nigeria's major nursing school has integrated injection safety and standard precautions into its national curricula, ensuring that all future nurses will have this knowledge. In Uganda, MMIS is training trainers in nursing and medical schools as well as targeting teaching hospitals to ensure continuity in the application of safe injection practices for students and recently graduated health professionals. In order to ensure improved practices in the long term, MMIS' approach to capacity building includes the strengthening of supervisors' ability to monitor and reinforce safe practices, adoption and introduction of norms and standards for safe practice, development of job aides, and the creation of feedback mechanisms to strengthen capacity and guide decision-making.

- **Behavior Change and Advocacy:** MMIS implements behavior change and communication (BCC) strategies to reduce unnecessary injections, improve safe injection practices among health workers, and promote safe health care waste management. By promoting less invasive forms of treatment when possible, MMIS works to decrease the potential exposure of health workers and patients to HIV infection through injections. MMIS's behavior change interventions target policymakers, health workers, their supervisors, waste handlers, patients, and community members to promote specific key behaviors, and create professional and social norms of only safe and necessary injections. These interventions are bolstered by messaging that reinforces and encourages change among target groups. For example, the Uganda team developed injection safety video messages to reduce the demand for unnecessary injections that reached an estimated 400,000 community members using mobile vans equipped with screens. Advocacy strategies are another integral part of the MMIS approach to ensuring the long-term impact of injection safety interventions. For instance, advocacy efforts in Mozambique led to the revision of national standard treatment guidelines for sexually transmitted infections, reducing the high number of injections once given.

- **Health Care Waste Management:** Contaminated needles in medical waste pose a risk of needlestick injury and HIV infection to health workers and the community. MMIS has pioneered efforts to systematically improve the management of health care waste to better protect health workers and the community, including the introduction of safety boxes, segregation of waste and

safe disposal of sharps waste. With the widespread introduction of non-reusable needles and syringes and the rapid scale-up of HIV/AIDS prevention and treatment activities through programs like PEPFAR, the volume of contaminated health care waste has substantially increased in recent years. MMIS's efforts to improve waste management practices are designed to minimize health care worker and community exposure to infectious waste. National-level efforts to bring partners together to address the challenge of health care waste management have involved government ministries, WHO, the World Bank, and international donors as well as local non-governmental organizations (NGO) and other partners. MMIS has been a catalyst for application for and utilization of GAVI (formerly the Global Alliance for Vaccines and Immunization) funds to develop national health care waste management plans, bringing together major stakeholders to develop a strategy and action plan for improving the situation in these four USAID-funded countries.

From its inception, MMIS has actively engaged partners to ensure long-term commitment to injection safety in the countries where it works. In-country partnerships with Ministries of Health, influential NGOs, and international institutions such as WHO, SIGN, UNICEF and the World Bank are paramount to a diversified base of support that can sustain efforts to reduce infections from unsafe injections. The project's field-based structure with in-country teams of host-country nationals allows interventions to be tailored to each country context and provides a ground-level perspective in project implementation. MMIS's role as a catalyst and its focus on partnerships facilitates country ownership of injection safety programming and institutionalization of injection safety as a professional norm.

MMIS countries are diverse, and each faces it own set of challenges. Despite inevitable difficulties, each program has made great strides in strengthening the PEPFAR prevention portfolio by establishing injection safety as a priority. Local support for MMIS's continued technical expertise is strong, with USAID missions recognizing the positive contribution the project has made in strengthening health systems in their respective countries and preventing transmission of HIV through improved injection safety. In light of budget reductions at global level, both the Nigeria and Uganda MMIS programs were able to secure additional financial support through the local USAID missions.

While much progress has been made in the first half of the project, the final two years of implementation are crucial to securing long-term, widespread improvements in injection safety. In order to ensure the smooth and complete transition of injection safety programming to local counterparts and ministries of health, MMIS will continue to focus its efforts over the remaining years of the project to reinforce country ownership of the program, secure a broad base of support for continued effort, and ensure sustainability of safe injection practices.

This Annual Report for the period October 2006 to September 2007 provides a summary of the Making Medical Injections Safer (MMIS) project's progress to date. General global summaries are provided for each technical area that comprise the project's approach to reducing HIV transmission through safer injections, followed by country-specific developments, activities, and achievements for Ethiopia, Mozambique, Nigeria, and Uganda.

I. BACKGROUND

Of the 16 billion injections given worldwide each year, up to 50 percent are unnecessary and unsafe, according to World Health Organization (WHO) estimates[3]. The use of unsterile injection equipment and mishandling of contaminated needles can place patients, health care workers and the community at risk of contracting human immunodeficiency virus (HIV) and other bloodborne diseases. High patient demand for injections in many developing countries, and health workers' willingness to provide them, have resulted in a high volume of medically unnecessary injections, creating greater need for new, sterile injection equipment and a means of disposing of used sharps waste safely. Inadequate disposal of sharps waste contaminates the community, exposing the wider public to health risks. These unsafe and unnecessary injections spread deadly diseases in communities that are already burdened by poverty and disease and that have limited resources to address these complex problems.

With funds from the President's Emergency Plan for AIDS Relief (PEPFAR) focusing on countries with high HIV prevalence, the United States Agency for International Development (USAID) awarded funding to John Snow Inc. (JSI) and its subcontractors, Program for Appropriate Technology in Health (PATH), Academy for Educational Development (AED), and the Manoff Group 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 officially began 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 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, MMIS provides direct programming or technical assistance to 12 PEPFAR-supported countries.

This Annual Performance Monitoring Report for the MMIS project covers the period October 2006-September 2007. It summarizes the accomplishments of global and country activities in Ethiopia, Mozambique, Nigeria, and Uganda in the following technical areas: commodity procurement and management, capacity-building and training, behavior change communication and advocacy, health care waste management, and monitoring and evaluation.

1.1 PROJECT MANAGEMENT

1.1.1 MMIS Headquarters (HQ) Office

MMIS/HQ office in Virginia currently has a total of 15 full-time staff members to implement both the USAID and CDC contract and cooperative agreement, respectively, in 11 countries. Jules Millogo,

[3] L.Simonsen, A. Kane, J. Lloyd, M. Zaffran, & M. Kane. "Unsafe injections in the developing world and transmission of blood borne pathogens: a review." Bulletin of the World Health Organization, 1999, 77 (10).

MD, resigned from his position as Project Director at the end of April 2007. As the prospect for future project funding was uncertain at that time, JSI, with USAID's concurrence, assigned a current JSI employee, Mary Carnell, MD, MPH, to serve as Interim Project Director through October 2007. Due to other work-related commitments, Dr. Carnell will not be able to continue to serve in this capacity. Based on conversations with USAID and a more optimistic picture for future funding, JSI has begun the recruitment process for a new Project Director. Several candidates have been interviewed, and a prospective final candidate has been identified. The prospective final candidate has interviewed with project and JSI corporate staff. The next steps are to proceed with reference checks and then seek approval from USAID for this key personnel position by the end of October 2007.

Ms. Vanessa Richart, Technical Officer for Rwanda, Côte d'Ivoire and Haiti resigned from her position in July 2007 and transferred to another JSI project, the USAID | DELIVER PROJECT, Task Order 2, focusing on Avian Influenza as Country Operations Manager. She will still be based at the HQ office, and as such will continue to serve as a valuable in-house resource for the MMIS project when needed.

Richard Fozo Alombah, MD was hired in August 2007 to replace Ms. Richart as Technical Officer for MMIS' francophone countries. Richard is originally from Cameroon and is a graduate of the University of Yaounde Medical School. In addition, he recently completed a Masters of Science program in international health policy and management from The Heller School for Social Policy and Management at Brandeis University in Boston.

Mr. Glenn Conklin, Technical Program Coordinator, left MMIS in October 2006 to pursue other professional endeavors. This position has not been refilled due to funding constraints.

1.1.2 MMIS Field Offices

The MMIS project assures a constant presence in its program countries through its field offices and host country national staff. The keys to MMIS's success to date have been the field staffs' familiarity with their respective countries, their continued support to local injection safety (IS) partners, and their ability to influence change within the health system. In USAID countries, the MMIS field offices are staffed with a Country Director, a Logistics Advisor, a Waste Management Advisor, a BCC Advisor, and an Administrative/Finance Officer.

1.1.3 Mid-Term Reviews

As the MMIS project is at its mid-point, each country team conducted a mid-term review of its program. Mid-term reviews included input from project staff, in-country injection safety partners, and, where possible, USAID mission staff. The purpose of the review was to: examine achievements to date, evaluate the effectiveness of interventions to date, record lessons learned, identify current gaps, address challenges with possible solutions, and fine-tune program strategies and priorities for maximum impact through the end of the project. The mid-term review provided an opportunity to critically examine each program's interventions to decide how limited resources can be used innovatively to maximize achievements. The results of these country-level reviews are country-specific recommendations that have been incorporated into FY2008 activities.

The Mid-term review report for Uganda will be finalized in October 2007, and reports for Mozambique, Nigeria and Ethiopia will be finalized in November 2007.

II. TECHNICAL APPROACH

In the four countries supported by USAID, MMIS incorporates the strategy recommended by WHO's Safe Injection Global Network (SIGN) and includes the following components:

1. ***Commodity management and procurement*** support for estimating, financing, procuring, and distributing injection equipment and waste disposal containers
2. ***Capacity building and training*** to improve injection practices, supply management, health care waste handling, and interpersonal communications
3. ***Behavior change and advocacy*** to encourage safe injection practices and reduce demand for medically unnecessary injections
4. Standardized systems for proper sharps ***waste disposal***
5. Strategies for working with ***private providers and the informal health sector***
6. Strengthening the ***policy environment*** that supports injection safety with guidelines, resources, and monitoring of injection practices
7. ***Monitoring and evaluation*** of injection safety interventions and their impact
8. ***Phlebotomy*** to identify current practices to inform future strategies
9. ***Conference participation*** to share lessons learned

The cornerstone of the MMIS project is its field-based approach to project implementation and its emphasis on local partnerships. MMIS has 11 field offices and relies on its in-country partnerships with local institutions and organizations to successfully integrate injection safety into local health systems. This approach assures that the project is progressing towards country ownership of injection safety initiatives and maximizing leveraged resources to strengthen the sustainability of improved injection practices beyond the life of the project.

In each of the four countries, the Ministry of Health (MOH) and the local USAID mission are key MMIS partners in the planning and implementation of injection safety activities that respond to each country's needs. MMIS also supports ministries of health with technical advice in the areas of injection safety and health care waste management. In addition, the Minister of Health, or some other high-level official, chairs a National Injection Safety Task Force made up of key MOH departments, Ministry of Environment officials, 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. MMIS Country Directors have also been successful in establishing strong working relationships with influential partners such as the World Bank, UNICEF, the Carter Center and WHO.

At the international level, MMIS continues to have strong relationships with the East, Central and Southern African Health Ministers' Conference (ECSA), the WHO Africa Regional Office (WHO/AFRO), WHO headquarters in Geneva, and WHO/SIGN . For example, MMIS collaborated with WHO/SIGN in the revision of Tool C, WHO's standard injection safety assessment tool. MMIS's extensive field experience and input was requested by WHO/SIGN so that the revised Tool C would be both relevant and practical in the field. Additionally, MMIS participates in the quarterly PEPFAR Partners meetings chaired by USAID to share success and progress with other injection safety projects funded under the initiative.

GLOBAL PROJECT ACTIVITIES:

TASK 1: ENSURE THE AVAILABILITY OF SAFE INJECTION EQUIPMENT AND SUPPLIES AT SERVICE DELIVERY POINTS THROUGH EFFECTIVE COMMODITY PROCUREMENT AND IN-COUNTRY LOGISTICS MANAGEMENT, INCLUDING THE DEVELOPMENT OF STRATEGIES TO ACHIEVE INJECTION DEVICE SECURITY

To reduce syringe reuse—and the related transmission of HIV and other bloodborne diseases—sufficient and appropriate injection equipment must be available to ensure the safety of necessary injections. Commodity management strategies and the introduction of safe injection technologies are a key component to MMIS's approach to improving injection safety through access to adequate supplies of new, safe injection devices. In most USAID countries, early assessments showed that a severe lack of planning data, combined with haphazard procurement practices for injection equipment, led to frequent stockouts of new syringes and insufficient quantities of safety boxes. While syringes that prevent reuse and protect health workers from needlestick injuries have been successfully adopted in immunization settings, the majority of injections—90 to 95 percent according to WHO— occur in curative procedures, underscoring the need to expand safe injection practices to curative care settings. As MMIS has evolved, responses from country programs and international fora also confirm that supporting occupational safety, specifically through the use of appropriate equipment to reduce exposure to HIV, is a high-level concern.

Implementation of the logistics management information system (LMIS) and other forecasting tools have been an important step in supporting the objective of injection device security. Additional support is leveraged through international pooled procurement and capacity development initiatives. MMIS also leverages the procurement and supply of materials to prime in-country systems to support behavior change and as an additional channel through which policy and advocacy objectives can be achieved.

Before MMIS intervention, forecasting in all countries was based simply on previously placed orders. This method was not accurate, and did not account for actual need in terms of quantity or correct mix of syringes. The LMIS tool is providing information to improve procurement forecasting and commodity management, allowing for more effective advocacy and planning for future financial resources. The ability to review and manage stock in the pipeline has reduced the incidence and duration of stockouts in MMIS intervention areas and strengthened host country capacity to effectively manage its scarce resources. The LMIS also strengthens the ability of central medical stores (CMS) to improve distribution and planning at facility- or point-of-service level.

1.1 Procurement

Based on the previously awarded tender, commodities continue on a phased-delivery schedule to all countries. Because syringes have a high cubic volume for shipment and storage, it is important to maintain the phased-delivery schedule to avoid storage space problems in CMS facilities. In all MMIS countries, the CMS hosts other programs and failure on the part of those programs to provide accurate information on their commodities can lead to storage space conflicts. Deliveries under the current tender have been made as depicted in Table 1.

Table 1: October 2006 – September 2007 Commodity Deliveries

Country	Total Standard Disposable Syringes	Total Re-use Prevention Detachable Syringes	Total Re-Use Prevention Fixed Syringes	Total Retractable Syringes	Total Syringes
Uganda	0	11,062,200	5,136,000	0	16,198,200
Ethiopia	4,011,200	9,617,200	0	1,234,200	14,862,600
Nigeria	2,707,200	4,600,400	1,830,400	3,322,200	12,460,200
Mozambique	0	0	0	0	0

Note: Nigeria commodities were adjusted downward and a delivery in process at the last time of reporting was removed from their schedule.

Estimating a tender for this year is on hold pending a careful review of budget considerations. In the interim, current procurement contracts have been extended to cover a longer period of time and MMIS is continuing to review and monitor the commodity situation in each country. Also, commodities in current production schedules were re-allocated among USAID MMIS countries to avoid disruptions in supplies and manage with available resources. For example, Ethiopia's consumption dropped substantially due to a re-structuring of USG program activities. Prior to shipment, a substantial portion of the commodities in the pipeline for Ethiopia were therefore reprogrammed to Uganda to support their expansion plans.

To accommodate the reduced procurement, some countries have delayed expansion plans, while others have negotiated with local partners to support a more rapid phase out of MMIS goods in some facilities. Overall, commodities to USAID countries were reduced by an average of 15% from the originally awarded contracts and are covering an extra 3-5 months. The net effect to the program is a reduction of over 35%. While obligations had been made prior to the budget shortfall, MMIS undertook significant negotiations with manufacturers to reduce contractual commitments without costly penalties.

1.2 Transition to Country Ownership

MMIS provides technical assistance along with the commodities to ensure a rational approach to commodity management and to strengthen the ability of local systems to procure injection safety devices.

As identified in the original strategy, the third year of the program was designated as the point to begin encouraging local procurement of safe injection equipment. In keeping with this, the technical assistance in Uganda focused on continuing the MMIS support to the National Medical Stores (NMS) in transitioning their national supplies to safety syringes. NMS launched a tender for safety syringes, and MMIS supported them with need simulations. In Nigeria, MMIS supported advocacy efforts for a policy requiring safe injection equipment. Mozambique adopted a policy phasing out glass syringes, and MMIS supported them with a transition plan. The restructuring in Ethiopia will shift MMIS's technical assistance focus to partner programs, and may need to accommodate a new, national procurement organization.

MMIS activities support sustainability of the systems being implemented and recognizes that financial self-sufficiency (one component of sustainability) is impacted by a variety of factors outside of MMIS's scope. While national budgets may remain insufficient to support full supply, the transfer of ownership to local structures has successfully begun. Technical assistance and commodity support will still be required during this transition to country ownership and to continue assisting countries in identifying other means to cover financial gaps.

1.3 Industry Relations

At the country level, overall sustainability requires the willingness of industry to support local manufacturers and distributors to ensure availability of commodities. MMIS recognizes the importance of leveraging industry in a neutral, systematic, and transparent manner to promote the sustainability of products at reasonable costs. As previously reported, MMIS has reviewed importation information in several countries and noted that over 50 percent of all injection equipment is imported through private distributors. MMIS is encouraged that manufacturers have begun introducing safety syringes into local markets on their own initiative.

In USAID countries, industry has begun investing in local manufacturing. In Nigeria, a privately funded factory has opened with an annual capacity of 90 million safety syringes per year. A second factory supported by the Nigerian government is under construction and is expected to produce an estimated 160 million per year. MMIS is also aware that another investor is considering Uganda as a potential safety syringe manufacturing site as well. To acknowledge the progress represented by their presence, MMIS advocated to the national regulatory agencies or the integrated logistics programs to begin establishing minimum quality standards for syringes. This will serve to ensure that locally manufactured safety syringes and imported goods adhere to established quality standards.

1.4 Technical Assistance

MMIS provided technical assistance via follow-up, reports, and feedback to country logisticians, and conducted situational assessments throughout the year. On-site technical assistance was provided to Ethiopia, Nigeria and Uganda.

The technical assistance also highlighted the need to support other USG programs in MMIS countries. In Nigeria, MMIS is extending its activities beyond the project's focal LGAs. With other PEPFAR partners and the Government of Nigeria (GON), MMIS will ensure that intervention sites of other partners include injection safety in their holistic approach to HIV prevention. Specifically, it was noted that these projects would benefit from assistance with using bundling principles (e.g., syringes or blood draw equipment + test kits + safety boxes), and MMIS is providing safety boxes to these expanded sites and will be providing technical assistance regarding procurement of injection safety supplies.

In Ethiopia, assistance was provided to support the mid-term review and also to assess the impact of a recent restructuring of USG programs. While this restructuring expands MMIS to a broader geographic region, it limits it to lower-level facilities which may result in significant coverage challenges.

In Uganda, technical assistance was provided in preparation for their mid-term review. As above mentioned, specific support in implementing the national tender for safety syringes was provided in June 2007.

1.5 Policy Environment and Collaborations

MMIS recognizes that the policy environment related to procurement is important in supporting sustainability goals. In June 2007 Uganda began implementing its policy to shift to use of safety syringes. In July, Nigeria's National Agency on Food and Drug Administration and Control (NAFDAC) announced a similar policy that will be phased in over a 24-month period.

MMIS procurement and logistics representatives also attended the 2006 SIGN meeting, providing contributions to various technical sessions on global injection safety issues. MMIS also participated in the 44th Annual East, Central and Southern African Community Health Ministers Conference (ECSA), where a resolution was passed among member states to recognize injection safety as an

important element in scaling up cost effective health interventions. Mozambique and Uganda are ECSA member countries.

1.6 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 the details of regulations, providing reports, and other assistance as needed. MMIS provides monthly reports to each country logistics advisor on quantities delivered as well as in-transit and pending release.

1.7 Progress with the Logistics Management Information System (LMIS)

LMIS data continues to accrue with regular technical support from MMIS country team logistics advisors in intervention areas. The LMIS reports and information from surveys provide valuable information on consumption patterns that will continue to be used to improve forecasting, planning, and distribution of commodities.

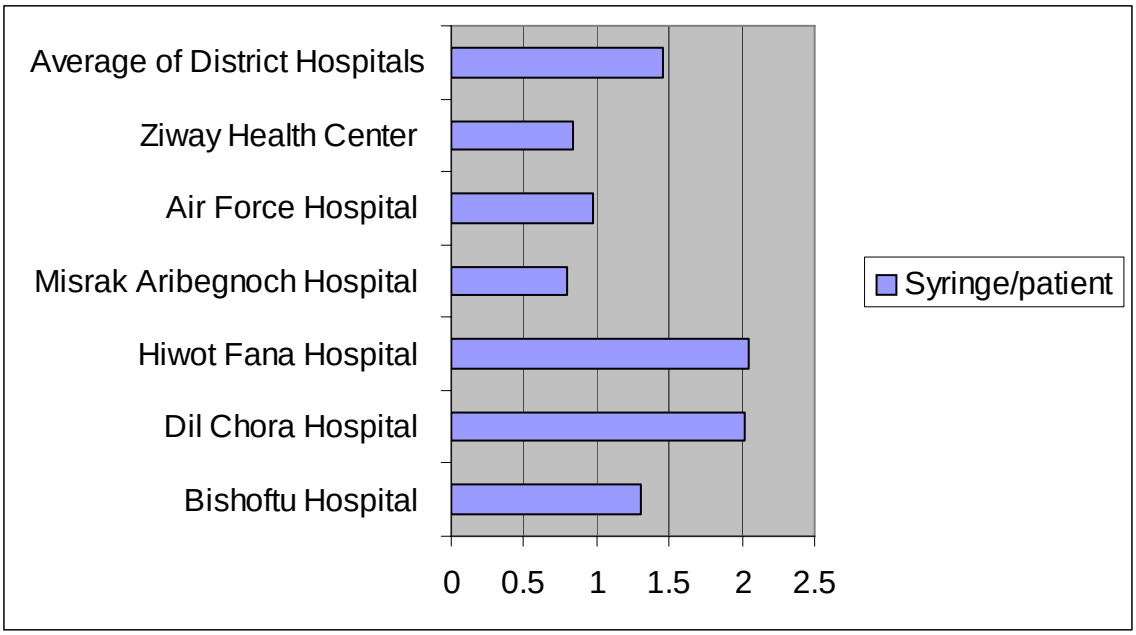
All four countries are reporting through the LMIS. Country logisticians are analyzing their own data and taking appropriate corrective decisions, such as bundling and re-directing commodities when necessary. The number of facilities reporting has increased, most notably in the districts where MMIS has conducted a consumption survey. This information is critical in supporting the country's ability to improve planning at all levels in these countries. Some examples are provided below.

Nigeria: Out of 6 targeted states, MMIS is intervening in 20 LGA, including 446 facilities. The consumption monitoring began in June 2007. Reporting rates were expected to start slowly given the high number of facilities involved in the new activity. However, rapid progress was achieved and a 70% reporting rate was achieved by September 2007, with additional progress expected.

Uganda: The MMIS team conducted a study reviewing total consumption in all public and NGO facilities in four districts over a 6 month period. With a reporting rate of 83%, it appears that the number of syringes per person per year (NSPY) was 1.86, with 2ml/3ml and 5ml syringes, accounting for 90% of all curative syringes.

Ethiopia: The LMIS in Ethiopia showed varying NSPY among districts. Upon additional analysis, the difference appears to be related to the number, size and types of services provided in the hospitals of each districts. This is relevant for planning at district levels, which is where most planning occurs in this country context. Table 2 shows this variability across several hospitals. Note that the consumption per patient is as high as 2 in the referral hospitals, with smaller or rural hospitals consuming at lower rates.

Table 2: Consumption of Syringes Per Patient in District Hospitals in Ethiopia



The mix across sizes also varied according to the type and size of facility. Note in Table 3 that lower-level facilities consume more syringes in small sizes (associated with immunizations and prevention), while hospitals and larger facilities used a higher percentage of 5 ml syringes. This consumption data is being used to refine syringe size mix that is being procured by each facility type and to minimize stock outs.

Table 3: Actual Syringe Size Use by Facility Level in Ethiopia

Syringe size	Hospital	Health center	Health posts/Clinics	Average
Syringe 0.05ml	0.9%	2.4%	9.3%	1.6%
Syringe 0.5ml	8.5%	16.6%	27.8%	11.2%
Syringe 1ml	6.3%	13%	1.9%	7.7%
Syringe 2/3ml	15.2%	4%	18.6%	12.7%
Syringe 5ml	60%	58.8%	31.8%	57%
Syringe 10ml	9.1%	5.2%	11.6%	9.8%

TASK 2: CAPACITY BUILDING AND TRAINING

Throughout the past year the MMIS project has continued to strengthen and build the cost-efficiency of training and capacity building strategies. These efforts 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. Capacity building has focused on in-service training to introduce and standardize the appropriate instructional content required by different cadres of personnel and quickly reach a large number of health facility staff. The challenges of in-service training include high rates of health facility staff turnover (especially waste handlers who are typically casual laborers), limited availability of health workers, and competition for the time of qualified trainers due to the increased level of HIV-related training activities. Country teams are also focusing on sustainability and beginning to incorporate pre-service training into their training portfolios. To complement formal training activities, a combination of approaches is used, including continuing medical education, supportive supervision visits, job aides, on-the-job training, and other supports to performance improvement.

Table 4 presents the cumulative summary to date of people trained in each category. For more details by country, please refer to the country sections.

Table 4: Number of Persons Trained in USAID Countries to date, as of September 30, 2007

Training Category	Persons Trained by MMIS to Date
Training-of-Trainers	1,716
Injection safety	37,649
Interpersonal communications	395
Logistics and procurement	936
Waste management	11,402
TOTAL	**52,098**

2.1 Training Materials and Approaches

The training materials and approaches employed by MMIS programs have been widely implemented and adjusted throughout the past year to respond to lessons learned in each local context. 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. Each country's materials, based on the *Do No Harm Facilitators' Guide*, have had significant use in the field through MMIS direct training activities as well as through integration into partner training activities where possible.

MMIS HQ continues to support country office efforts to continuously improve the quality of training interventions. Based on country experiences and feedback received from country teams and Ministries of Health, MMIS finalized *Do No Harm: Training Tools and Job Aides,* a document which complements existing materials. The new document is a practical tool for trainers to help them transform the technical reference material from the *Do No Harm Facilitators' Guide* into appropriate lesson plans, learning activities, and job aides for participants. It will be disseminated to country teams and their counterparts to facilitate the uptake of training by additional partners. This document is available upon request.

MMIS continues to conduct training for each cadre of health worker and ancillary staff. Training for health workers includes safe injection practices, and prescriber training includes content on communicating with patients about why injections may not be necessary in cases where patient

demand for them may be high. MMIS's innovative and interactive training methods for waste handlers are improving the effectiveness of capacity building efforts for this often low-literate audience, focusing mostly on hands-on training approaches rather than didactic methods. In Mozambique, waste management training included facility managers and administrators since it is at this level that the management of waste can be made sustainable and integrated into both provincial and district level health agendas.

The MMIS/Uganda team finalized the revision of their training materials to reflect a competency-based approach, highlighting 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. In addition, MMIS/Nigeria has completed their adaptation of the *Do No Harm Facilitators' Guide*, in collaboration with the FMOH, state-level trainers, professional associations, and other PEPFAR implementing partners.

Cascade trainings continue to be used in Ethiopia to train health workers from health centers as well as health posts. In addition, MMIS provided training materials and technical support to a two-week TOT training on infection prevention, standard precautions, blood safety and injection safety. The workshop, sponsored by CDC/Ethiopia, was attended by 16 trainees from the Ethiopian Medical Association, Ethiopian Nurses Association, Ethiopian Nurse Midwifery Association and Ethiopian Public Health Association. These trainees are now ready to assist in the training of other health professionals and will also be available to serve as facilitators.

2.2 Building Capacities of Trainers and Supervisors

Trainers and supervisors are the most effective personnel in the introduction and reinforcement of safe injection practices. Ensuring that they have the information and assistance they need in order to effectively provide support to health workers is a priority of the MMIS project. MMIS/Nigeria supports exchange visits between districts and health facilities to share experiences and reinforce the capacity of district managers to understand and support injection safety interventions in their facilities.

As the project progresses in implementation, training approaches continue to be adapted to incorporate and respond to field experiences and lessons learned. MMIS/Uganda has designed a complementary approach to problem-solving to improve supervisors' capacity to support health workers and deal with issues that may arise after initial injection safety training is conducted as well as in the years following the project. A one-day problem-solving session with supervisors at the facility and district levels was developed to support the sustainability of safe practices among health workers. The materials will be made available to other MMIS countries for adaptation.

2.3 Pre-Service Training

A key strategy in ensuring the reach of MMIS training efforts and ultimately, the sustainability of safe health worker practices, is to integrate injection safety into the existing curricula of pre-service training institutions. MMIS/Nigeria successfully integrated injection safety elements into the curricula at national health worker pre-service training institutions, ensuring that future health workers will have hands-on training to improve injection practice. In Uganda, MMIS is training trainers at medical and nursing schools. In addition, teaching hospitals are being targeted as a critical venue for the immediate practical application of safe injection practices for both current students as well as recently graduated health professionals. This focus on teaching hospitals is an essential element of the capacity building program in Uganda, ensuring that safe practice becomes a professional norm in these important institutions.

2.4 Expanding Project Reach through Partnership

To reach nationwide coverage, most MMIS countries have capitalized on partnerships with PEPFAR implementers and other partners and institutions. MMIS has been successful in adding injection safety modules to training programs when partners conduct training in related areas. This has allowed 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. Nigeria has trained trainers at the bilateral organization COMPASS, the Institute of Human Virology, and other NGOs to serve as injection safety trainers in their respective states. The WHO, CDC, and Sino-Africa offices in Uganda are using MMIS trainers and materials to train health workers in 14 additional districts.

The reach of MMIS training materials has extended beyond the MMIS countries. MMIS has contributed materials or technical expertise to trainings conducted by other institutions in Liberia, Georgia, and Southern Sudan.

2.5 Capacity Building Strategy Review

The July 2006 MMIS Country Directors' Meeting provided an opportunity to analyze the challenges faced in the implementation of training activities and identify potential strategies for maximizing coverage while ensuring quality in training. The recommendations from that meeting (including maintaining an emphasis on shorter, focused trainings and reinforcing other capacity building interventions such as on-the-job training and peer exchanges) have been incorporated as appropriate in each country. The MMIS mid-term review process provided an opportunity to further analyze any necessary program strategy adjustments. Countries explored questions related to the effectiveness of the training and capacity building activities to date and increased efforts to maximize synergies with other in-country partners, especially in light of the new budget environment so as to maintain momentum.

2.6 Nationwide Coverage

Currently, most MMIS countries are on track to achieve some form of nationwide coverage by the end of the project in 2009. Uganda has successfully engaged several partners including CDC, WHO and Sino-Africa, to increase injection safety and waste management training activities to attain nationwide coverage. MMIS/Nigeria is implementing a new expansion strategy where they target one or two facilities per LGA that has been selected by PEPFAR and the Government of Nigeria. Meanwhile, work in the original 6 MMIS "focal states" is continuing. In MMIS/Ethiopia, as a result of a revised expansion plan, PEPFAR designated 255 woredas as MMIS coverage targets in Ethiopia. To date, facilitites in 22% of these targeted woredas are covered with MMIS interventions. Mozambique experienced delays in program activity implementation and nationwide coverage efforts due to a temporary work stoppage requested by the Ministry of Health. Please see the country-specific sections for additional details on nationwide coverage.

TASK 3: BEHAVIOR CHANGE COMMUNICATION AND ADVOCACY

A central element of MMIS's strategy is implementing activities aimed at changing the practices and behaviors of providers and prescribers of injections, waste handlers, community members, and policymakers/decision makers in order to bring about long-term improvements in injection safety. MMIS continues to make progress in the areas of behavior change communication (BCC) and advocacy by reaching selected target audiences with tailored messages that promote desired behaviors through multiple channels that are effective for those audiences. This work spans different MMIS tasks, particularly Task 2 (capacity-building and training), Task 4 (sharps disposal/health care waste management), and to a lesser extent, Task 7 (monitoring and evaluation) and Task 8 (conference participation).

For Task 3, the emphasis during this year has been on expanding behavior change communication efforts directed to the community, increasing the project's emphasis on advocacy for particular aspects of injection safety, building and diversifying a base of support for injection safety, and working to maintain desirable changes in behavior.

3.1 Implementation of Behavior Change Communication Strategies

MMIS country teams continue to implement their multi-year BCC strategies. In broad terms, this work is directed toward three main target groups: health care personnel, community members, and decision makers or leaders who can take specific actions in support of injection safety.

Most MMIS country teams have put a heavy emphasis on changing the behaviors of health workers through training and capacity building. Therefore, during this reporting period, BCC advisors at both country and global level have worked extensively in the training activities that are described under Task 2. Health workers are a target audience not only because of their role in administering injections safely but also because they serve an important communication function: they are viewed by patients and community members as credible, authoritative sources of health information and they interact with patients on a one-on-one basis. A continuing challenge for sustained safe injection practices is to ensure that health workers not only initially adopt the practice of communicating about injections (and alternatives to them) with their patients, but that they maintain this behavior.

During this past year, MMIS country teams have increased their efforts to promote rational injection use. This includes efforts directed to physicians (e.g., talks at medical society meetings, changes in treatment guidelines, etc.) to prescribe injectable medications only when necessary, as well as to patients/communities to accept and adhere to their prescribers' advice when alternatives to injections are prescribed. Other target groups have also been engaged as credible "messengers": for example, in Uganda, MMIS has trained hundreds of community drug distributors to sensitize communities on correct treatment procedures, with special emphasis on the effectiveness of oral medications.

A major area of emphasis during this reporting period has been the development and implementation of BCC strategies directed toward the community. Through these strategies, the messages that patients receive during their contact with health workers are reinforced by the messages they receive through other channels. With regard to messages targeting the community, the project conscientiously focuses on the promotion of desired behaviors such as: follow the advice of the health care provider when he/she prescribes oral medications instead of injections; obtain injections only when necessary and from a qualified provider; demand the use of only new needles and syringes; and avoid sharps waste in the community.

MMIS collaborates with its counterparts to assure consistency in the messages that are disseminated and to assure the safety of those injections that are needed. The project routinely pre-tests messages with their intended target audiences for comprehension, acceptability, feasibility, identification, and intent to take action.

The channels and techniques used for reaching the community vary among countries, based upon an examination by MMIS country teams and their counterparts of circumstances, opportunities, and past approaches that have proven effective for other health interventions. Most MMIS country teams use a mix of interpersonal communication and mass media, combining the personalization of the former with the broader reach of the latter to reinforce messages. In Nigeria, a renowned, highly respected advocate for safe medicines has lent her support to injection safety, and the momentum from a high visibility launch ceremony in which she figured prominently is being complemented by a range of community-based approaches for behavior change. In Uganda and Ethiopia, teams have developed injection safety videos that are shown at clinics, in communities (using mobile vans equipped with

screens), in schools, and elsewhere. Radio spots and jingles have been developed and aired in several countries, including Nigeria, Ethiopia, and Uganda in a variety of local languages.

With a range of strategies and activities for reaching the community now being employed, several MMIS BCC Advisors have expressed a desire to monitor and assess the effectiveness of these efforts. At present, the mechanisms for doing so include the addition of specific questions to both the health facility assessment (see Task 7) and supervision checklists used in different countries. However, these measurement instruments will need to be adapted to reach the community at large.

3.2 Increasing the Attention to Advocacy

At this stage of the project, advocacy to key decision makers has become a critical means for securing support for activities that are likely to have far-reaching impact beyond the life of MMIS. Advocacy can be defined as an action directed at changing the policies, positions, or programs of any type of institution. This is a cross-cutting approach that is important to multiple areas of MMIS activity. As the project has matured, the role of advocacy to bring about favorable decision-making outcomes for particular aspects of injection safety has increased. Initial project efforts to create visibility and a broad base of support for issues surrounding injection safety are now supplanted by much more focused efforts. Specific issues for advocacy vary from country to country, but generally they include: diversifying the base of support for injection safety to include additional partners (both within and outside of host governments); securing resource allocations for injection commodities and waste management; including injection safety in pre-service training curricula; and adopting standard treatment guidelines to support the rational use of injections.

With two years remaining in the project, MMIS has recognized the need for each country to formulate a coherent advocacy agenda that articulates clear, specific, feasible advocacy objectives and detailed plans for achieving those objectives. The advocacy agenda needs to stipulate not only specific objectives, but well-defined target groups and a call to action (the “ask”) for that specific group. The project has already experienced a number of advocacy successes, including Nigeria’s formal adoption of a safe injection policy; Uganda’s decisions to replace standard needles and syringes with auto-disable devices and revise its essential drugs list to substitute oral medications for injectables when possible; Mozambique’s revision of standard treatment guidelines for sexually-transmitted infections to reduce injection use; and Ethiopia’s inclusion of injection safety supplies in a revolving drug fund.

All of these accomplishments required not only high quality technical input but also a process of active engagement of selected partners to take action on a specific objective. While not always recognized as such, this is advocacy in action. The MMIS mid-term review process provided an excellent opportunity to identify remaining advocacy needs across all technical areas of the project, including logistics and supplies, training, health care waste management, and rational use of injections. Such efforts are engaging all MMIS country team members, particularly the country directors and BCC advisors.

Recognizing both the importance of advocacy to the long-term impact of MMIS, as well as the desire by MMIS country teams to build their advocacy skills, MMIS convened a workshop of all MMIS BCC advisors in Bagamoyo, Tanzania in November 2006 to help accelerate the advocacy planning process, build skills in conducting advocacy and documenting successes, and share successful experiences across countries. Using participatory approaches that helped strengthen the communication network among BCC advisors, the workshop yielded draft advocacy plans from the country teams. These are subsequently being discussed at country level, with results from the mid-term review process also contributing to the refinement of these plans and their implementation.

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 each focus country. The project's approach combines global-level collaboration, work at the local level to introduce improved health care waste management (HCWM) practices, and support at the national level to build policy and high-level prioritization of medical waste management activities. Experience with locally appropriate systems for waste segregation, handling, treatment, and disposal has helped MMIS countries identify practical approaches that consider staff, equipment, and financial limitations. These country-appropriate experiences are applied as MMIS works with government partners in the national policy development and planning processes to create experience-based national plans and policies that are tailored to each country context.

4.1 National Planning

MMIS continues to work with WHO as GAVI funding becomes available to countries to facilitate national waste management assessment and plan development. MMIS has been providing technical support for national planning activities in collaboration with HCWM sub-committees and utilizing WHO and/or GAVI funding. In countries where GAVI is not funding national planning work, MMIS maintains its effort to raise awareness among stakeholders and garner support from Ministries of Health in efforts aimed at improving HCWM. As experience with the national planning process broadens and the required funding becomes available, MMIS countries will use South-to-South collaborations to share national planning experiences and lessons learned.

MMIS/Uganda has supported the HCWM working group efforts to develop a national plan by working on commodity specifications, summarizing existing laws on HCWM and transport, identifying an acceptable incinerator, and assisting the working group with the collection of data and analysis and reporting of the WHO rapid HCWM assessment.

In the last year, Nigeria has formed a National Steering Committee on Health Care Waste Management (NSCHCWM) and both the national HCWM plan and national guidelines were ratified by stakeholders. A Health Care Waste Management Policy is drafted and it is expected to be ratified by the end of 2007.

In Ethiopia, national HCWM guidelines were finalized by a panel of stakeholders and presented to the MOH for their review. The guidelines are designed to lay an important foundation in establishing safe HCWM systems in health care facilities throughout Ethiopia for all personnel involved in HCWM, from national and regional levels to zonal, woreda and kebele levels.

4.2 Partnerships

MMIS is leveraging partnerships to support the implementation of effective HCWM systems in several countries and helping countries to identify new funding mechanisms to support health care waste infrastructure and capacity building For example, to accommodate recent funding limitations and expand the awareness and reach of HCWM to all PEPFAR partners generating infectious waste, the team in Uganda has worked with stakeholders to secure $300,000 in Mission Plus-Up funds for MMIS to provide technical assistance to partners in budgeting for and developing HCWM systems during FY08.

MMIS is working closely with MOH counterparts to include HCWM strengthening in GAVI 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 is supporting each country to identify donor mechanisms and make donor contacts.

MMIS works closely with WHO counterparts both in-country and at the headquarters level to inform them of HCWM issues and standards for safe injection equipment as appropriate. For example, MMIS continues to advocate for WHO to review issues to make safety boxes more universally useful in curative services, raising awareness about the wide range of injection devices that do not easily fit into safety boxes such as butterfly needles.

4.3 Expanding Improved Practices

All MMIS countries are refining their HCWM 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 project implementation areas, and color-coded segregation of infectious and non-hazardous medical waste is being expanded. To facilitate the purchase of medical waste segregation supplies and personal protective equipment, MMIS developed specifications that have been adapted by several countries for the in-country purchase of equipment by other stakeholders.

As the program expands, improvement of simple disposal methods, such as installation of protected medical waste pits has expanded in several countries, including Uganda. MMIS is also providing the training and supplies required to properly segregate and incinerate infectious waste to reduce incinerator emissions.

TASK 5: PRIVATE PROVIDERS AND THE INFORMAL HEALTH SECTOR

During this reporting period, MMIS implemented its process for developing country-specific strategies for addressing injection safety in the informal health sector. As agreed with USAID/Washington, each MMIS country has undertaken a review of available documentation on the informal health sector in their respective countries. This included a review of relevant policies, legislation, reports, and published literature to better understand the nature of informal sector health care and injection practice and the relationship to the formal health sector institutions and governments, as well as what types (if any) of interventions had been implemented to date to reach informal sector providers.

The reviews generally found that there has been little research investigating injection practices among informal sector providers. Across a number of countries, recent policies on injection safety and waste management tend to apply solely to formal sector health care providers. The need for evidence-based policies and interventions requires that research be conducted to investigate the source and frequency of injections, as well as qualitative studies to learn more about injection-seeking behaviors, including why and for what ailments people are frequenting informal sector injection providers.

Reports from all USAID countries have been submitted to the local country USAID Missions. Feedback has been received and incorporated for the Ethiopia and Uganda reports. These reports will be submitted to USAID/Washington for review and approval by November 2007. The Mozambique and Nigeria reports are being finalized and will be submitted to USAID/Washington for review and approval by December 2007. Upon approval, the documents will be disseminated through the appropriate channels, including SIGNPost, the MMIS website, and distribution to in-country partners.

To complement the information from the document reviews and to better inform strategy development, qualitative and quantitative formative research is necessary. In collaboration with USAID and CDC, MMIS developed a focus group discussion (FGD) guide and protocol for use in program countries. As the funding situation has changed significantly since the beginning of the project's work in the informal sector, it is anticipated that the research activities related to the informal sector will not be undertaken until further funding becomes available so that emphasis can remain on MMIS activities within the formal health sector.

TASK 6: POLICY ENVIRONMENT

Health care workers are exposed to bloodborne pathogens through needlestick and sharp object injuries that result from unsafe injection practices such as recapping. These injuries are one of the greatest occupational risks faced by providers and can lead to disease, disability and death a number of years after exposure to the unsafe injection and therefore can decrease the health care workforce of the country. MMIS, recognizes the importance of policy development aimed at protecting health workers is paramount to long term improvements in health delivery systems and ultimately sustainability of safe medical practices.

In each of the four USAID countries, MMIS has been largely successful in its strategic approach of conducting injection safety advocacy activities and sensitization meetings with stakeholders inside and outside the MOH. These MMIS efforts have been critical in fostering an environment where key decision makers at country level see injection safety as their country's responsibility and are mobilized to work together towards developing national policies to protect patients, health workers, and the environment from the medical transmission of HIV. In these efforts, MMIS continues to promote policies and action plans that are sustainable, country-specific, and can also serve as a framework for expansion.

Progress made in policies at the country level in the past year include the finalization of National HCWM guidelines in Ethiopia. In the past year, Nigeria has formed a National Steering Committee on Health Care Waste Management (NSCHCWM). In addition, the National Policy on Injection Safety and Health Care Waste Management for Nigeria was approved by the National Council on Health and has been presented to the Minister of Health for approval. In Mozambique, as a result of MMIS advocacy, the MOH has planned to replace use of glass syringes with single use safety syringe. MMIS has been supporting the MOH in this transition process by providing technical assistance in estimating syringe requirements for the country. Once a policy is developed, MMIS also plays a key role in the technical support and implementation of the policy. For example in Uganda, MMIS played an important role in the National Injection Safety Task Force, which continues to meet to discuss the newly adopted nationwide policy promoting the use of syringes with re-use prevention features in the curative sector. MMIS/Uganda continued to support Uganda in the transition phase of this new policy. MMIS/Uganda is also playing a major role in the HCWM assessment which will be used for the development of the HCWM national plan. Additionally, MMIS/Mozambique worked in partnership with the MOH on its new Sexually Transmitted Infections (STI) protocol to identify training needs and materials needed to support this policy. These all have been achieved through partnerships with the Ministry of Health.

TASK 7: MONITORING AND EVALUATION

During this reporting period progress was made in monitoring and evaluation (M&E) in the planning and preparations for upcoming data collection as well as the completion of a technical review of datasets and draft reports for data already collected.

7.1 Training Data

In response to a request for more frequent reports of training data than the semi-annual reporting cycle, MMIS prepared additional quarterly training updates for all countries that covered the periods from October-December 2006, January-March 2007, and April-June 2007. These reports were submitted to USAID at the end of each quarter with the data for the final quarter of this fiscal year (July-September 2007) included in the present report. In addition, MMIS regularly collects up-to-date facility coverage data, which is used to estimate population coverage in each country. Updated versions of all three reports (training, facility coverage, and population coverage) are sent in each quarter along with the latest training data or in combination with the semi-annual or annual progress

reports, as appropriate. They will continue to be updated quarterly for the remaining years of the project.

7.2 Health Facility Assessments and Supervision Data

Health facility assessments (HFA) – which provide data for the majority of MMIS's indicators – were updated during this reporting period. The hospital and lower-level tools were combined into a single tool to facilitate revisions and use of the tool in the field; some modifications were made to the format and existing questions, based on lessons learned in surveys conducted to date. In addition, questions relating to phlebotomy were added to the tool to permit the collection of more detailed data on this issue. Questions related to the project's BCC efforts were added to allow the project to collect data on the effectiveness of BCC materials. MMIS had expected to collect this data via community surveys, but given the reduced budget, collecting this information via the existing HFA, while not as comprehensive, is a more cost-effective approach than fielding separate BCC surveys in each country.

Efforts to improve the quality of analysis and survey reports received from local consultants continue as part of an ongoing effort to assist the project in streamlining the technical review process and completing the final reports. During this period, a set of syntax files was developed in SPSS statistical software that will be used both to guide local consultants in providing better, more complete draft reports and to facilitate technical review of each draft report at MMIS/HQ. In addition, during this period, MMIS developed a data entry program in Microsoft Access to facilitate processing HFA survey data and conversion of this data into SPSS where the standardized analysis tools can be used. Currently, the data entry program has been developed for all sections of the questionnaire and is being tested. MMIS plans to use this tool in the field for the next HFA. Finally, in September, a template for the Conclusions section of the HFA reports was completed. This tool draws together the individual variables in the HFA into an overall picture of the risk of an HIV or hepatitis infection among health workers, patients and the community at large. This template is being incorporated into the overall HFA report template under development. All other HFA materials, including the analysis plan, indicator table, and data collector training guidelines, will be revised to match the current general health facility assessment questionnaire once the revisions to that tool are finalized with both donor organizations. The revised version of the questionnaire will be translated into Portuguese for use in Mozambique once it is finalized.

In terms of progress in completing HFAs, all countries have completed data collection for pilot area follow-up surveys. The reports for Uganda and Ethiopia were finalized and sent to USAID in September 2006 and December 2006, respectively. In Nigeria, the dataset for the follow-up survey underwent extensive review in October and November 2006, and as a result of problems uncovered during that review, the data were re-entered for the survey. The revised dataset underwent a second round of technical review at MMIS/HQ to ensure that the dataset had been properly cleaned and structured for analysis. Technical assistance was provided to complete the analysis, and the draft report is now undergoing technical review. In Mozambique, technical assistance was provided in October 2006 to assist with planning and training data collectors. The survey was fielded in November 2006. Data collection was completed, and technical assistance on cleaning the files and preparing the analysis was provided in February and March 2007. The first draft of the survey report was completed and is now undergoing technical review.

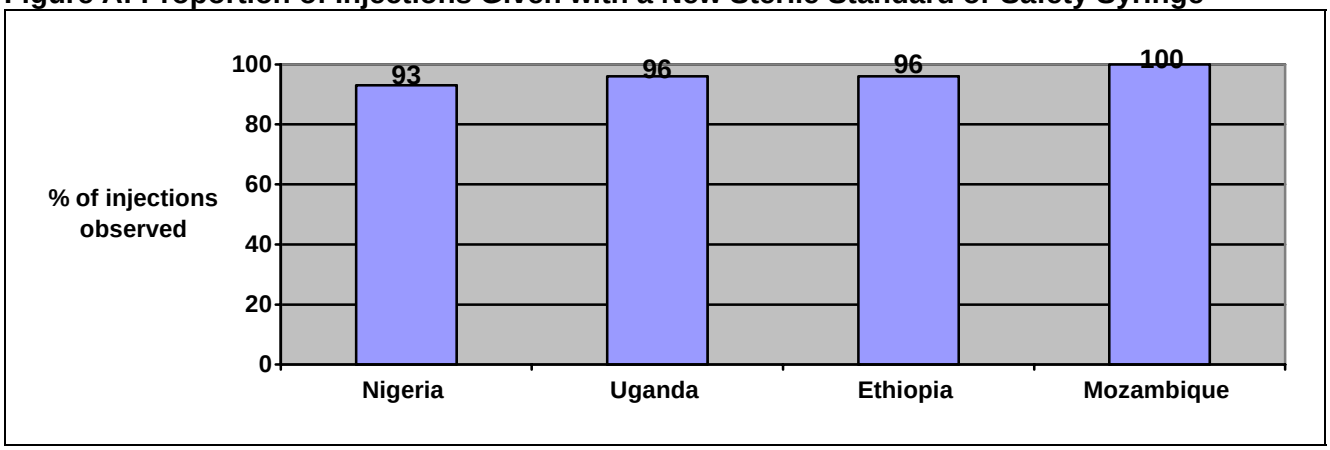
In addition to the formal HFAs in project expansion areas, MMIS developed a tool in June 2006 for collecting data on key indicators during routine MOH supervision visits. This tool was distributed to all MMIS countries. MMIS prepared an overall summary of findings on each key indicator for presentation at the PEPFAR Partners meeting on Thursday, January 18, 2007. This summary included pilot survey follow-up data from Ethiopia and Uganda. Subsequently, pilot area supervision data from Nigeria and survey data from Mozambique were added in February 2007. An overview and analysis of this data was sent out to all MMIS countries in February 2007 to assist them

in incorporating lessons learned from these visits to implementation of the project in the expansion areas and to help prepare for midterm reviews.

In the following presentation, two sets of data are provided: pilot area follow up studies in each country and a comparison of expansion area baseline and follow up data in Uganda.

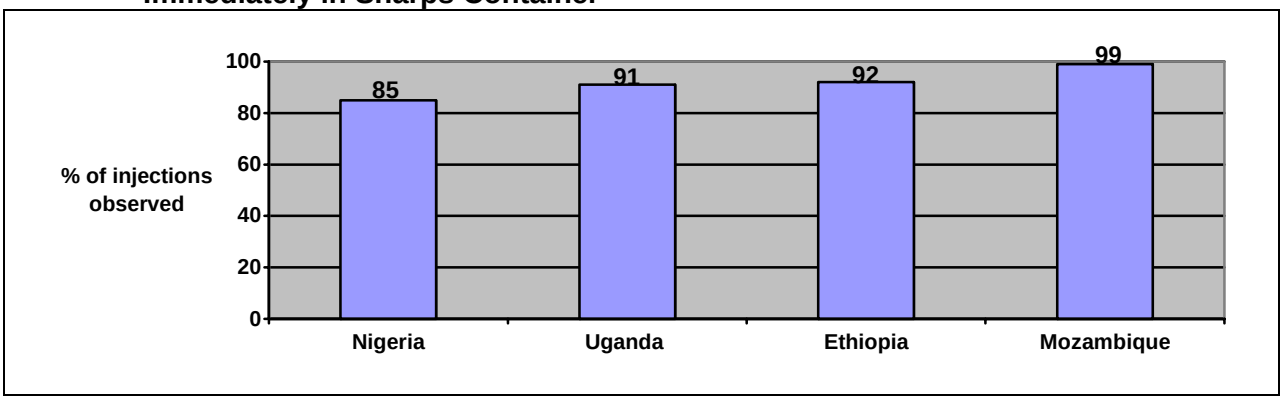
The results that follow are *pilot area follow-up survey data* from Ethiopia, Nigeria, Uganda and Mozambique. As shown in Figure A data collectors found nearly universal use of new needles and syringes for the injections that were observed. However, there were some isolated cases of evidence of reuse of injection equipment observed in facilities in Uganda and Ethiopia. No such evidence was found in Nigerian or Mozambican facilities. Although these data are encouraging, it is important to note that MMIS promotes the use of a new disposable needle and syringe for every injection given. When feedback was sent to the country teams concerning these indicators, they were reminded that the target for this indicator is 100%, and they were asked to investigate the reasons why some injections were still being given with something other than a device from a sealed package so that these lessons learned can be incorporated into interventions in expansion areas that will be evaluated in the next round of health facility assessments.

Figure A: Proportion of Injections Given with a New Sterile Standard or Safety Syringe



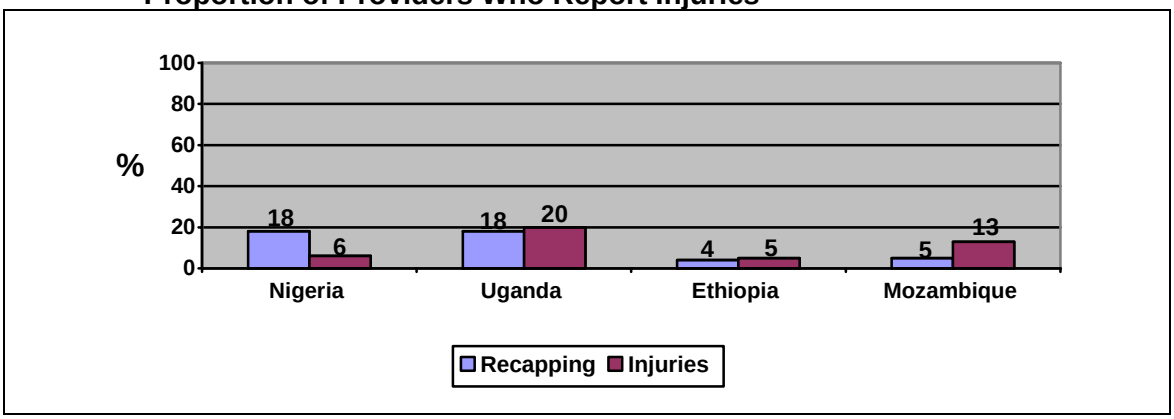
During these observations, data collectors also sought to observe how the health workers giving injections disposed of the used devices and whether the disposal was *immediate* since any delay increases the risk of injury with the used device. All four countries met or exceeded the midterm targets of 80-85% immediate disposal, and Mozambique has nearly reached the final target of 100% (Figure B). Lessons learned to date in achieving the goal of immediate disposal in pilot areas are now being incorporated into work in the expansion areas of these countries.

Figure B: Proportion of Injections in which the Used Device was Disposed of Immediately in Sharps Container



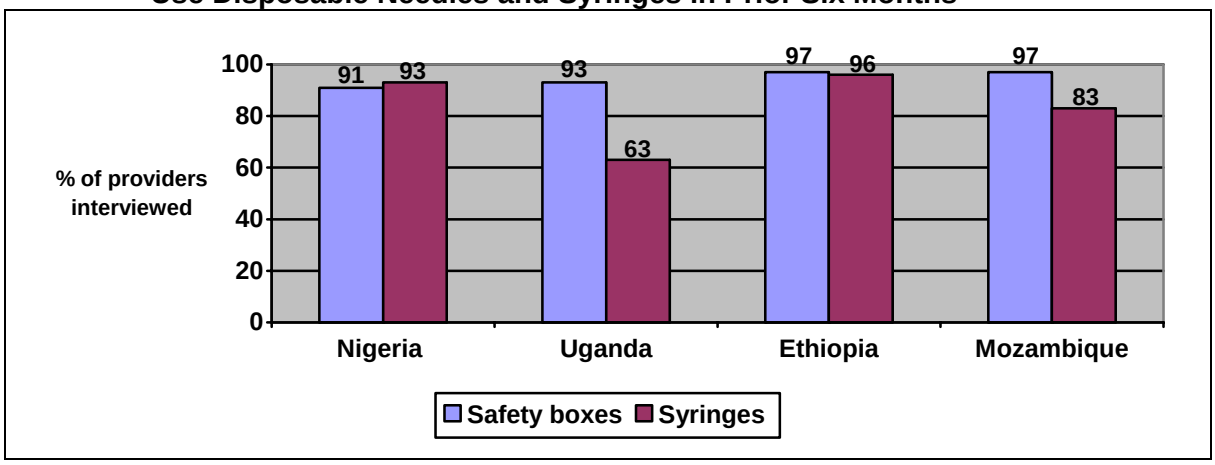
Recapping used injection devices is one of the unsafe practices of health workers that is the most likely to result in a needlestick injury and a possible infection with HIV and/or hepatitis. For this reason, MMIS compared results of recapping during the injections that were observed on the day of the data collection against the recall of injection providers of injuries sustained over the prior six months. As shown in Figure C, both recapping and injuries were most common in Uganda and least common in Ethiopia. In Nigeria, the prevalence of needlestick injuries would be expected to be higher, given the proportion of used injection devices which were observed to be recapped, while the opposite is true in Mozambique where injuries were fairly common despite little recapping. It is possible that the recapping practice in Mozambique was affected by the health worker's awareness of being observed and that normally there is more recapping, but the data are limited to the day of the survey. In any event, these results from pilot areas show that work remains to be done in improving disposal of used devices without recapping (except in the few cases where it may be required, such as phlebotomy procedures) to reach the final project goals of universal safe disposal of devices from curative and immunization services without recapping so that no providers report injuries.

Figure C: Proportion of Injections in Which Providers Were Observed to Recap vs. Proportion of Providers Who Report Injuries



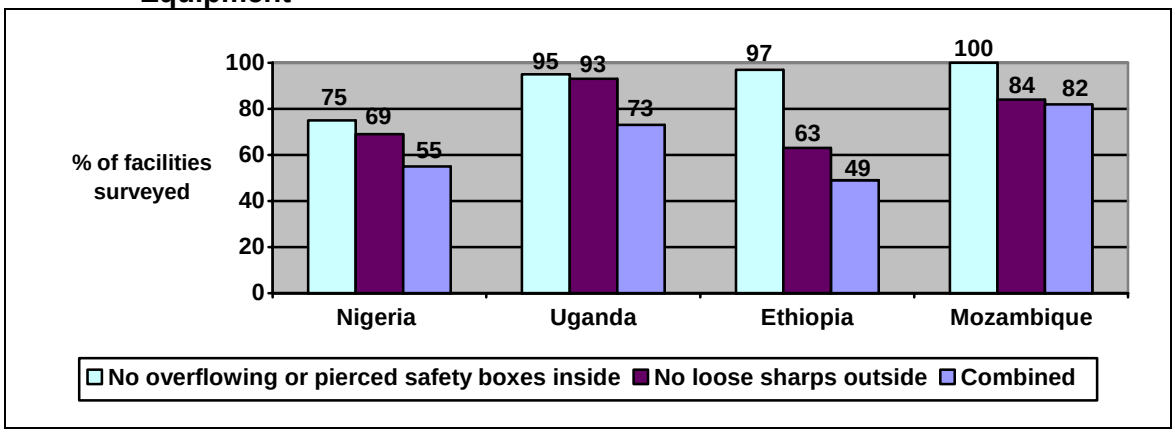
In the logistics component of the project, ensuring the availability of stocks of safety boxes and single-use disposable needles and syringes is considered a critical intervention. However, the data collected to date show that stockouts continue to present challenges to varying degrees in all countries, but particularly in Uganda and Mozambique, where stockouts of syringes were more common than stock outs of safety boxes (Figure D).

Figure D: Proportion of Providers Reporting No Stockouts of Safety Boxes or Single-Use Disposable Needles and Syringes in Prior Six Months



Finally, in the area of waste management, as shown in Figure E, Mozambique was the only country in which no pilot area facilities were found to have loose sharps inside or open, pierced or overflowing safety boxes. It was followed closely by Ethiopia and Uganda, where such cases were rare. In Nigeria, loose sharps or overflowing or pierced safety boxes inside the facility were more common than in the other countries, similarly, the proportion of facilities with loose sharps outside the facilities was also frequent. It is interesting to note, however, that the final goal of MMIS is satisfactory disposal *overall*, an indicator which takes into account both of these individual factors. For all countries, it is clear that the intermediate goals (which ranged from 85% to 95% satisfactory disposal depending on the country) have not yet been met.

Figure E: Proportion of Facilities with Satisfactory Disposal of Used Injection Equipment

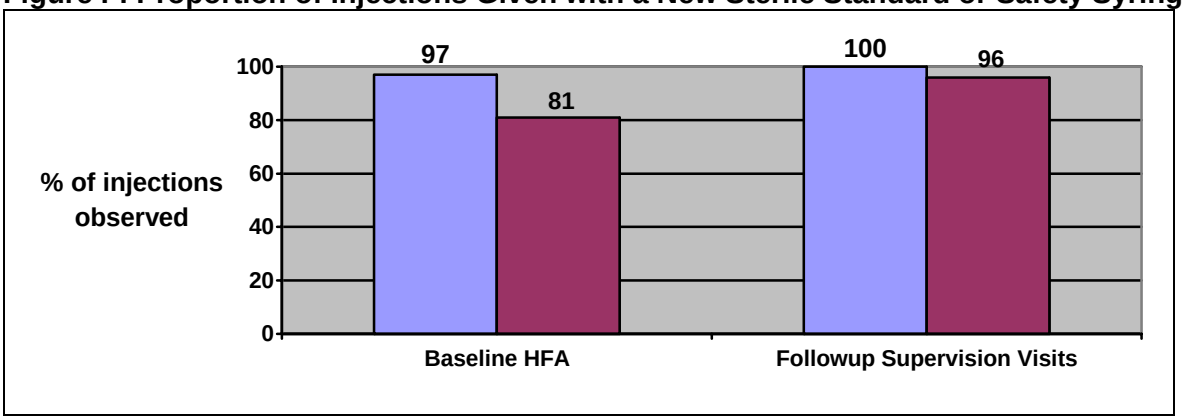


In addition to the pilot area surveys reported above, all countries have completed data collection for expansion area baseline surveys, including Uganda, which undertook two separate surveys in the expansion area as a whole and in Mulago Hospital (a major training site for health care providers). In this reporting period, the Nigeria dataset was cleaned and the outputs created, and the Ethiopia dataset was also cleaned. The dataset and draft report from Mozambique have not yet been reviewed because the priority there was given to fielding the pilot area follow-up survey.

The baseline survey in the expansion area of Uganda underwent technical review and preliminary results were sent to USAID in March 2007. In June 2007, Uganda undertook a round of supervision visits in the expansion area facilities in which baseline data had been collected to assess the progress

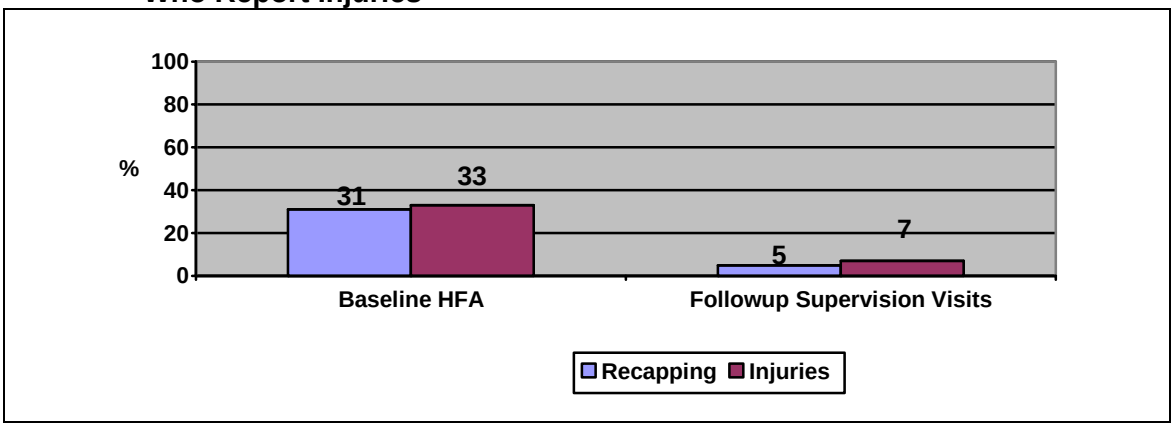
that had been made. A presentation providing a comparison between baseline and follow-up results in the expansion areas relative to midterm targets from the Ugandan M&E plan was used in a high profile meeting with local stakeholders in July. The full presentation was also sent to USAID at the same time. Some selected variables from that presentation are reported below. As these results show, the Uganda program met or exceeded its midterm targets in use of new needles and syringes, immediate disposal of used sharps, disposal without recapping, and reduction in needle stick injuries among providers and waste handlers. Furthermore, it is important to note that the indicator of immediate disposal showed improvement over time that exceeded the result in the pilot area follow up (96% vs. 91%). This is a positive sign that the lessons learned from the pilot areas are further strengthening MMIS interventions in expansion areas.

Figure F: Proportion of Injections Given with a New Sterile Standard or Safety Syringe



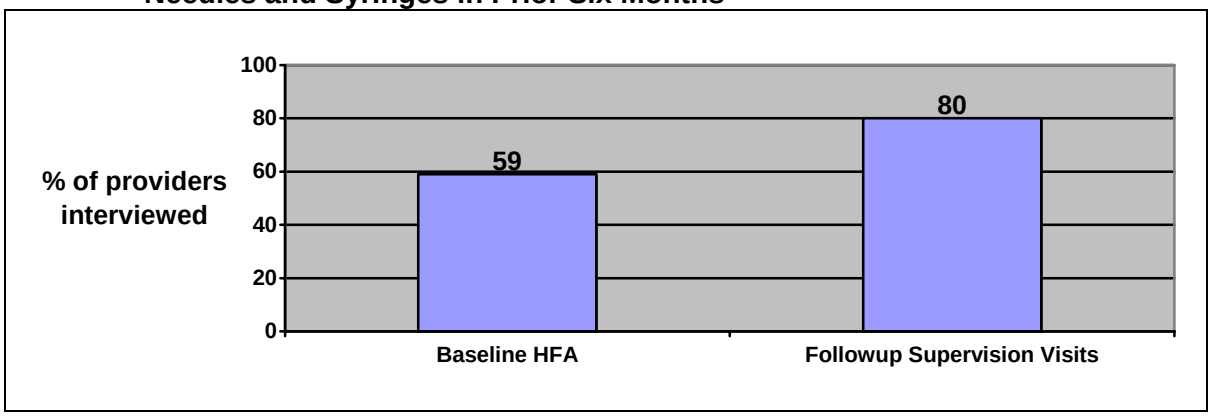
As Figure G demonstrates, there is an apparent relationship between the prevalence of recapping used needles and accidental needlestick injuries among providers. This key indicator of injection safety and HIV prevention showed considerable progress over time, moving from 33% of the providers reporting injuries at baseline to 7% at follow up. It is important to note that this result of 7% in the expansion areas is yet another example of further strengthening of MMIS interventions over time compared to the result of 20% injuries found in the pilot area followup study reported earlier.

Figure G: Proportion of Injection Providers Who Were Observed to Recap vs. Those Who Report Injuries



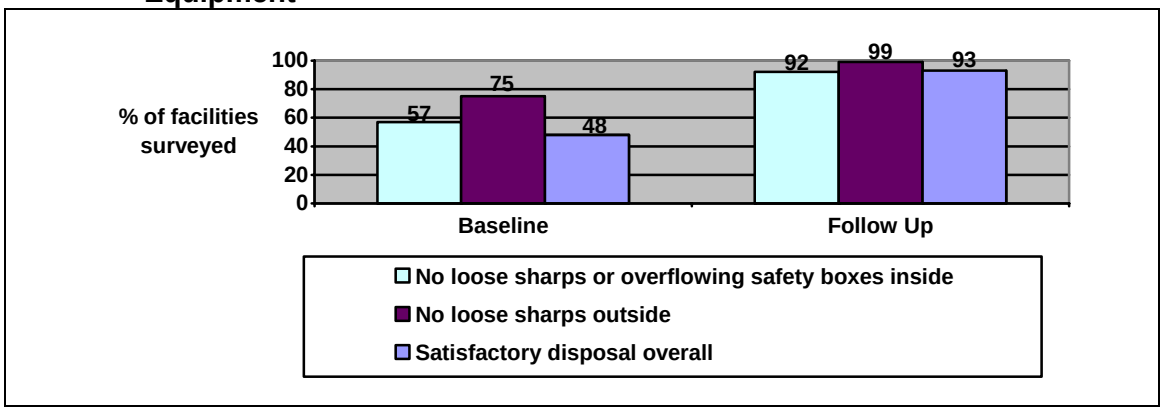
The indicator on stockouts of syringes showed considerable progress, moving from 59% of facilities with no stockouts at baseline to 80% at follow up. Although this fell short of the midterm goal of 90%, it is important to note that it greatly exceeded the pilot area followup result of 63%, evidence of further strengthening of MMIS interventions over time.

Figure H: Proportion of Providers Reporting No Stockouts of Single-Use Disposable Needles and Syringes in Prior Six Months



Similarly, the indicator of satisfactory disposal with no open, overflowing or pierced safety boxes or loose sharps inside or outside facilities increased substantially from 48% of facilities at baseline to 93% of facilities at followup, a noticeable increase over the pilot area followup that fell just shy of the midterm goal for the expansion areas of 95%.

Figure I: Proportion of Facilities with Satisfactory Disposal of Used Injection Equipment



7.3 Prescription Record Reviews

In the area of prescription record reviews, MMIS has continued to build on the experience in Uganda, which served as the field test site for this activity. As with the HFAs, a standard set of materials, including the protocol, data collection forms, database, and initial reports were developed in Microsoft Access in the period from December 2006 to March 2007. The tools were field tested in Guyana in March 2007 and have been updated with the lessons learned from that survey. Currently, MMIS is developing a set of training materials to use in orienting the local consultants who will be hired to collect prescription review data. These tools will be adapted as needed to country-specific settings as will the analysis by diagnostic group. All of these tools will be available for use in the project countries once IRB approvals are received. The draft protocol and tool were sent to USAID for the initial technical review and were approved. They were translated into Portuguese in preparation for the baseline data collection in Mozambique. Technical assistance is being provided to improve the record keeping system at the facilities selected for this study to ensure that all the necessary data are being captured by the facility staff. In Nigeria, it is believed that the existing

records will be sufficient for this study. Data collection will be scheduled there once IRB approval process now underway has been completed.

7.4 Institutional Review Board Submissions

As has been the case in the past, MMIS continues to submit data collection tools for IRB review. In addition to overall reviews conducted in the U.S., MMIS is engaged in the process of completing the paperwork needed to add local IRBs (which have been formally registered with the Office of Human Research Protection and are needed for country-specific work) to the JSI Federal Wide Assurance to facilitate their use in reviewing the prescription record review protocol.

7.5 Collaboration with WHO

In September 2006, MMIS reviewed the draft phlebotomy module that had been developed by WHO. Subsequently, a revised version of Tool C was developed by a WHO consultant and sent to MMIS for review. In December 2006, MMIS provided extensive comments based on the project's experience in implementing health facility assessments, the earliest of which had used revisions of Tool C. This was followed by an intensive discussion with WHO in February 2007 at which time the entire protocol and tool were reviewed. WHO then revised the tool again and requested a second round of MMIS review prior to a field test by WHO. MMIS completed that review in April 2007.

For more country-specific activities, please refer to the country sections of this report.

PHLEBOTOMY

Phlebotomy is a common invasive procedure that carries risk of transmission of HIV and other bloodborne pathogens. With increasing amounts of HIV testing and ARV monitoring, there is an increase in the demand for phlebotomy procedures in areas with a high HIV prevalence. There are a number of risk factors associated with phlebotomy; however, there is little information about phlebotomy practices and the risks associated with the practices in developing countries.

In informal observations, MMIS has noted several potential concerns, some related to equipment and others related to practices. For example, health workers have mentioned being trained to re-use the tube holders included in vacuum blood collection sets. This practice involves the user removing the double-ended needle, a potential risk area.

MMIS is aware that industry has been responding to concerns regarding phlebotomy, and thus surveyed its current suppliers. It was noted that some safety devices are available, including but not limited to, vacuum tube holders with retracting needles, butterfly needles with automatic and manual retraction devices, and vacuum tube holders clearly marked "single use only".

In May 2007, USAID, CDC, and MMIS identified priorities and next steps to address phlebotomy issues, including the formation of a working group devoted to strategy development. The working group began meeting in July 2007 and designed situation analysis guidelines that each country will employ to identify key issues and needs. Issues to be examined in the situation analysis include the cadres of health workers performing phlebotomy, types of facilities where phlebotomy is performed, and types of equipment available and in use for phlebotomy. This is in addition to a global literature review identifying available resources on risk factors and best practices. However, there is very little information available about phlebotomy in developing countries and therefore country teams will gather available grey literature as a part of the situation analysis to supplement the formal reports that MMIS anticipates finding during the literature review. The working group will also guide the development of training materials and guidelines for practice and any country-specific revisions as needed to address the core phlebotomy competencies.

To further improve health worker safety, MMIS over the past year developed an approach to address additional high-risk procedures that use sharps, such as phlebotomy.

MMIS, in collaboration with CDC, is in the process of planning a short workshop to provide a basic overview of phlebotomy to be held at MMIS/HQ. The workshop will be available for MMIS staff as well as other injection safety PEPFAR partners and will cover equipment selection and procurement, use of equipment following best practices, safety and infection control procedures, and quality assurance.

In addition, beginning in September 2006, MMIS collaborated with USAID and CDC and to develop more detailed phlebotomy questions, such as types of equipment and the process for transferring blood, for inclusion in the MMIS Health Facility Assessment data collection tool. MMIS also engaged in discussions and working sessions with WHO/Geneva to revise the WHO Tool C data collection tool and protocol in order to address aspects of safety in phlebotomy practices among other topics. For more information, please refer to the M&E section of this report.

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 information and lessons learned from implementation 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 Mexico in October 2006. The successful participation of MMIS in past SIGN meetings led to the project's invitation to participate in the 2006 meeting. Dr. Jules Millogo, MMIS project director at that time; Mr. Ousmane Dia, senior logistics advisor; Ms. Rebecca Fields, senior program officer; Mr. Carib Nelson, senior technical officer; Ms. Lisa Hedman, senior procurement officer; and several MMIS country directors—together with host government and country counterparts from Botswana, Haiti, Mozambique, and Uganda—shared each country's innovative approaches and progress in several technical areas of interest to the international injection safety community.

Presentations by country counterparts working in collaboration with MMIS described partnerships for improving both injection safety overall and, specifically, health worker safety; the process for revising treatment guidelines; and efforts to promote the rational use of injections. Dr. Jean Antoine Alceus, Director of the Planning and Evaluation Unit, represented Haiti with a presentation describing partnerships for injection safety. Ms. Joyce Tamocha, president of the Nurses Association of Botswana, shared her experience involving a partnership formed to improve health worker safety in Botswana. Dr. Bernardina de Souza, national director of the STI Programme, MOH, Mozambique, discussed the revision of STI treatment guidelines to reduce unnecessary injections; and Dr. Jacinto Amandua, commissioner for Health Services, Clinical Services, MOH, Uganda, presented data and general information from a study on the rational use of injections in Uganda. Global presentations were made by Dr. Millogo on *Lessons Learned and the Way Forward for Sustainable Injection Safety Programs*; Mr. Nelson on *the Use of Safety Syringes in Curative Settings*; and Ms. Fields on *Reducing Unnecessary Medical Injections: Formative Research and Implications for Action.*

Two presentations by MMIS staff were given at the annual ***Global Health Council Conference*** held May 30 through June 1 in Washington, DC. Ms. Marjan Najafi, technical officer, presented *"Partnerships for Improved Healthcare Worker Safety in Botswana"* The presentation described the implications of health care worker (HCW) safety in a high HIV-prevalence setting and the partnerships currently in place to improve safety for HCWs in Botswana. Injection safety assessments

conducted in 2003 and 2004 in Botswana observed that, despite comparatively better health infrastructure than other Sub-Saharan African countries, 26 percent of nurses sustain needlestick injuries annually, 23 percent of injections administered for curative care were unnecessary, and unsafe injection practices such as recapping were prevalent. Because HIV/AIDS patients constitute over 50 percent of the patient population, promoting HCW safety is one of the government's core strategies for improving health care delivery services. To aid in this effort, MMIS has partnered with MOH, the Ministry of Local Government (MLG), the Nurses Association of Botswana, and others to avert the negative outcomes of unsafe working conditions and risk of infections among HCWs. Some of the strategies employed were outlined in this presentation. As a result of the presentation, several organizations have contacted MMIS to obtain technical assistance for similar healthcare worker safety programs currently being conducted. Project Hope is currently initiating a needlestick injury prevention study in Egypt, and the Pan American Health Organisation (PAHO) is compiling information for their member states so that they can design a plan of action on health care workers and HIV prevention. These present opportunities for MMIS to share their evidence-based working experiences beyond the current geographic area of the PEPFAR countries.

Mr. Nelson participated in a roundtable session that discussed locally-appropriate approaches to improving health care waste management. The presentation used hands-on demonstrations with safety boxes, needle removers, and segregation bins to show simple and affordable means for improving waste management in health facilities with limited resources. Additionally, examples and photos of segregation, training, incinerator improvements, and protective gear being introduced in MMIS countries were shown.

The PEPFAR Implementers Meeting was held in Kigali, Rwanda in June 2007, and for the first time included international partners such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF and WHO as co-sponsors of the meeting. Dr. Nelson Mwaniki from the Ministry of Health in Botswana gave a presentation titled *Partnerships for Improved Health Care Worker Safety in Botswana – A Strategy to Prevent Transmission of HIV and other Bloodborne Pathogens in Health Facilities*, in which he discussed the partnership between MMIS and the MOH, MLG, the Nurses Association of Botswana, and others to avert the negative outcomes of unsafe working conditions and the risk of infections among HCWs. This presentation was prepared by Dr. Mwaniki with Mr. Styn Jamu, country director for MMIS/Bostwana and Ms. Najafi.

Dr. Abimbola Sowande, country director for MMIS/Nigeria; Dr. Mamadou Diallo, country director for MMIS/Rwanda; and Eugene Rutanegwa, logistics advisor for MMIS/Rwanda, attended the meeting on behalf of MMIS as well. The meeting served as an opportunity for MMIS participants to learn about both the experiences and future direction of PEPFAR programs. Additionally, it was apparent that, although injection safety is a smaller component of prevention, its relevance to other programs—including care and treatment, other prevention programs, and health worker safety—is highly significant. It was also observed that injection safety efforts are still limited to mainly PEPFAR programs and that needle-stick injuries remain a pressing issue. MMIS felt the meeting presented an opportunity to participate in discussions and gain perspectives that could be applied to the MMIS program, particularly towards strengthening and expanding existing partnerships.

The WHO Meeting on Health Care Waste Management took place in June 2007 in Geneva, Switzerland. Mr. Nelson and Ms. Marcia Rock, technical officer, participated in the meeting on behalf of MMIS. Representatives from WHO global and regional offices, universities, NGOs, an interest network (Healthcare Without Harm), and the public and private sectors of both developed and developing countries attended. The meeting began with a review of the "Safe Management of Wastes from Health-care Activities" document, which is also referred to as the "blue book." Subsequent sessions consisted of presentations by each organization sharing experiences and lessons learned in health care waste management. Ms. Rock and Mr. Nelson presented on behalf of MMIS, and shared

the experiences of a few MMIS countries. The meeting concluded with participants reviewing and revising a joint statement on HCWM.

A principal finding of the meeting was that technical and financial resources remain crucial to improving HCWM. Two main accomplishments from the meeting were the assignment of chapter authors for a revision of the blue book, and a revision of the "Joint statement on achieving safe and sustainable management of health care waste." This statement will be signed by partner organizations working in HCWM.

COMMUNICATIONS AND KNOWLEDGE MANAGEMENT

MMIS remains focused on meeting the information needs of USAID, project partners, and project staff through developing core products; establishing standards and guidelines for project materials; managing participation at local, regional, and international conferences; and managing the project website. Additionally, efforts to build the capacity of MMIS staff, with particular focus on field staff, to develop effective project documentation and materials have been intensified since the Country Directors' Meeting in July 2006. Planned travel to provide in-country technical assistance for documentation and writing support (e.g. success story training) to country teams has been postponed until FY 08 funding is available.

Core products, which include the quarterly Program Highlights Newsletter and monthly Injection Safety News, continue to be produced and distributed to their target audiences. The project has developed success stories focusing on various aspects of positive programmatic interventions for several countries. Success stories from Kenya were vetted through CDC for approval and release. An article on the project's training efforts in Kenya was submitted to the PEPFAR Public Affairs office through coordination with CDC and published in the August PEPFAR newsletter. The article, which highlighted injection safety's role in HIV prevention, was also posted on the PEPFAR homepage for several weeks. An article on the commitment of the Nigerian government to injection safety efforts through national funding and the launching of the national policy was produced by the MMIS/Nigeria team with support from the MMIS Communications Team. This article was published in the USAID/Nigeria Mission Newsletter in the summer of 2007. Also, the Recommendations Document on Small Scale Incineration in Rwanda was finalized and distributed in French, English and Portuguese. In January 2007, the MMIS Communications Team gave a presentation on community outreach efforts in Kenya to the USAID HIV Communications Working Group, which consists of communicators from all of the primary USAID Office of HIV/AIDS/PEPFAR partners.

As the project enters a critical phase for documentation and lessons learned, MMIS is in the process of developing a plan to further focus documentation efforts. Currently, additional success stories, stories of hope, case studies, and other program documentation for all project countries are also planned or in progress. MMIS continues to update website content as possible and seek opportunities to cross-link with other injection safety-related organizations (i.e. SIGN, WHO, project partners, etc). For example, MMIS materials have been posted and cross-linked with the WHO Management for Health Services Delivery (MAKER) website. Efforts continue to update branding guidance and create branded templates for new materials as needed.

The overall communication strategy continues to be implemented. MMIS will continue to identify opportunities to increase awareness of the need for and importance of injection safety in preventing HIV transmission. Efforts include finalizing additional documentation, submitting additional articles and stories of hope to the PEPFAR Newsletter and website, and continuing to expand distribution of materials (e.g. Program Highlights Newsletter) to a broader audience.

B. COUNTRY ACTIVITIES: OCTOBER 2006–SEPTEMBER 2007

ETHIOPIA

The MMIS project in Ethiopia works closely with the Ministry of Health, partners, and stakeholders to support injection safety efforts for the promotion of health care worker safety and the reduction of medical transmission of HIV. During the reporting period from October 2006 to September 2007, rapid scale-up of interventions occurred in health facilities in 38 districts of 3 regions, Tigray, SNNP, and Amhara. Cascade trainings allowed a large number of health workers to be trained on safe injection practices. Behavior change communication materials, as well as safe injection commodities and personal protective equipment (PPE) for waste handlers, were widely distributed to these sites. As per the target set by the national PEPFAR coordinating group in early 2006, the project is expected to reach 392 health centers and 1,335 health posts. Therefore, around 42% of the health centers and 62% of health posts were covered during the fiscal year.

MMIS's role in HIV prevention and treatment activities was highlighted at a PEPFAR meeting in Ethiopia where partners and stakeholders agreed that synergetic programs need to complement each other since injection safety is a cross-cutting issue for projects working in these areas. In this regard, MMIS is working collaboratively with infection prevention and control (IPC) partners and is a major partner of the National HIV/AIDS Prevention and Control Office (HAPCO) of the MOH.

MMIS collaborated with the MOH to conduct workshops for federal hospital management teams and regional hygiene and environmental sanitation department heads. The half-day IPC sensitization/advocacy workshops attracted representatives from more than 40 different NGO, bilateral, and international organizations. The expected outcome is that these organizations identify potential areas of collaboration with MMIS, as they relate to injection safety activities.

National HCWM guidelines were finalized and were presented to the MOH. The guidelines are designed to lay an important foundation in establishing safe HCWM systems in health care facilities throughout Ethiopia for all personnel involved in HCWM, from national and regional levels to zonal, woreda and kebele levels.

MMIS/Ethiopia held a mid-term review meeting in June 2007 for stakeholders and partners. The goal was to identify accomplishments to date, lessons learned, and programmatic challenges to determine the best strategic direction for the remainder of the project years. The recommendations from the mid-term review have been incorporated into the FY08 workplans.

Task 1: Commodity Management and Procurement

- During FY 2007, a total of 6,933,600 syringes, 163,110 safety boxes, waste management commodities, and PPE for waste handlers were distributed. Waste segregation color-coded bins, diagrams, and supplies were purchased in country and distributed to project health facilities. All injection rooms and wards have started to use the color-coded bins with biohazard stickers (Please refer to Task 4 for more information).
- A continuing shortage of appropriate storage space and lack of supply chain professionals led MMIS/Ethiopia to lease a central warehouse. The MOH recommended this activity so that a greater quantity of supplies could be efficiently managed and distributed. However, technical and material assistance is currently being provided to regional health bureaus (RHBs) to increase their districts' storage capacity.

- In collaboration with USAID-DELIVER, MMIS provided technical assistance to improve the storage capacity and commodity management of two regional warehouses in Dire Dawa and Harari.

- Consumption of syringes was monitored in 6 MMIS districts during this period in order to determine per capita syringe consumption as well as percentage of syringe size mix. Data sources included injection tally sheets, issue vouchers, and log books from immunization, family planning, tuberculosis, and laboratory departments. Table 5 shows the compiled results among districts.

Table 5: Number of syringes consumed per person by district in Ethiopia

Districts/Regions	Catchment population	Number of Syringes consumed	Number of syringes/person
Dire Dawa	365,000	236,036	1.29
Harari	185,000	150,695	1.63
Ada	133,487	21,647	0.32
Liben	70,000	18,182	0.52
Adamitulu	156,708	49,843	0.64
Bishoftu	129,017	71,302	1.11
Total/Average		547,685	1.05

The results are relevant for planning at district levels, which is where most planning occurs in this country context. Table 6 shows the variability seen in syringe consumption across several hospitals, with consumption per patient as high as 2 in the referral hospitals and lower at rural hospitals.

Table 6: Number of syringes consumed per patient by health facility in Ethiopia

Name of Health Facility	Syringes consumed	Number of patients	Number of syringes/patient
Bishoftu Hospital	33,069	25,314	1.31
Dil Chora Hospital	51,442	25,466	2.02
Hiwot Fana Hospital	57,976	28,459	2.04
Misrak Arbegnoch Hospital	14,444	17,980	0.8
Air Force Hospital	6,497	6,690	0.97
Ziway Health Center	17,191	20,523	0.84
Total/Average	**180,619**	**124,432**	**1.45**

- MMIS contributed to the national HIV/AIDS commodities forecasting workshop held in March 2007 and organized by the MOH. The main objective of the workshop was to forecast the national demand for HIV/AIDS commodities, including infection control supplies for the next five years. MMIS recommended the inclusion of injection safety commodities, such as safety syringes with/without reuse prevention features, safety boxes, and PPE in the infection control list. MMIS consumption data was used to forecast safe injection commodities. The national safe injection commodities supply gap was determined by comparing national annual import volume with per capita syringe consumption, thus avoiding under or over supply of commodities.

- A memorandum of understanding (MOU) was signed between the Tigray RHB and the Mekelle, Axum and Adwa Hospitals regarding the sustainability of injection safety supplies using the revolving drug fund (RDF) pharmacies. This mechanism ensures sustainability and is in line with recent government policy highlighting the importance of health care financing.

- The RDF pharmacies of 6 health facilities in the Harari and Dire Dawa Regions were evaluated to determine the effectiveness of a strategy introduced to sustain adequate availability of injection safety supplies. In some health facilities, low sales of syringes made the amount of profit generated too low to expend on injection safety activities. In other facilities with higher sales, the terms of the MOU were not always followed. To address this, MMIS debriefed health facility and RHB officials on the evaluation findings. Also, MMIS reviewed the use of RDF as a sustainability strategy and the responsibilities of each entity under the MOU. In addition, guidance was provided on the steps to take to address low sales as well as steps to assure that funds generated are used for the provision of injection safety supplies. This sustainability strategy has also been introduced to an additional 40 health facilities with RDF pharmacies and the lessons learned from the initial facilities have been applied.

- MMIS/Ethiopia supplied five revolving drug fund pharmacies (Chelelektu, Wonago, Yirgachefe, Dessie and Bahir Dar Health Center) in SNNP and Amhara Regions with safety syringes.

Task 2: Capacity-Building and Training

- Based on an agreement reached with the Ethiopian Public Health Association and JHPIEGO, 16 trainees drawn from the Ethiopian Medical Association, Ethiopian Nurses Association, Ethiopian Nurse Midwifery Association, and Ethiopian Public Health Association participated in a two-week training-of-trainer (TOT) on infection prevention, standard precautions, blood safety and injection safety. MMIS/Ethiopia provided material and technical support during the training, which was fully sponsored by CDC/Ethiopia. These trainers could serve as a pool of facilitators if needed in the future.

- Cascade trainings were conducted in three regions, Tigray (26 districts), SNNPR (16 districts), and Amhara (7 districts) with a total of 2,669 health workers trained during this period on injection safety (including interpersonal communication), logistics, and waste management. Focal personnel from the RHBs were instrumental in coordinating the training sessions.

- A training module translated into Tigregna was delivered to the RHB in Tigray. The module is used during the cascade trainings in this region.

- In collaboration with JSI/ESHE/Oromiya, 16 field officers received injection safety training, with special emphasis on integrating supervisory activities. The officers will be in a position to collect injection safety indicator data (such as use of safety boxes and availability of supplies) and provide in-service training in 25 woredas. Oromiya Region is one of the most populous regions in Ethiopia, with nearly 30% of the country's entire population.

- As a result of a revised expansion plan, PEPFAR designated 255 woredas as MMIS coverage targets in Ethiopia. Interventions began in these areas in October 2006. To date, facilities in 22% of these targeted woredas are covered with MMIS interventions, which equals 55 out of an estimated 498 (11%) of total woredas nationwide. For details on coverage by woreda, please refer to Table 7. Training and coverage data for MMIS activities in Ethiopia is summarized in the following tables.

Table 7: Ethiopia Woreda coverage nationwide as of September 30, 2007

Region	Targeted woredas covered by MMIS to date	Targeted woredas nationwide (life of project)	Total woredas nationwide
Amhara	7	66	105
Oromiya	4	73	180
SNNPR	16	36	77
Tigray	26	32	35
Diredawa	1	1	1
Harari	1	1	1
Remaining regions (4)	0	46	99
TOTAL	**55**	**255**	**498**

Table 8: Ethiopia facility coverage as of September 30, 2007

Region	Facilities covered by MMIS to date[1]	Total targeted facilities in MMIS regions	Proportion covered by MMIS to date
Amhara[2]	176	240	73%
Oromiya	31	99	31%
SNNPR[2]	282	312	90%
Tigray	582	604	96%
Diredawa	12	12	100%
Harari	20	20	100%
Remaining regions (4)	0	42	0%
TOTAL	**1103**	**1329**	**83%**

[1] *Includes 4 referral hospitals, as well as regional hospitals and lower level health facilities.*
[2] *MMIS targets have been adjusted based on new information from the country team.*

Table 9: Ethiopia population coverage nationwide as of September 30, 2007

Region	Population covered in MMIS regions to date	Targeted population in MMIS regions[1]	Proportion covered by MMIS to date[2]
Amhara	1,274,665	12,018,270	11%
Oromiya	583,584	10,650,408	5%
SNNPR	3,096,512	6,967,152	44%
Tigray	3,186,545	3,715,710	86%
Diredawa	398,000	398,000	100%
Harari	196,000	196,000	100%
Remaining regions (4)	0	4,165,182	0%
TOTAL target population nationwide[3]	**8,735,306**	**38,110,722**	**23%**

[1]Calculation based on regional population projections for 2006 by the Central Statistics Agency of Ethiopia (CSA). Woreda populations are estimated by dividing the region population by the total number of woredas. To calculate regional population targets, the woreda population estimate was multiplied by the number of targeted woredas in each region.
[2]MMIS uses a proportion of facilities and woredas covered in each region to calculate the proportion of the population covered there.
[3]The total national population of Ethiopia is estimated at 75,067,000 persons (CSA, 2006).

Table 10: Number of persons trained in Ethiopia by category (July - September 2007)

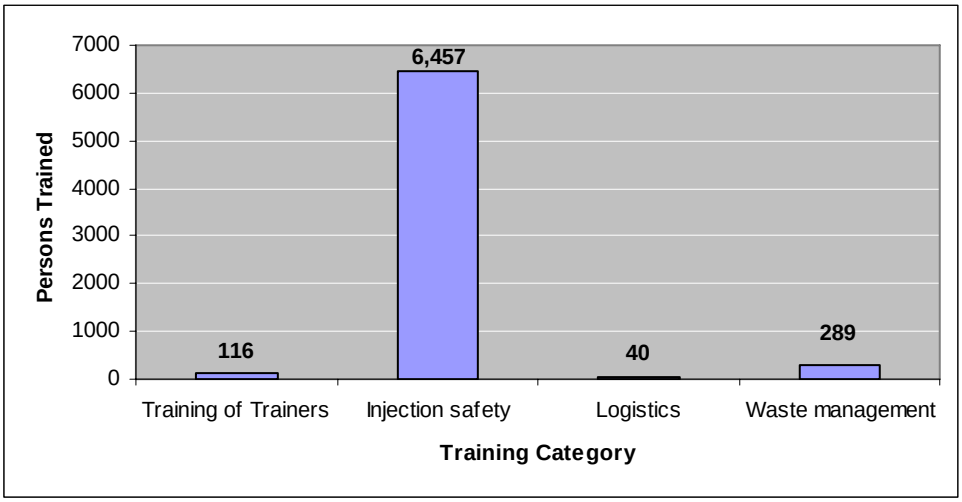
Training category	Persons trained by MMIS this period
Training of Trainers	0
Injection safety	665
Logistics	0
Waste management	0
TOTAL	**665**

Table 11: Cumulative number of persons trained in Ethiopia by category as of September 30, 2007

Training category	Persons trained by MMIS to date	Total health workers in woredas where MMIS works	Proportion MMIS trained to date
Training of Trainers	116	116	100%
Injection safety[1,2]	6,457	9,015	72%
Logistics	40	42	95%
Waste management	289	352	82%
TOTAL	**6,902**	**9,525**	**72%**

[1]Injection safety training includes training on interpersonal communications.
[2] Denominators for injection safety training were revised based upon new information from the country team.

Figure J: Ethiopia cumulative training as of September 30, 2007



Task 3: Behavior Change and Advocacy

- MMIS/Ethiopia organized a meeting with media professionals in May 2007 to familiarize them on issues related with safe injection, enhance their knowledge of global, regional and national injection safety concerns, and stimulate dialogue among different social groups on injection safety.
- MMIS/Ethiopia, in collaboration with the MOH, held an injection safety familiarization workshop for international organizations, including the World Bank, UNICEF, bilateral projects, and other NGOs who are working on HIV/AIDS and areas related to injection safety. The workshop was intended to create a national-level initiative where the importance of injection safety activities are highlighted across programs.
- An edition of the Dewel newsletter was prepared in English and Amharic and distributed to partners, NGOs and international organizations and 250 health facilities in Harari, Tigray and, as a trial, to Diredawa via the regional health bureaus. A decision whether to continue targeting health professionals with the newsletter through the regional health bureaus will be made after assessing its effectiveness in the selected sites.
- Rehoboth Promotion Company has been retained to produce five radio spots and one jingle. A creative brief was developed for them, and a workshop was arranged for the producers, editors, script writers and production manager to familiarize them on injection safety and health care waste management in order to enhance their capacity to produce effective radio spots. A script has been prepared and is currently undergoing review.
- BCC materials were reprinted in anticipation of the increased number of scheduled trainings, including 5,000 pocket size reference books and brochures on injection safety. These materials target health professionals and are distributed during the training workshops and during other relevant events. In total, 622 brochures, 532 pocket size reference books, 415 posters, 237 table calendars, 20 agenda books, and 300 waste segregation diagrams were distributed during this reporting period.
- A draft Advocacy Implementation Plan for 2007-2009 was prepared. The draft plan highlights project-wide activities that can benefit from advocacy and has incorporated the Logistics and Waste Management advisors' ideas.

- MMIS/Ethiopia participated in the MMIS project-wide workshop on advocacy and documentation held in Tanzania in November 2006.
- An agreement was reached with a program at the Clinton Foundation's Hospital Management Initiative in which they are assisting the MOH to refurbish 200 health centers so that they are able to improve the quality of their service. MMIS will work collaboratively on IPC, blood safety and injection safety issues, including the maintenance of incinerators and the provision of waste receptacles.

Task 4: Establishing a Standardized System for Proper Sharps Disposal

- During this fiscal year, 8 incinerators were refurbished, 6 ash pits were prepared, and 8 disposal sites were properly secured to prevent any risk to the community.
- A sensitization workshop on HCWM was held for 33 participants of four federal hospitals in Addis Ababa in March 2007. During the workshop, HCWM issues were presented to raise the level of understanding of participants. The meeting was successful in increasing participants' commitment to HCWM activities, and participants pledged to improve the HCWM system of their respective health care facilities. A second workshop was attended by 19 environmental health experts from 8 RHBs and two city administrations in March 2007. Participants promised to strengthen HCWM activities in all facilities in their respective regions as part of the overall IPC effort.
- The National HCWM guidelines and facility-based implementation manual were presented for comment and endorsement during the second HCWM stakeholders meeting in May 2007. Comments received during the meeting are being incorporated into the guidelines, which should be ready for printing and duplication in the near future.
- The workshops also presented an opportunity to present minimum HCWM standards/options and the roles and responsibilities of committee members. The documents have now been endorsed for use in all HCFs in the country. It is believed that these minimum standards will be an important step in putting a uniform HCWM system in the country in place.
- As part of leveraging support for waste management activities in Harari Region, a request was made of the MOH resulting in an additional 18,000 safety boxes allotted to facilities in the region. Additionally, the MOH has allocated resources to rehabilitate incinerators in three of the region's hospitals.
- To improve the management of health care waste in health facilities and minimize the hazards associated with waste handling, PPE for waste handlers was distributed to 38 health facilities. Additionally, a total of 2,000 waste segregation posters and 2,000 biohazard symbol stickers were printed for distribution to the health facilities.
- Waste management and personal protective equipment including 1,470 color coded bins plastic boots, goggles, and heavy duty gloves was distributed.

Task 5: Private Providers and the Informal Health Sector

- A literature review of injection practices among informal health sector providers was conducted, and the report, Injection Practices in the Ethiopian Informal Health Sector, was produced. Although information on injection practices within the informal sector is limited, evidence suggests that injections are common within this sector and are popular and preferred by the local community. Suggested recommendations of this report include: revising the national strategic frameworks, guidelines, and communication and advocacy strategies to address injection issues in the context of the informal health sector; strengthening national- and community-level advocacy for policy

development that serves both formal and informal health providers; and mobilizing communities to raise awareness of the hazards associated with injections provided by the informal sector.

- During October 2006, MMIS sponsored the annual conferences of the Medical Association of Physicians in Private Practice (MAPPP), held in Addis Abba, and the Ethiopian Public Health Association held in Harari, during which they advocated for increased attention to injection safety issues. MMIS contributed to MAPPP's five year strategic framework, demonstrating the interest of private practitioners on injection safety issues.

- A proposal to produce safety boxes in-country was discussed with MAPPP and the Burayu carton company. A consensus was reached to produce 1,000 safety boxes and initiate their use in one of the model private hospitals after which feedback would be provided. MAPPP has also drafted a proposal to initiate infection prevention/standard precaution activities in private facilities and set up a central incineration system for sharps and infectious waste.

- Numerous requests from private institutions for the supply of safety boxes have been made over the course of the past fiscal year. This may be a result of health workers trained in the public sector moving to private health institutions. A needs assessment for importers is necessary to support the new Ministry of Health plan to have private importers take the lead role in procurement and distribution for private facilities.

Task 6: Policy Environment

- The FMOH reviewed and commented on the national health care waste management guidelines, which will undergo further review to ensure that there is no duplication of effort.The guidelines describe the procedures and tools required for each step of proper waste management. For example, they define the proper color coding systems and collection containers for each type of waste and clarify who is responsible for each element of the system, along with acceptable methods of disposing of waste. Several appropriate options are presented so that hospitals and health facilities are able to tailor plans to their particular circumstances. The guidelines are planned for translation into the major languages in Ethiopia.

- The project continues to advocate for hepatitis B vaccination for health workers during different infection prevention/standard precaution forums. Some of the referral hospitals have already notified health workers that post exposure prophylaxis is available to those who report needlestick incidents according to the guidelines.

Task 7: Monitoring and Evaluation

- Technical review and publication of the follow up evaluation of MMIS interventions in the original pilot districts was completed in December 2006.

- Supervision visits were conducted at 31 health facilities in SNNP and Oromiya Regions, and a supervisory checklist was used to collect data, which was then entered into SPSS for analysis, the results of which are forthcoming. Preliminary observations show that there were no stock outs of supplies, an influx of new health workers that will need training, and a high attrition rate among trained health workers that are leaving public facilities. On-site trainings based on observational analysis were provided as needed. Data valuable for the Technical Information Management System (TIMS) was also collected for the joint CDC/USAID collective program, where different donors working in the same area provide data for a central database.

- Planning for the prescription record review study this period included investigating organizations to conduct an in-country ethics review of the study protocol. Information was also collected on

existing records systems in order to select candidate facilities that meet criteria for conducting data collection. This activity is on hold pending availability of funds.

- The Health Facility Assessment, to be fielded in the original expansion sites, will provide follow up data to be compared to the baseline HFA fielded in 2006. This activity is on hold pending availability of funds.

Challenges

While the MMIS project in Ethiopia is making strong headway in expanding injection safety interventions in the country, the budget situation has impacted the five-year strategic framework, making it difficult to meet expansion expectations set by the local PEPFAR mission. Reaching all 392 health centers and their satellite health posts involved in HIV program activities, as stipulated by the COP '07 and '08 plans, is a concern given current funding limitations. As a result, the national PEPFAR program is now planning to redirect and focus its activities on 100 selected health centers where service demand for HIV/AIDS intervention programs is high.

The warehouse improvement plan, along with obtaining a central warehouse, has alleviated the shortage of storage space for supplies at the health facility level that was reported in the last period. However, slow project expansion has limited the rate of commodity distribution, resulting in congestion at the central warehouse. The lack of assigned personnel to mange the central warehouse, as well as limited storage capacity at district level, has further affected the project's distribution volume. Finally, supervision visits must continue in order to reinforce the recently introduced tools and practices at the health facilities covered during this reporting period. Conducting supervisory activities is difficult for facility staff because they are focused on coordinating and conducting training sessions for the remaining health facilities in the expansion area. To address this, MMIS will continue to involve MOH staff in active supervision of health care worker practices as a follow up to training and as a way to ensure sustainability of project interventions.

MOZAMBIQUE

In this reporting period, MMIS/Mozambique concentrated on building the capacity of provincial health authorities through review meetings and by providing technical support in developing work plans for injection safety and health care waste management. Provincial health authorities also participated in meetings to discuss effective methods of training health workers on injection safety. Revision of the BCC Strategy was included the MOH's Division for Public Health Education (Repartição de Educação para Saúde Pública or RESP), and BCC materials, including posters on injection safety and waste management, were distributed to health facilities. The MOH and provincial officers at the initial project sites at Maputo, Gaza, Zambezia and Nampul assisted in the review of register books as a logistics information tool, and a meeting with DAG identified the target groups to conduct a workshop for standardizing the logistics management procedures. MMIS staff provided technical assistance to the Department of Environmental Health in preparing for the national meeting on health care waste management that is planed for next reporting period. MMIS/Mozambique continues to coordinate with provincial health authorities and establish new partnerships with NGOs to promote injection safety activities in the target health facilities. This has helped maintain a focus on injection safety during the uncertainty created by a letter issued by the MOH to stop work and merge activities with infection control and prevention (IPC).

Mozambique has reduced its total number of targeted districts from 56 to 19 due to limited resources. The expansion of the project beyond the 16 districts in which the project is currently active will be limited to 3 provincial capital cities (a capital city corresponds to one district). The targeted districts include the provincial cities which are the most densely populated areas for each province. However, the target will be revised when funding has been restored.

A consultant to conduct mid-term review has been selected, and the review is expected to take place in October 2007. The mid-term review report will be available in the next reporting period.

Task 1: Commodity Management and Procurement

- The project has completed training to introduce injection register books and forms for data collection of syringe consumption in 3 new MMIS project areas. The training was organized with participants from provincial, district and health facility levels. Injection register books were printed and distributed to the health facilities and new project sites by the MMIS/Mozambique team.

The MMIS/Mozambique logistics advisor supervises the distribution of the register books.

- MMIS, in coordination with the MOH, organized logistics management training courses that included inventory control, forecasting and monitoring topics. The provincial head of logistics in Maputo Province (Matola City) and Manica Province (Chimoio City and Gondola District) received the training to improve the logistic management systems in the country.
- MMIS/Mozambique staff visited 3 health facilities in Maputo City and Mavalane Health Area to monitor prescribing practices, promote oral medication, and collect injection equipment inventory information.

- MMIS/Mozambique collected data on the consumption and stock level of injection commodities from all 11 provincial medical stores. The information collected included material provided by the MOH as well as MMIS and will be analyzed and used to forecast injection equipment needs.
- The MMIS/Mozambique Logistics Advisor supported the data manager of Mavalane Area and Maputo City in the use of tools to monitor injection and syringe use as well as other relevant materials for infection prevention and control.
- MMIS/Mozambique provided information and technical assistance for costing of AD and retractable syringes for the national transition from glass to safety syringes. Two technical meetings were organized involving MMIS and the MOH/Nursing Department.
- The MMIS/Mozambique team provided logistics management support to the Bilene District for stock control and distribution of commodities to the health facilities using register books and a monthly reporting system to collect consumption data for injection commodities.
- The Procurement and Logistics Advisor reviewed the current logistics information collection tool (i.e. register book) between January and March 2007 with the involvement of the MOH and provincial officers. This exercise was conducted in the project's initial intervention sites in Maputo, Gaza, Zambezia and Nampula.
- Injection materials (AD syringes and safety boxes) were delivered to Chimoio, Matola, Quelimane (capital cities) and the Gondola District. MMIS expansion of commodity distribution has been delayed due to various MOH issues.
- Routine supervision visits were conducted by the Logistics Advisor who paid particular attention to stock management, distribution systems, and the consumption report of injection commodities.
- A meeting was held with DAG to identify the target groups for logistics training to help standardize management procedures in warehouses, provinces, districts, and health facilities.

Task 2: Capacity Building and Training

- Between July and September 2007, MMIS/Mozambique trained 201 health workers from Maputo Province in Matola City and Manica Province in Chimoio city and Gondola district. The trainings were organized at the health facility level to emphasize on-the-job training. Between April and June 2007, MMIS trained 75 health workers in waste management in 4 districts of the Gaza province. These trainings were done in partnership with Medicus Mundi Catalunya and the objective of the training was to ensure that health workers understand the importance of waste management in general.
- MMIS/Mozambique organized 3 coordination meetings with the MOH to better integrate in IS and IPC activities, review and develop integrated IPC and IS training curriculum, and discuss how to institutionalize injection safety through in-service training.
- MMIS is collaborating with the MOH and JHPIEGO to develop a course for provincial supervisors and managers to improve supervision skills and on-the-job training to ensure that every health worker observes standard precautions while providing health services.
- MMIS conducted two meetings in the Gaza Province involving the Provincial Medical Chiefs, Provincial Supervisors, District Directors of Health and District Health Facilities Managers to orient them on the technical aspects of IS/WM to build their capacity and competency in planning safe injections. The meetings also addressed how to establish and improve safe disposal treatment areas and train staff. MMIS encouraged its implementation partner in Gaza Province (Medicus Mundi) to participate in the meetings held at the province/district level so that they receive clear

technical guidance in safe injection and for the improvement of waste management treatment areas to allow them to provide technical assistance to health facilities.

- Between October and December 2006, six workshops were conducted, including five TOT workshops and one on-the-job training for nurses from the Maputo Central Hospital. The participants of the TOTs included medical doctors, nurses, laboratory technicians and other health professionals selected as trainers at the district and provincial levels. The trainings addressed injection safety, infection prevention and control, behavior change communication, logistics, and waste management issues.

- To date, facilities in 16 of 19 targeted districts (84%), or 11% of 144 districts nationwide, are covered with MMIS interventions. For details on coverage by district, please refer to Table 12.

Table 12: Mozambique District coverage nationwide as of September 30, 2007

Province/City[1]	Districts covered by MMIS to date	Total targeted districts (life of project)[2]
Gaza Province	6	6
Nampula Province	2	2
Maputo City[3]	1	1
Zambezia Province	2	2
Tete Province	1	1
Inhambane Province	0	1
Maputo Province	1	1
Manica Province	2	2
Sofala Province	1	1
Niassa Province	0	1
Cabo Delgado Province	0	1
TOTAL	**16**	**19**

[1]In all provinces, provincial capital cities are counted as '1' District.
[2] The number of targeted districts has been adjusted to reflect targets over the life of the project. Please note that this target may be revised once funding is restored.
[3] Maputo City includes three health sub-areas.

Table 13: Facility coverage in Mozambique as of September 30, 2007

Province/City	Facilities covered by MMIS to date	Total facilities in target districts covered by MMIS (life of project)[1,2]	Proportion covered by MMIS to date
Gaza Province	35	53	66%
Nampula Province	20	20	100%
Maputo City	11	12	92%
Zambezia Province	10	24	42%
Tete Province	4	9	44%
Inhambane Province	0	7	0%
Maputo Province	17	18	94%
Manica Province[3]	16	17	94%
Sofala Province	12	13	92%
Niassa Province	0	9	0%
Cabo Delgado Province	0	6	0%
TOTAL	**125**	**188**	**66%**

[1]Numbers include public hospitals and lower level facilities.
[2]The total number of facilities has been revised to show coverage among facilities in targeted districts.
[3]Figures for Manica province includes training conducted in one facility in Manica district although this district is not part of the targeted districts for Manica province.

Table 14: Population coverage in Mozambique as of September 30, 2007

Province/City	Population covered by MMIS to date	Targeted population by province[1]	Proportion covered by MMIS to date[2]
Gaza Province	465,679	666,768	70%
Nampula Province	339,354	339,354	100%
Maputo City	328,147	357,979	92%
Zambezia Province	214,449	428,898	50%
Tete Province	49,971	112,435	44%
Inhambane Province	0	100,087	0%
Maputo Province	126,885	134,349	94%
Manica Province	102,466	128,083	80%
Sofala Province	112,350	121,712	92%
Niassa Province	0	60,411	0%
Cabo Delgado Province	0	93,455	0%
Population coverage in provinces/cities where MMIS has started to work	**1,739,302**	**2,543,531**	**68%**

[1] Targeted population by province has been adjusted according to the revised life of project coverage target of 19 districts. Numbers are based on data from Mozambique National Institution of Statistics (NIS), projections for 2004.
[2] Population coverage is calculated as 50% in districts where all public hospitals have MMIS interventions and 100% where all public facilities, including lower-level, have MMIS interventions.
[3]The total national population of Mozambique is estimated to be 18,972,396 (NIS, 2004).

Table 15: Number of persons trained in Mozambique by category (July - September 2007)

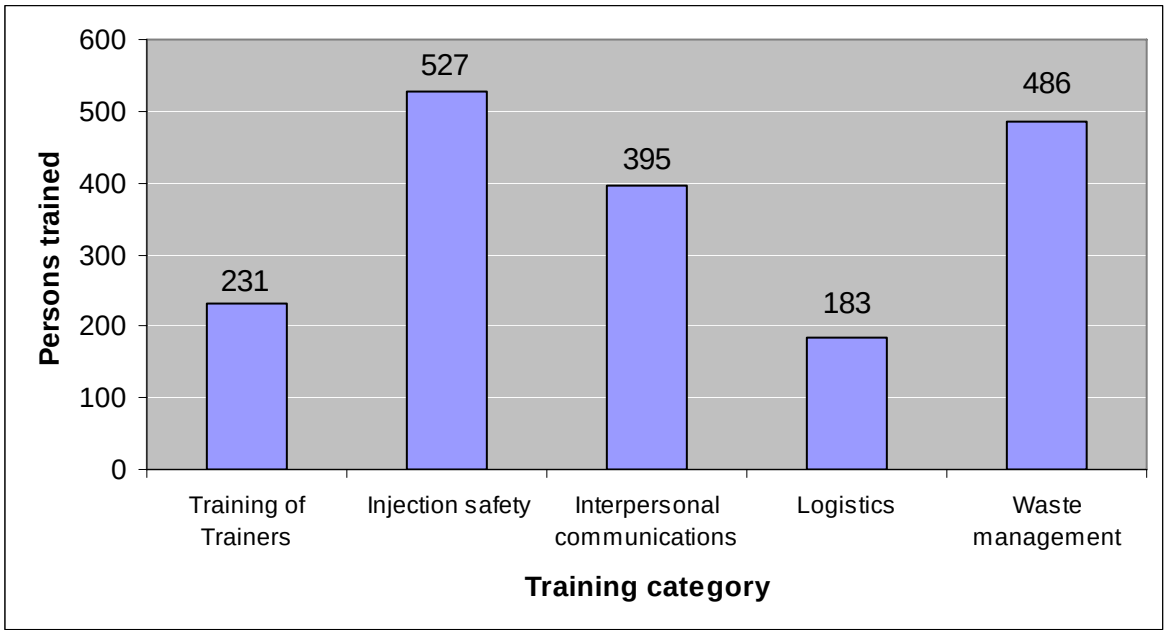
Training category	Persons trained by MMIS this period
Training of Trainers	0
Injection safety	0
Interpersonal communications	0
Logistics	115
Waste management	86
TOTAL	**201**

Table 16: Cumulative persons trained in Mozambique by category as of September 30, 2007

Training category	Persons trained by MMIS to date	Total health workers targeted in the districts where MMIS works[1]	Proportion MMIS trained to date
Training of Trainers	231	321	72%
Injection safety	527	743	71%
Interpersonal communications	395	431	92%
Logistics	183	385	48%
Waste management	486	594	82%
TOTAL Targeted	**1,822**	**2,474**	**74%**

[1] Total health workers targeted in the districts where MMIS works has been adjusted according to the revised life of project coverage target of 19 districts.

Figure K: Mozambique cumulative training as of September 30, 2007



Task 3: Behavior Change Communication and Advocacy

- Preparations for interactive group discussions with health workers to promote oral medications and advocate for the reduction of unnecessary injections were completed. Preparation was done with the MOH, and the group discussions will be held in Gaza Province, Xax- Xai City.
- Training on interpersonal communication and counseling under IPC/Injection Prevention and Control program with health workers was held in Gaza Province, Chocue district.
- Three new posters have been finalized and are ready for pre-testing. The posters include promotion of oral medication for health workers; the risk of medical waste for community members who live near health facilities; and the correct use of personal protective equipment for waste handlers.
- Two leaflets have been finalized for pre-testing. One leaflet targets health facility managers and focuses on waste segregation and treatment. The second leaflet targets standard precautions for infection prevention and control and targets prescribers and all health staff involved in treatment.
- Posters have been distributed in the MMIS implementation sites of Maputo, Manica, and Zambezia Provinces. These sites include provincial hospitals and health centers where health workers had already received injection safety training. MMIS distributed posters in the new implementation sites of the Gaza provinces, which include Carmelo, Mabalane, Massinguir, Guijá and Chokwe Health Center and Chokwe Rural Hospital.
- MMIS/Mozambique developed a quarterly newsletter on safe injection practices in Mozambique. The newsletter will serve as an advocacy tool to reinforce the importance of injection safety for health workers and decision makers. The inaugural edition of the newsletter is awaiting approval from the Ministry of Health.
- The revision of the BCC strategy was completed with contributions from RESP. The approval process for the BCC strategy was expanded within the Ministry of Health to maximize support for country-wide implementation of the strategy. MMIS held discussions with the National AIDS Council (CNCS) and MOH to facilitate the rapid approval of this document.

- 423 copies of injection safety BCC /IEC materials have been distributed to health facilities in the Mavalane Health Area. These materials include posters on waste segregation, injection safety procedures, and personal protective equipment. As requested, samples of the materials were also supplied to the local USAID and CDC missions, Project HOPE, and MOH staff.

Waste handlers receive BCC materials during a MMIS training.

- MMIS/Mozambique participated in meetings and provided input to the team responsible for producing IEC material under the National AIDS Council that implements the Country HIV/AIDS Communication Strategy implemented with technical support of the Center for Communication Program - Johns Hopkins University.
- MMIS/Mozambique is now part of the CNCS team that provides technical support for the communication team and participates regularly in their meetings.
- MMIS/Mozambique developed an Annual Report on Injection Safety Interventions for 2006 in Mozambique that is being used as not only as a reference on key achievements in 2006, but also as a tool to highlight the relevance and importance of injection safety interventions in the fight against HIV/AIDS and other bloodborne pathogens. Copies of the annual report were distributed to the MOH at the central and provincial levels. Partner organizations and donors in the country were also given the report as part of the distribution plan.
- The MMIS/Mozambique team participated in two quarterly review planning meetings with other partners and stakeholders working in the health sector in Gaza and Maputo City Provinces. The meetings were presided over by the Gaza provincial director and the director of the Mavalane Health Area.

Task 4: Establishing a Standardized System for Proper Sharps Disposal

- A HCWM rapid assessment was conducted in coordination with MMIS/Mozambique, the MOH, WHO's Mozambique Office, and NGO implementing partners. The MMIS team supported the MOH in data analysis and the review and preparation of the final report.
- Training was provided to health worker assistants and waste handlers in the health facilities of Matola City, Chimoio City and Gondola District and included the recommended practices in medical waste management and maintenance of waste treatment zones.
- Personal protective equipment for waste handlers was distributed to 17 health facilities in Matola City, 4 health facilities in Chimoio City and 11 health facilities in Gondola District.
- Work to rehabilitate the waste treatment zone affected by floods in Beira City began by increasing the height of needle pits. In Quelimane City, MMIS in joint collaboration with Provincial Directorate of Health was responsible for the improvement of the conditions of sharps disposal and medical waste treatment areas in 5 health facilities.
- Organizations like Medicus Mundi have decided to partner with MMIS to implement standardized and improved safe disposal treatment areas for waste management. As a result of this partnership

Medicus Mundi supported the improvement of health care waste treatment areas in four districts of the Gaza Province. MMIS has provided hands-on training in the maintenance of the areas.

- MMIS/Mozambique collaborated with the MOH to conduct two coordination meetings with the Department of Environmental Health. The meeting objectives were to establish a coordination process with the Department of Environmental Health as well as to define strategies to involve more partners in waste management. It was decided in the meeting that the National Waste Management Plan needs to be updated. This update will occur in the national meeting on waste management planned for the next reporting period.

- The MMIS team continues to support the MOH/MOE with efforts to develop a national plan for HCWM. During this reporting period, the MOH received funds from WHO/GAVI to support national planning activities.

- In the Mavalene Heath Area, partnerships were established with several NGOs to enable them to implement waste management segregation in their project sites, especially the NGOs that are interested in establishing and/or improving treatment areas with sustainable waste segregation procedures and policies. For example, Medicus Mundi requested technical assistance from MMIS in planning treatment areas in four districts of the Gaza province. Also, Soldary Medic expressed interest in becoming involved with waste management technical issues, including the provision of support to the Provincial Directorate of Heath to develop six treatment areas in the Chiúre District of Cabo Delgado Province.

Trainees participate in an on-the- job training session on HCWM.

- The MMIS/Mozambique team assessed and observed current waste management practices during a visit to Niassa, Cabo Delgado, and Inhambane. As a result of the visit, health facilities areas established priority areas for waste management.

- Twenty-nine (29) students were trained in proper waste management during their pre-service training at the Health Institute Science of Maputo.

- Follow-up and technical assistance was provided to the pilot project sites and new scale-up areas to observe and confirm that facilities are segregating waste using the provided color-coded bins from the point of production to the point of final disposal.

Task 5: Private Providers and the Informal Health Sector

- A literature review on the informal health sector in Mozambique was conducted by a consultant to document injection practices in these settings, as well as to make recommendations for potential interventions. The report will be submitted to USAID in November 2007.

- MMIS/Mozambique is working with the MOH at the Provincial and District Directorate to collect information about members and associations of the private and informal sector at the provincial and district level. This will enable MMIS to work with the associations to reinforce and support the promotion of IS/IPC in the private and informal sector in Mozambique.

Task 6: Policy Environment

- MMIS participated in several meetings of the STI subcommittee organized by the MOH's STI Department. Discussion centered on the need to put in place supportive materials to be used during training for the implementation of the new STI protocol and to organize a TOT in support of training health workers who must implement the new STI protocol.

- MMIS provided information to the MOH to reinforce waste management policies and approaches. As a result, the MOH is interested in promoting waste management issues, including segregation of waste and final safe disposal. Additionally, the MOH is planning a national campaign for waste management and requested technical assistance from MMIS in the organization of the campaign.

Task 7: Monitoring and Evaluation

- A follow-up assessment was conducted in 4 pilot project areas with technical guidance from MMIS/HQ to finalize the survey planning with a local consultant and training data collectors. Data entry and cleaning have been completed. Basic data for key indicators were reported to USAID/Washington and included in the overall report on pilot area follow-up data that was provided to all country teams in February 2007. The local consultant in Mozambique has completed the draft survey report. Technical review of this report has begun and is expected to be completed in the first quarter of FY 2008.

- Supervision checklists on injection safety were also provided by MMIS headquarters are available for use in Mozambique. All of the supportive supervision tools have been adapted to the Mozambique context.

- The protocol for the prescription record review was translated into Portuguese in March 2007 to facilitate local IRB review and in-country planning. The protocol was submitted for approval by the MOH. A coordination meeting with Nurses Department and National Institute of Health (INS) were held for submission of Prescription Record Review (PRR) study protocol for approval. Currently, MMIS is providing technical assistance to ensure improved record keeping in the 3 selected health facilities of Maputo City, Mavalane Health Area.

- MMIS/Mozambique conducted supervision activities in Nampula, Zambézia, Sofala and Gaza Province. In the Gaza Province the follow-up visits helped improve standardized treatment areas for waste disposal as well as for training on waste management.

Challenges

In January 2007, the MMIS project was directed to stop implementation of the project as it currently interfaces with the Ministry of Health and instead integrate its activities under the MOH's infection prevention and control program. In order to facilitate as smooth a transition as possible with limited disruption in implementation, the team decided to focus on producing an annual report on its many activities to familiarize the MOH and other key organizations with injection safety issues and MMIS activities in Mozambique. With the support of local USAID Mission, MMIS resolved this issue with the MOH, especially with the Minister of Health, and normalized the working environment that affected the implementation of project activities.

Since activity implementation was restored, close collaboration with the MOH has continued. While collaboration with MOH officers is important for implementation of project activities, the limited availability of the MOH officers has become a constraint. MMIS continues its coordination efforts to implement activities that are already planned. Also, MMIS works to keep the MOH informed of its contact and communication with provincial and health directorate officers. This helps MMIS to continue its progress in project implementation while maintaining close collaboration with the MOH.

NIGERIA

MMIS/Nigeria has continued to make progress in all technical areas in this reporting period. With MMIS's support, the National Policy on Injection Safety and Health Care Waste Management was approved by the National Council on Health and Nigeria's Minister of Health, Eyitayo Lambo, launched it in May 2007. This, as well as the Ministry of Health's involvement in the project's community behavior change communication (BCC) strategy, demonstrates involvement from high government officials, which is a good indication there is political support for injection safety in Nigeria. In recognition of injection safety's significant role in preventing HIV in the medical setting, MMIS was invited to participate in the Nigeria HIV/AIDS Summit Meeting, an important venue for discussing prevention and treatment strategies with the country's various stakeholders. The project conducted a mid-term review with injection safety stakeholders in May 2007 and the recommendations were used in the FY08 workplan and budget preparations.

MMIS/Nigeria progressed in establishing sustainable injection safety training for the country's health care workers by adapting the injection safety training manual *Do No Harm* to the Nigerian context. The adaptation process was carried out through a workshop with participation from federal and state MOH officials, existing trainers, professional associations and other PEPFAR implementing partners (IPs). As urged by the local USAID Mission, MMIS conducted training of trainers (TOT) for other IPs. MMIS/Nigeria also carried out a TOT for COMPASS, a USAID/Nigeria bilateral project, and EU-PRIME, a European NGO that will help to extend injection safety interventions beyond the MMIS target areas. Because HIV status among patients in emergency and dental care services is usually unknown, MMIS trained nurses in accident and emergency preparedness through a course organized by the Federal Ministry of Health (FMOH) and trained dental surgeons and laboratory workers to help protect them from medical transmission of HIV. To incorporate injection safety in the pre-service training curricula, MMIS conducted a workshop involving regulatory bodies and professional institutions.

Nigeria's expansion strategy has shifted from coverage of all facilities within target LGAs to include other districts in which coverage will be limited to one or more PEPFAR or Government of Nigeria health facility per LGA. The latter strategy is dependent upon PEPFAR and the Government of Nigeria (GON) identifying facilities for MMIS activities. To date, facilities in 100% of targeted local government areas (LGAs) in 6 focus states (Anambra, Cross Rivers, Edo, Kano, Lagos, and Federal Capital Territory (FCT)) are covered with MMIS interventions. Nigeria has 36 states and one Federal Capital Territory.

An integrated and sustainable commodity distribution method was developed within the existing government drug supply system in different States. Leveraging support with other stakeholders (The World Bank, NACA and UNICEF) MMIS held a workshop to draft the National Health Care Waste Management Plan with the participation of FMOH, FMOE, State MOH, and other stakeholders.

Task 1: Commodity Management and Procurement

- Implementation of the logistics management information system (LMIS) has made significant progress in this reporting period. With regular technical support from the logistics advisor, reporting has increased from 47% in June to 70 % in July 2007. The purpose of the consumption data collection is to improve forecasting by having reliable information on actual syringe use (MMIS and non-MMIS). The LMIS tool is providing information to improve procurement forecasts and commodity management so that the incidence and duration of stock outs in MMIS intervention areas can be reduced. In addition, the information is useful for effective advocacy for future financial resources for commodity security and sustainability.

- During a technical assistance visit, the MMIS Senior Logistics Advisor visited some project sites to evaluate project activities and identify any issue that may impact project implementation. The Country Logistics Advisor was trained on the use of the MMIS LMIS tool, which was adapted

specifically for Nigeria and discussed in a special session with the project team. An evaluation of the stock in the national pipeline, a projection of required commodities was also carried out to determine how long the current stock will last. Results showed that the quantities of syringes will cover up to a year and a half based on current levels of consumption. Quantities of safety boxes were also satisfactorily matched with the quantities of syringes based on the bundling policy.

- At national level, the overall sustainability of safe injection commodities requires that industry support the market. MMIS recognizes the importance of leveraging industry in a neutral, systematic, and transparent manner to promote sustainability of products at reasonable costs. MMIS is encouraged that manufacturers have begun introducing safety syringes into local markets on their own initiative following MMIS's interventions in Nigeria.

- MMIS observed two different local manufacturers who are at different stages. In Port Harcourt, the Pan African factory site is 90% complete and is expected to start production by early 2008. The anticipated annual production capacity is 160 million auto-disable (AD) syringes using Star technology. In Calabar, First Medical & Sterile Products Limited has been producing and marketing AD syringes with a capacity of 90 million syringes per year. There is provision for two more production lines to allow for future expansion. The factory is also fully registered with NAFDAC, the National Drug Regulatory Agency in Nigeria. In order to assess the production and identify issues that may impact the production unit, the MMIS Senior Logistics Advisor, along with the MMIS/Nigeria country director and logistics advisor, visited the factory.

- To build local capacity to improve and strengthen safe injection commodities, logistics supportive training was conducted at sites among the various facilities within MMIS intervention sites. Emphasis was placed on tracking logistics records using stock cards to generate monthly consumption data of injection safety commodities.

- In maintaining an effective LMIS to inform effective decisions, concerted efforts were made to ensure that generated data is qualitative. The low level of education and exposure of responsible personnel in generating similar technical data is a major challenge. A system is being developed to strengthen the process of an efficient and qualitative LMIS through continuous field monitoring and training of focal persons who are expected to share their knowledge of key issues with other relevant personnel.

- From January to September 2007, MMIS received and cleared from the ports, shipments of about 12,462,000 syringes and 162,900 safety boxes, which are currently being distributed in project sites. A total of 9,428,200 auto disable and retractable syringes and 111,400.00 safety boxes were distributed among the following: Lagos, Anambra, Kano Edo States , FCT and the PEPFAR-affiliated Institute of Human Virology (IHVN).

- Warehousing has been a major challenge. However, MMIS has advocated for a warehouse in Edo State, which has already been secured. It is expected that this warehouse will service the states in the southern part of the country (Edo, Anambra & Cross Rivers) and plans are underway to move commodities from the federal stores in Lagos to this store. Some constraints for warehousing are also faced in Anambra State. However renovation of stores will provide MMIS an opportunity of securing needed storage space. At the LGA level, warehousing is less problematic, although few cases of inadequate storage spaces also exist in some LGAs.

- All products used under MMIS are fully registered with NAFDAC. The shipments received for this year carries the NAFDAC Registration number on all of the products.

- MMIS is also making a concerted effort to encourage a local manufacturer to produce safety boxes. Samples have already been sent to PATH for technical evaluation to ensure they comply with WHO policy on the manufacture of safety boxes.

Task 2: Capacity-Building and Training

- In August 2007 a TOT was held for 32 nurse tutors and clinical instructors from the 6 geopolitical zones of the country in collaboration with the Nursing and Midwifery Council of Nigeria to support the pre-service training of nurses. The capacity of the tutors to teach injection safety and health care waste management in the various nursing schools and training institutions has been increased to prepare for the review and update of the nurses' pre-service curriculum.

- A TOT was held in collaboration with Columbia University/International Centre for Treatment and Care of AIDS Program (CU/ICAP) for 27 health care providers in Makurdi Benue State in September 2007. The participants were from Benue, Cross River and Kogi States.

Safe injection commodities are demonstrated by participants during Nurse/Midwife Tutors TOT in Nigeria.

- During September 2007, a TOT was held for 36 participants from facilities in Adamawa, Benue, Katsina, Kogi, Nasarawa, Niger and Taraba States in collaboration with the Global HIV/AIDS Initiative in Nigeria (GHAIN) comprehensive sites. Also, a TOT was conducted for the Federal Road Safety Commission (FRSC) clinic. The FRSC invited its members from its health facilities throughout the country so that they will be able to implement training in all of their facilities.

- Between July and August 2007, new health care providers were trained in public and private facilities in 3 of the pilot LGAs (Badagry in Lagos, Tarauni in Kano, and Gwagwalada in the Federal Capital Territory). Since staff turnover is high, especially in the private facilities, MMIS revisits implementing facilities to periodically train new staff.

Trainees learn infection prevention techniques at the Nurse and Midwife Tutors TOT in Nigeria.

- MMIS trained health care providers of the TB Directly Observed Treatment Short-term (DOTS) sites across Lagos State on injection safety and health care waste management at the request of the Lagos State Ministry of Health.

- MMIS conducted training on injection safety and healthcare waste management for staff of the Central Bank Clinic in Abuja and the Nigerian Security Printing and Minting Clinic.

- Clinical meetings were held at the departments of Medicine and Surgery at the Lagos University Teaching Hospital (LUTH) for doctors, nurses and medical students to update them on waste management and injection safety.

- The Community Health Practitioners Registration Board, who holds zonal continuing education workshops for its members each year, invited MMIS/Nigeria to facilitate a session on injection safety. Participants were from the South East, South South and South West Zones of the country in Akure Ondo State. 130 community health practitioners received continuing education at this year's workshops.

- MMIS/Nigeria sensitized participants on injection safety and health care waste management in emergencies at the disaster nursing and emergency preparedness workshops conducted by the West African College of Nurses in Lagos and Kano. A total of 46 nurses from Lagos and 68 from Kano States attended.

- MMIS/Nigeria supported the Department of Hospital Services of Federal Ministry of Health (FMOH) in developing a module for the national nursing curriculum for care of people living with and affected by HIV/AIDS. The MMIS project also contributed injection safety content in the development of a continuous professional development curriculum for the Medical and Dental Council of Nigeria.

- MMIS/Nigeria conducted a pre-service sensitization of dental students on safe injection practices in dental settings during a symposium organized by the University of Lagos Association of Dental Students.

- Between April and June 2007, health worker and waste handler training continued in nine states and mop-up trainings commenced in Tarauni Local Government Area, Kano State. Training for doctors, nurses, pharmacists, community health officers and laboratory scientists focused on injection safety and health care waste management in the context of infection prevention and control, while waste handlers were trained only on health care waste management.

- Training for health care workers and waste handlers will continue to focus on PEPFAR health facilities in the focal states. The project also plans to support trainings organized by the Federal Ministry of Health (Public Health Department) while sensitization will continue in the other focal states for trained facilitators on the adapted training document.

- A Liberian medical practitioner trained in Nigeria and working in the Lagos University Teaching Hospital (LUTH) organized training activities in injection safety and health care waste management for 68 health care workers in two facilities in Monrovia Liberia: Seventh Day Adventist Cooper Hospital and the Tubman National Institute of Medical Arts. Dr. Augustus Quiah was previously trained by the MMIS project in Nigeria and saw a need for injection safety for Liberian health workers. The MMIS/Nigeria team provided technical guidance, support and sample training materials for Dr. Quiah to adapt and use.

- The *Do No Harm* generic injection safety training manual was adapted in a workshop held in October 2006 with input from government parastatals, trainers from current MMIS target sites and other implementing partners. The content of the training modules were discussed and modified in groups and include the addition of a behavior change communication module. The Nigerian version of *Do No Harm* guide was finalized by the Government of Nigeria, and MMIS printed and distributed the manual to all project sites, medical training institutions for curricular review, continuing education departments of tertiary and secondary health facilities, and other major stakeholders.

- Sensitization workshops were held to familiarize facilitators with the *Do No Harm Facilitators Guide* in Lagos and Kano States along with the revised health workers' manual, waste handlers' manual and the new policy document. There was a Master trainers' training conducted for 32 health workers in the University of Ilorin Teaching Hospital, Kwara State at the request of the FMOH– Department of Hospital Services.

- To extend prevention of medical transmission of HIV efforts beyond MMIS intervention areas, the USAID local mission decided to fund other PEPFAR Implementing Partners (IP) to work in injection safety and requested MMIS's technical assistance. MMIS conducted a training of trainers (TOT) for 36 participants from other IPs and staff from the government parastatal of the FMOH

and trainers in the private sector. The goal of the workshop was to build the capacity of other IPs so that they are able to train their own staff of health workers.

- MMIS facilitators and training consultants conducted relevant injection safety training in seven states for health workers, including doctors, nurses, community health officers, laboratory technologists, and waste handlers/attendants.
- MMIS participated in the training of 86 nurses in an accident and emergency preparedness course organized by the FMOH in Kaduna State. Also, health workers, including surgeons, dental practitioners, and laboratory workers received the same training in a workshop at the Regional Centre for Oral Health and Research Training Institute in Jos, Plateau State.
- Between January and March 2007, MMIS also conducted 4 TOT workshops in Kano State in collaboration with USAID bilateral project COMPASS (Community Participatory for Action in the Social Sector), in Bauchi and Nasarawa States. In total, 110 persons were trained and will serve as injection safety trainers in their respective states. The project also collaborated with the Lagos State Waste Management Authority (LAWMA) to conduct training on health care waste management. Cascade training was also conducted in collaboration with Institute of Human Virology-Nigeria (IHVN) in Plateau State at Mangu Hospital, a faith-based institution where both health workers and waste handlers were trained.
- MMIS organized a workshop to review the existing training curricula of the different health institutions (medical, nursing and pharmacist) and support inclusion of infection prevention and injection safety components. Workshop participants included staff from health regulatory and professional bodies and other stakeholders. After agreeing on relevant material for inclusion, participants developed action plans for the various professions/institutions for comprehensive incorporation of injection safety content in the different curricula. As follow up action, Lagos University Teaching Hospital has initiated steps to revise medical students' training curriculum, while the Nursing Council in Lagos State is planning to do the same.
- To date, facilities in 100% of targeted local government areas (LGAs) in the 6 focus states (Anambra, Cross Rivers, Edo, Kano, Lagos, and Federal Capital Territory (FCT)) where MMIS is working are covered with MMIS interventions.
- Coverage in the 9 expansion states includes conducting training of trainers (TOT) and providing materials for cascade training that will be carried out by other PEPFAR partners. To avoid double counting, and in agreement with the USAID Mission, MMIS counts TOT only in those areas. In the original states, training will continue to be counted and reported in all categories.

Table 17: Nigeria LGA coverage as of September 30, 2007

State	LGAs covered by MMIS to date	LGAs targeted in six focus states (life of project)
Anambra	2	2
Cross Rivers	2	2
Edo	8	8
Kano	8	8
Lagos	9	9
Federal Capital Territory (FCT)	6	6
TOTAL	**35**	**35**

- The facility coverage data has been split into two tables showing the different expansion strategies. Table 18 has facility coverage of the initial target LGA's in the 6 focal states and Table 19 has coverage of facilities in the additional 18 LGAs in 9 states under the new expansion strategy.

Table 18: Facility coverage in MMIS/Nigeria target LGAs as of September 30, 2007

State	Facilities covered by MMIS to date [1]	Total facilities in target LGAs (life of project)	Proportion covered by MMIS to date
Anambra	59	59	100%
Cross Rivers	47	47	100%
Edo	105	138	76%
Kano	129	130	99%
Lagos	258	291	89%
FCT[2]	159	196	81%
TOTAL	**757**	**861**	**88%**

[1]Numbers include hospitals and lower level facilities of all types of ownership – public, private, NGO, FBO.
[2]The total number of facilities in FCT has been updated due to the addition of new facilities in the state.

Table 19: Facility coverage in PEPFAR and GON scale-up states in Nigeria as of September 30, 2007

State	Facilities covered by MMIS to date	Total target facilities in these LGAs	Proportion covered by MMIS to date
Cross Rivers[1]	10	TBD	TBD
Kano[1]	6	TBD	TBD
Lagos[1]	4	TBD	TBD
Benue	1	TBD	TBD
Plateau	2	TBD	TBD
Niger	1	TBD	TBD
Nassarawa	2	TBD	TBD
Kwara	1	TBD	TBD
Ogun	1	TBD	TBD
TOTAL	**28**	TBD	TBD

[1]Cross Rivers, Kano, and Lagos include additional PEPFAR and GON LGAs not included in the MMIS target LGAs.

- Targets facilities and the proportion of facility coverage to date by MMIS in Table 19 will be filled in as information becomes available.

Table 20: Population coverage nationwide in Nigeria as of September 30, 2007

State	Population covered by MMIS to date	Targeted population in states covered by MMIS[1]	Percentage covered by MMIS to date [2]
Anambra	919,385	4,182,032	22%
Cross Rivers	704,543	2,888,966	24%
Edo	1,628,434	3,218,000	51%
Kano	6,421,221	9,384,000	91%
Lagos	5,876,254	9,014,000	65%
FCT	1,423,026	1,531,198	93%
Benue	4,094	4,219,244	< 1%
Plateau	4,685	3,178,712	< 1%
Niger	4,156	3,950,249	< 1%
Nassarawa	7,713	1,863,275	< 1%
Kwara	4,524	2,371,089	< 1%
Ogun	5,432	3,728,098	< 1%
TOTAL population in states covered by MMIS[3]	**17,003,467**	**49,528,863**	**34%**

[1]Source: Nigeria National Population Commission (NPC), 2006.
[2]Population coverage is calculated as 50% in districts where all public hospitals have MMIS interventions and 100% where all public facilities, including lower level, have MMIS interventions.
[3]The total national population of Nigeria is estimated to be 140,003,542 persons (NPC, 2006).

- MMIS/Nigeria held sensitization sessions for 488 people outside of the project's target areas, including participants from the West African College of Nurses, Community Health Practitioners Registration Board, and University of Lagos Association of Dental Students.

Table 21: Number of persons trained in Nigeria by category (July - September 2007)

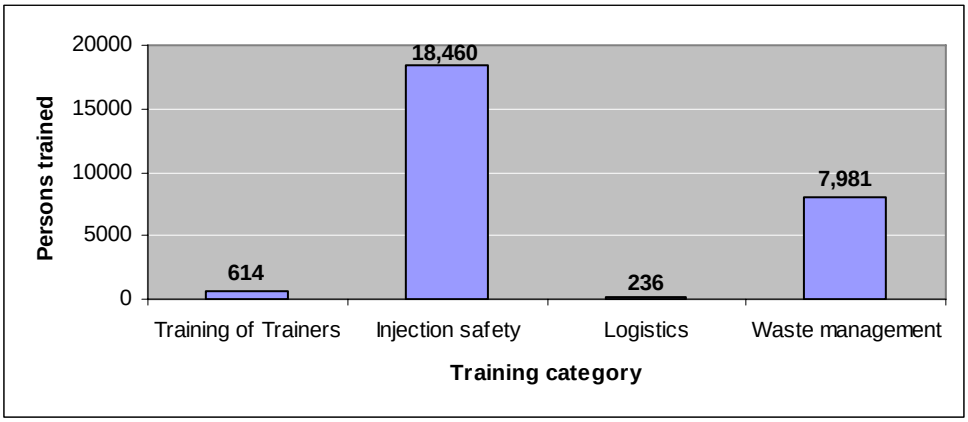
Training category	Persons trained by MMIS this period
Training of Trainers	95
Injection safety	1,241
Logistics	0
Waste management	208
TOTAL	**1,544**

Table 22: Cumulative number of persons trained in Nigeria by category as of September 30, 2007

Training category	Persons trained by MMIS to date	Total health workers targeted in the LGA's where MMIS works	Proportion MMIS trained to date
Training of Trainers	614	618	99%
Injection safety[1]	18,460	19,412	95%
Logistics	236	532	44%
Waste management	7,981	10,239	78%
TOTAL	**27,291**	**30,801**	**89%**

[1]Injection safety training includes training on interpersonal communications.

Figure L: Nigeria training as of September 30, 2007



Task 3: Behavior Change and Advocacy

- In collaboration with the Internews/ENHANSE project, MMIS/Nigeria participated in a workshop that briefed ten journalists on injection safety and health care waste management issues. During the workshop, the participants visited the Aminu Kano Teaching Hospital (AKTH) to gain first hand experience in injection safety practices in Nigeria. The site was chosen because it is one of the role model sites for the MMIS project in Nigeria. They also visited Dawakin Kudu Hospital, a nearby health facility, as well as a dump site for waste close to the Dawakin Kudu Hospital. Since the workshop, the journalists have published various reports on injection safety, health care waste management and the promotion of oral medications in the Nigerian newspapers.

- A new partnership was initiated with the National Orientation Agency to continue the implementation of the BCC and community-based BCC strategy for the next year.

- The MMIS project continues to distribute the National Policy on Injection Safety and Health Care Waste Management to stakeholders as well as the *Do No Harm* Facilitators Guide to other USG implementing partners involved in the training of health workers.

- The MMIS project has been leveraging other partners, including GON University of Ilorin Teaching Hospital, to produce BCC materials, especially posters, as they continue to be requested for intervention sites. MMIS is not currently producing any posters, due to financial constraints.

- Since the GON changed following the April 2007 elections, advocacy to new commissioners for health and principal new officials was initiated to gain continuous support for the project. The Lagos State Commissioner, Permanent Secretary, and Director of Disease Control were visited. Visits for Edo and Kano states will be planned as officials are available.

The Etiowerien (Traditional Council leader) with other members of the traditional council during the awareness session in Ugor LGA, Edo State.

- Three types of audio messages were developed, translated into Hausa, Igbo, and Yoruba languages and pre-tested on target audiences in Kano, Lagos, and Anambra States. MMIS aired these messages with local broadcasting services and other designated radio stations in project sites at

least twice daily, four days a week for 13 weeks. Beginning in April and continuing through June 2007, MMIS/Nigeria continued airing radio messages on local radio stations in three states (Lagos, Edo and Kano) as well as the FCT. Cross River State was also added during this time. The project plans to focus on the implementation and sustainability of community outreach activities through the involvement of health educators in the Local Government Areas who will continue to oversee community interventions during the full funding period.

- Advocacy visits were made to different stakeholders including the Minister of Health, Director General of the National Agency for Food and Drug Administration and Control (NAFDAC) and the Director of Public Health to prepare for the launch of the national injection safety policy, promote collaboration in the review of essential drug lists to include more oral treatments, and to provide information regarding current injection safety activities in Nigeria.

Professor Lambo, Honorable Minister of Health at the launch of the MMIS Community based BCC strategy and materials shows high political support for injection safety.

- Advocacy kits were printed and letters of introduction to new Commissioners of Health in the states were sent prior to planned follow-up advocacy visits to the states. The Commissioner for Health in Lagos State and his management team have been visited while plans are in place to visit Kano, Edo and other states soon.

- Advocacy visits were made to the Minister of Health to seek support for the launch of MMIS community strategy. The National Community-Based BCC Strategy developed in June 2006 was reviewed, finalized and launched by the Minister of Health in December 2006. During the official launch, Professor Dora Akunyili, Director General of the National Agency for Food and Drug Administration and Control (NAFDAC) was also officially recognized as the National Injection Safety Champion.

- Several advocacy visits were paid to major stakeholders and leaders in order to start the community intervention activities. MMIS visited the State MOH, State AIDS Control Agency (SACA), local government chairmen and traditional leaders to seek support for planned activities and familiarize them with MMIS activities within the LGAs. MMIS received support from the leaders, who pledged to ask community members to attend these sessions, which resulted in a high turnout for the planned activities.

- Between January and March 2006, MMIS/Nigeria continued to increase access to information to communities in Anambra and Edo States through multiple educations sessions. One educational session was held with community traditional leaders and the governing council in Ugor Community of Oredo LGA in Edo State. The focus of the session was to increase awareness on injection safety, especially reducing demand for unnecessary injections and discouraging reuse of syringes. MMIS also held two similar educational sessions with 109 women receiving antenatal and immunization services at the General Hospital in Onitsha LGA of Anambra State, as well as a session with 32 Parent Teachers' Association (PTA) members of the Anglican Girls Secondary School, Nnewi.

- In March 2007 in Edo State, MMIS held educational sessions with 90 community members in the Egor LGA and 50 members of the Oredo LGA. An educational guide was developed for this type of session consisting of information on health care waste management and promotion of oral medication. The draft manual was developed for community intervention and based on the

feedback received from the pre-test of the material, final comments will be incorporated and a review will be conducted to determine the manual's readiness for production in May 2007. As part of the activities to encourage participation, brainstorming and questions and answers were introduced to determine why individuals prefer injections to oral medication with a view of promoting oral medication where available. Also, the manual provides information to raise community awareness to encourage proper management of sharps waste in communities.

- MMIS/Nigeria attended the HIV/AIDS Summit Meeting to help plan HIV prevention in Nigeria and was given the opportunity to present on injection safety during the meeting. The MMIS team also worked as part of the Technical Planning Sub-Committee.

- MMIS/Nigeria distributed BCC materials for health facilities and educated health workers on the proper placement and use of materials during monthly supportive supervision. The BCC materials were circulated across project sites and PEPFAR-supported sites. Materials, including pamphlets on the nine rights of a safe injection, a job aid for waste managers, and 2007 table calendars with BCC messages for health professionals, were produced in November and December 2006 and distributed along with existing MMIS educational materials to health workers in the different districts of MMIS implementing facilities.

- MMIS/Nigeria advocated and supported the (FMOH) to ensure that injection safety is included in their workplan with appropriate budget allocations. As a result of this advocacy effort the Hospital Services and the National AIDS and STI Control Departments of the FMOH are actively planning to provide injection safety training and supplies in the six political zones.

- Based on the observations at the Aminu Kano Teaching Hospital of the high incidence of needlestick injuries among phlebotomists, the training and supportive supervision tool has been revised to include observation of laboratory technicians. MMIS/Nigeria is actively involved with the USG Quality ASSURANCE Technical Group and advocacy is ongoing on the issue needlestick injuries among phlebotomists.

Task 4: Establishing a Standardized System for Proper Sharps Disposal

- In March 2007, MMIS convened a 3-day workshop to engage the HCWM Technical Working Group in the development of a 5-year national plan to safely manage health care waste. During this workshop, funded by UNICEF, WHO, National Action Committee on AIDS (NACA), and MMIS/Nigeria, draft national HCWM guidelines were developed that outline the minimum national standards for safe HCWM practices in all health care facilities. The MMIS/Nigeria project successfully held a ratification workshop for the national health care waste management plan and national health care waste management guidelines in conjunction with the Federal Ministry of Environment Housing and Urban Development (FMEH&UD). The workshop resulted in a ratified national HCWM plan and guidelines. FMEH&UD, the World Bank through National Agency for the Control of AIDS (NACA), and UNICEF have all committed funds to support implementation of the plan.

- During the ratification workshop, the participants drafted a health care waste management policy document. MMIS/Nigeria will hold a workshop to validate the policy and will then produce and disseminate the documents and prepare the National Coordinators Office for implementation.

- MMIS/Nigeria has advocated for and provided technical assistance to various partners in waste management efforts in Nigeria. Activities included outreach to the European Union – Partnership for Reinforcing Routine Immunisation (EU-PRIME) for procurement of incinerators; the National Agency for the Control of AIDS (NACA) for support of the implementation of the National HCWM Plan; the Kano State MOH for inclusion of incinerators and segregation equipment in

their budget; and Lagos State Agency for Waste Management Authority (LAWMA) to help them sensitize their stakeholders in proper health care waste management activities in Lagos State.

- MMIS/Nigeria met with the Chief Medical Director (CMD) for LUTH for follow-up discussions on health care waste management issues. During previous MMIS visits, the CMD promised improvement of injection safety and waste management activities. MMIS learned from the CMD that orders had been made for segregation materials. Also during the visit, MMIS observed that the incinerator, for which MMIS advocated, had been installed and is able to handle a large volume of waste. The facility plans to be able to support the waste management of the facilities around it. Inputs were given for the location of an ash pit and the need to clear the area surrounding the incinerator site.

- MMIS/Nigeria provided technical assistance to the Lagos State Waste Management Authority (LAWMA) and the Edo State Ministry of Health to plan and implement its health care waste management strategy, which is in the initial phase of implementation. The effort has resulted in LAWMA procuring segregation materials for health facilities in Lagos State as well as plans for final medical waste disposal by incineration. MMIS/Nigeria continues to work with LAWMA to address challenges in the implementation of its health care waste management plan. MMIS/Nigeria is providing technical assistance in monitoring the HCWM approach as well as revising strategies as challenges emerge during implementation. The MMIS project also worked with the Refuse Management and Sanitation Board (REMASAB) in Kano to make the clinical waste department operational.

- MMIS/Nigeria worked closely with the Lagos State Waste Management Authority to plan and implement a HCWM plan and advocate for the special allocation of funds for managing medical waste.

- MMIS/Nigeria also increased the distribution of segregation materials, including color-coded pedal bins and liners and personal protective equipment (PPE) to facilities.

Task 5: Private Providers and the Informal Health Sector

- During this reporting period a literature review on the informal sector was completed and reviewed by headquarters and the USAID Local Mission in Nigeria. The document was approved by the Mission in late March 2006 and will be submitted to USAID Washington in late 2007.

Task 6: Policy Environment

- MMIS/Nigeria advocacy with the Director General (DG) of NAFDAC resulted in a declaration during the meeting of Nigeria Medical Association and the Nigeria Medical and Dental Council to replace standard disposable syringes with safety syringes in the country by August 2009.

- The National Policy on Injection Safety and Healthcare Waste Management was launched by the Minister of Health Professor Eyitayo Lambo in May 2007. The National Council of Health had earlier approved the policy during the 50th commemoration ceremony of the council in January 2007. Plans are being made with ENHANSE, a USAID-funded organization, to disseminate the policy in collaboration with MMIS and the Federal Government of Nigeria. The project is already distributing to stakeholders such as WHO,UNICEF , EU PRIME, ministries and focal states.

Task 7: Monitoring and Evaluation

- State facilitators were trained to use the injection safety supportive supervision tool in order to participate in the monitoring of trained health personnel in the focal facilities. The facilitators assisted in ensuring that knowledge and skills learned are being utilized to ensure improved injection safety in medical settings. MMIS consultants and staff also conducted periodic

monitoring visits and provided support to health care workers in need at the time of their visit. Supportive supervision was conducted in six states by the project's technical staff, training consultants, and the facilitators in the respective states that were trained to use the supportive supervision tool. One week a month is dedicated to carrying out this activity. Supervisory visits were conducted in facilities where the project is currently implementing interventions. A total of 171 supportive supervisory visits were made between January and March 2007. The information obtained was collated to allow for quick comparisons of sequential visits to a facility so that progress can be easily assessed and further interventions that may be necessary can be addressed.

- Supportive supervision is ongoing with the continuing supervisory visits by injection safety focal points, MMIS staff, and training facilitators. Between July and September 2007, supportive supervision visits were made to implementing facilities in the six focal states. One hundred and twenty two (122) facilities were visited. On-the-spot assessments were carried out to identify challenges which were solved jointly with facility management.

- Planning for the prescription record review study this period included investigating organizations to conduct an in-country ethics review of the study protocol. Information was also collected on existing record systems in order to select candidate facilities that meet criteria for conducting data collection. Preparation of documents for site-specific approvals has begun with seven facilities short-listed for the actual data collection. Final selection of the facilities will depend on these approvals in combination with the quality of the records. Data collection is currently scheduled to begin in the first quarter of FY2008.

- The data from the pilot follow-up survey conducted in June 2006 were re-entered where needed and the dataset was cleaned. Once this process was complete, MMIS sent the results for key indicators to the country team as input for the mid-term review process and informed USAID of the results on key indicators. The draft report is now undergoing a complete technical review, which is expected to be completed in the first quarter of FY2008.

Challenges

One of the primary challenges faced in training is the frequent turnover of staff either through redeployment or new appointments. This makes it difficult to have all staff of a facility trained at the same time and practicing injection safety and proper health care waste management. One of the ways the project is addressing this problem is to focus on training staff in a facility completely as well as other staff in the sister facilities where transfers could be made. Also, MMIS/Nigeria is conducting on-the-job training during monthly supportive supervision visits as appropriate.

The large size of the country and complex nature of the health care delivery system are major challenges. Also, the unstable political environment at different times in the country has made it impossible for training to be conducted in some states. Additionally, in some states, the National Immunisation Days (NIDs) led to cancellation of trainings because a substantial number of health workers were involved in the campaign. To overcome these constraints, trainings were conducted concurrently in states, thus making use of as many facilitators as possible. Tentative schedule for NIDs in MMIS focal states were obtained and training is being planned around them.

Also, the absence of segregation materials in most facilities has made it difficult for health workers to comply with proper segregation of medical waste; the project is unable to meet the high demand of segregation materials. Another major challenge is the absence of treatment (for final disposal of waste) options in some of the scale-up states. However, the project is collaborating with the Lagos State Waste Management Authority to supply segregation materials to facilities and advocating policymakers and heads of facilities for provisions of segregation materials. In the same vein, MMIS is in discussions with the Commissioners of Health to encourage affordable treatment options be put

in place. This has led to the approval of three incinerators in Edo State. MMIS is also facilitating the process and advocacy for the following documents - The National Health Care Waste Guideline and Plan as well as draft HCWM Policy, which are almost completed and will help GON implement proper waste segregation.

UGANDA

The MMIS project has continued to work with the Ministry of Health (MOH) and its stakeholders to improve the working environment of health workers and the safety of clients through the rapid reduction of unsafe and unnecessary injections. In 2007, MMIS Project interventions were expanded to 5 additional districts (containing 236 facilities), 2 national referral hospitals and 7 major medical training institutions. Project interventions which now cover a total of 25 of 80 (31%) districts nationwide, have improved the knowledge and skills of injection providers through training, on-the-job supportive supervision, and exchange visits between units and facilities. This reporting period, special consideration was given to health training institutions and referral hospitals in order to strengthen injection safety training in these institutions. To comprehensively address the needs of the training institutions and schools and increase sustainability of the efforts, WHO technical support was solicited.

The project has created public awareness through radio messages, village health team door-to-door education of households, drama shows, film shows, and radio talk shows. Local political and civic leaders were involved in most of the awareness activities, signifying significant local support and buy-in for improved injection practices to prevent HIV transmission. Key messages that emphasized the efficacy and cost effectiveness of oral medications not only reduced the unnecessary use of injections but also played a role in emphasizing compliance with drugs including compliance with ARVs.

A lot of advocacy and resource mobilization for HCWM was conducted among stakeholders. This has resulted into more partners buying in to support this area.

Towards the end of Year 3, MMIS/Uganda compared the project's progress in implementation with set targets. This exercise included review of training coverage both in training institutions and within health facilities, as well as the training's effect on health worker performance.

The project also supported the MOH in preparing for the national switch to syringes with re-use prevention features in curative care settings by providing technical assistance with assessing training needs, quantifying logistics requirements and designing awareness campaigns for both the public and the health workers.

Task 1: Commodity Management and Procurement

- The Ministry of Health passed and launched a policy recommending the importation/manufacture of syringes with re-use prevention features for use in the country. This policy is now operational and is a significant step in ensuring national sustainability of safe injection commodities.
- A total of 9,933,700 syringes and 119,400 safety boxes were distributed during this reporting period. Auto-disable syringes were introduced in the Kampala, Kayunga, Luwero, Wakiso and Kabarole districts by teams of central supervisors. The introduction included demonstrations and practice with using the devices. Most of the health workers in these districts had already received training on the safe injection devices, creating a smooth transition to the new technology.
- To facilitate safe disposal of medical waste at total of 2,345 pedal-operated waste bins, 1,034,800 bin liners to MMIS districts and 1,000 pairs of gumboots and 2,300 heavy-duty gloves were procured and distributed to MMIS expansion districts.
- In preparation for the nationwide switch from standard disposable syringes in July 2007, training materials for the rapid introduction of syringes with re-use prevention features were developed in collaboration with the MOH. New AD syringes, which are now available in National Medical

Stores, were introduced in all MMIS districts using the newly developed training materials. Weekly stakeholders meeting aided the preparation leading up to the implementation of the national policy.

- The MMIS/Uganda team conducted a six-month assessment on the consumption of needles and syringes (from October 2006 to March 2007) using data from four project districts of Mpigi, Mbale, Ibanda and Bududa. Results of the data analysis showed an average consumption per person per year to be 1.86 with a reporting rate of 83%. The results also showed a syringe consumption mix of approximately 45% for the 2ml, 45% for the 5ml and 10% for the 10ml. The data from the private sector from the districts of Ibanda and Mbale districts was not included in the results because of very poor reporting rates.

- During April 2007, a workshop for records assistants from Mbarara district was held in a bid to sensitize them on their role in supporting reporting requirements for injection safety commodities.

- Logistics review meetings were held in Yumbe, Pallisa, Mbale, and Nebbi districts in order to review the challenges of logistics management in the districts. The meetings targeted persons in charge of health units, who brainstormed on solutions to some of the challenges that had been identified. Poor reporting rates for monthly consumption was one of the problems raised. Participants were re-oriented on proper filling of the forms and they pledged to improve the reporting rates.

- A total of 681,000 syringes were procured through TATA Uganda Ltd., a local agent representing Hindustan Medical Devices (HMD) of India. This in-country procurement was made to cover demand (for October-December 2006) while awaiting commodities from overseas. In January 2007, 4,726,800 syringes and 84,150 safety boxes arrived in country. However, only four of the eleven containers were delivered to the National Medical Stores (NMS) due to lack of storage space there. The remaining containers have yet to be delivered from the ICD in Kampala.

- The MMIS Senior Logistics Advisor visited Uganda in March 2007 to provide technical assistance to the MMIS/Uganda team and MOH departments on logistics strategies to ensure a smooth transition to country-wide use of syringes with re-use prevention features in the curative sector. Additional assistance included working with MMIS/Uganda and the MOH in forecasting injection device demand based on consumption data collected. MMIS/Uganda's Logistics Advisor also received support to improve reporting of logistics data for in-depth analysis of consumption.

- Training sessions on best storage practices were held in selected districts stores such as Ibanda, Isingiro, Kiruhura and Pallisa and recently Mbale to improve on their storage capacity.

Task 2: Capacity-Building and Training

- During August 2007, a workshop was held in Jinja for a team of 30 central trainers on how to train district trainers. During the workshop, the participants' skills in training were improved and lesson plans for training district trainers were developed. Materials for training were reviewed and updated. The updated materials were then mass produced in preparation for the training of district trainers.

- Between July and September 2007, a training-of-trainers on injection safety was conducted in the 5 expansion Districts of Masindi, Mityana, Mikono, Sironko and Soroti and mop-up training was conducted in the Kabale and Kampala Districts.

- MMIS worked closely with the MOH and Sino Africa (suppliers of AD syringes to National Medical Stores) to introduce AD syringes in the 4 districts of Namutumba, Jinja, Tororo and Masaka. Using central trainers trained by MMIS, health workers were taught how to properly use

AD syringes. The trainers used this opportunity to introduce the concept of waste segregation as well.

- Due to limited funding, the project will not be able to offer Phase 3 districts training on reduction of unnecessary injections. However, the course will be offered after funds become available.
- During April 2007, a curriculum review was conducted with the Mbarara National Referral Hospital and Mbarara University of Science and Technology. Injection safety and infection prevention and control were incorporated in the pre-service training curricula for medical students. Guidelines for the orientation sessions for 3rd year and 5th year students were developed and are already being used in the hospital.
- A joint review meeting to evaluate the progress of incorporating injection safety into health training institutions' pre-service training curricula was conducted in April 2007. Participants included representatives from the Ministry of Health, MMIS, WHO/AFRO, the Ministry of Education and Sports, and tutors from the health training institutions. Technical assistance for the review process was provided by WHO/AFRO.
- In order to ease the adaptation of new policies in the education sector, the MOH should develop guidelines on how to operationalize new policies on injection safety in the education sector. The guidelines should highlight new information and what new skills are expected of students so that the tutors can easily assimilate and pass on new information to the trainees. The developed guidelines should then be actively handed over to the MOES for dissemination to the schools.
- Kabale Dstrict has been slow in completing training in the district. Several discussions have been held with the District Director of Health Services and the injection safety focal person. The numerous facilities in the district are difficult to reach because of impassable roads. The director, however, committed completing training by the end of July 2007, including the training of students in the training schools.
- Health workers in FY 2006 expansion districts of Kampala, Mulago, Kayunga, Luweero, Wakiso and Kabarole received injection safety training. Courses were conducted in the Phase 2 districts of Hoima, Mbale, Yumbe, Kabale and Manafwa and aimed to reduce unnecessary injections. A few of the new districts that resulted from redistricting were given an opportunity to conduct mop up training for their newly recruited health workers.
- Between January and March 2007, efforts focused on training health workers in expansion areas and within health training institutions. A total of 2,160 health workers were trained during this period.
- Of those trained, 247 were students in pre-service training. During the training sessions, copies of the injection safety policy and norms and standards were widely distributed to the trainees. The training was conducted jointly by teams of central trainers and selected clinical managers at the various health units. Whenever possible, the district injection safety focal person was involved to give him/her exposure to the heath workers for better understanding of their concerns and to facilitate acceptability of his/her guidance during follow-up supervision.
- Districts received assistance in utilizing data collected during supervision. This activity was conducted by central and district supervisors as part of the quarterly supervision exercise. The health facility-based health workers were encouraged to solve service delivery-related problems through clinical staff meetings. Empowering health workers to problem solve is an important step towards sustainability.
- Health unit store managers were given on-the-job supportive supervision to emphasize correct completion of logistics record keeping documents. This exercise proved useful because it addressed

individual personnel training needs and is expected to result in improved forecasting and record keeping, further reducing the number of stock outs.

- The project has continued to work with WHO, CDC, Blood Bank, MOH, District Health Offices, UPDF and political leaders at all levels. WHO is supporting districts in northern Uganda, while CDC is supporting 10 districts in different regions. Baseline assessments have been conducted in the CDC districts and findings will soon be shared. Meetings with Blood Bank officers resulted in the institution and MMIS agreeing to collaborate to scale up injection safety training within the transfusion services.
- Approximately 600 drug distributors from 6 sub-counties were sensitized on injection safety issues by Village Health Teams (VHTs) trained through MMIS.
- Over 300 health care waste handlers were trained in the expansion districts. The trainings were conducted in local languages using translated versions of the English waste management module. The module has been translated into seven local languages.
- Eight (8) districts completed their training of waste handlers reaching a total of 740 participants. Roles and responsibilities of the waste handlers were reviewed with the participants. The high turnover of this cadre of staff in most of the facilities has hampered the capacity building initiative, especially in faith-based facilities.
- Training and coverage data for MMIS activities in Uganda is summarized in the following tables.
- To date, facilities in 25 of 80 districts nationwide (31%) are covered with MMIS interventions. For details on coverage by region, please refer to Table 23.

Table 23: Uganda district coverage nationwide as of September 30, 2007

Region	Districts covered by MMIS to date	Total districts nationwide
Western	3	9
Southwestern	5	10
Eastern	7	24
West Nile	2	7
Central	8	17
Remaining regions (2)	0	13
National coverage	**25**	**80**

Table 24: Facility coverage in Uganda as of September 30, 2007

Region	Facilities covered to date[1]	Total facilities in MMIS districts[2]	Proportion covered by MMIS to date
Western	176	176	100%
Southwestern	278	278	100%
Eastern	208	208	100%
West Nile	72	72	100%
Central	558	1208	46%
TOTAL	**1,292**	**1,942**	**67%**

[1]Facilities include hospitals and lower level facilities of all ownership types: public, private, NGO, FBO.
[2]Total facilities in MMIS districts have been updated with the addition of facilities in 5 new districts.

Table 25:Population coverage in MMIS/Uganda districts as of September 30, 2007

Region	Population covered by MMIS to date	Population by MMIS region[1]	Percentage covered by MMIS to date [2]
Western	1,051,353	3,400,692	31%
Southwestern	1,670,953	3,627,040	46%
Eastern	2,114,948	7,023,310	30%
West Nile	788,335	2,242,824	35%
Central	3,869,278	7,456,799	52%
Remaining regions (2)	0	3,732,859	0%
Population coverage in regions where MMIS has started to work	**9,494,867**	**27,483,524**	**40%**

[2]Population coverage is calculated as 50% in districts where all public hospitals have MMIS interventions and 100% where all public facilities, including lower level, have MMIS interventions.

- Injection safety training activities in Uganda have been separated into two categories, injection safety and rational injection use. Injection safety training is offered when MMIS initiates work in a district. Rational injection use training has been conducted as funding permits and is a mechanism to permit an in-depth focus on prescribing practices. These training workshops included some of the same health personnel already trained in injection safety although the subject matter is different and training workshops occur in different years. For this reason, both types of training are counted in Table 26. In order to avoid double counting the same individual health workers over time, however, MMIS has not included the rational injection use training in the cumulative life-of-project total presented in Table 27. For details please refer to Tables 26 and 27.

Table 26: Number of persons trained in Uganda by category (July - September 2007)

Training category	Persons trained by MMIS this period
Training of Trainers	130
Injection Safety	1,809
Logistics	27
Waste management	338
TOTAL	**2,304**

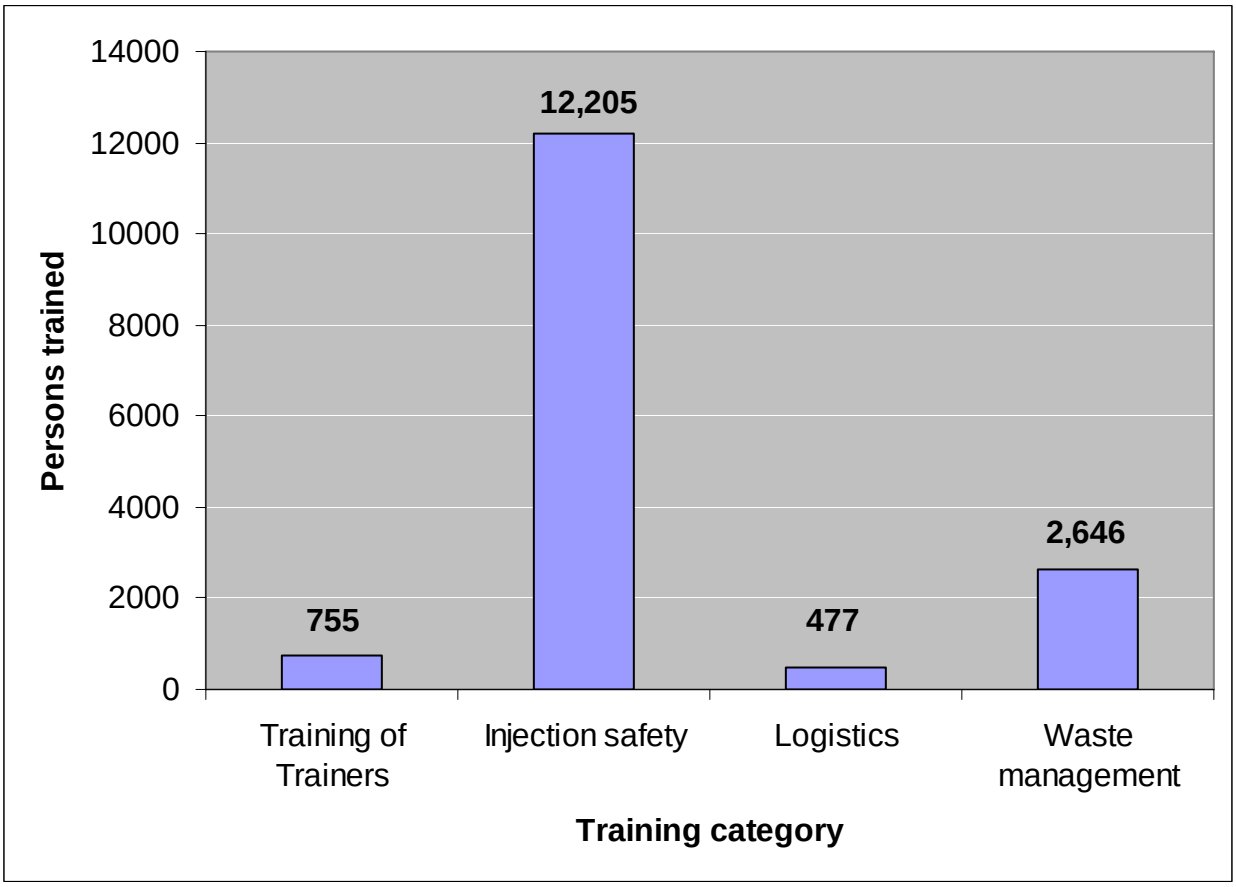
- In addition to persons counted in Table 26 health workers in one additional CDC and four Sino-Africa-supported districts in Uganda were trained by CDC & Sino-Africa using MMIS-trained trainers and MMIS training materials.

Table 27: Cumulative number of persons trained in Uganda by category as of September 30, 2007

Training category	Persons trained by MMIS to date	Total health workers targeted	Proportion MMIS trained to date
Training of Trainers	755	755	100%
Injection safety[1,2]	12,205	14,213	86%
Logistics	477	908	53%
Waste management[3]	2,646	1,744	152%
TOTAL	**16,083**	**17,620**	**91%**

[1]Injection safety training includes training on interpersonal communications.
[2]Total health workers targeted for injection safety training has been updated based on new estimates for the number of students in the 25 districts MMIS is currently working in.
[3]Due to high turnover of waste management personnel, the proportion trained may exceed 100%.

Figure M: Uganda cumulative training as of September 30, 2007



Task 3: Behavior Change and Advocacy

- In response to a recommendation by the midterm review team, the project sought opportunities to involve political leaders at sub-county level in mobilizing communities. Awareness meetings were conducted in the Mbarara Dstrict with 251 sub-county leaders with the purpose of giving the leaders accurate information to pass on to communities. The political leaders were eager to learn and have already started talking about injection safety during their interactions with the communities.

- MMIS educational materials including posters, leaflets, and participants notes were distributed by the MOH and other stakeholders beyond MMIS districts during the rapid introduction of ADs.
- During April and June 2007, local council leaders of the Kampala Central Division, Makindye, Manafwa, and Kabarole were sensitized on the injection safety project by the BCC Advisor, the District Health Officers of these districts and the focal persons. District leaders identified their roles in injection safety promotion and monitoring.
- MMIS/Uganda organized and conducted 5 television talk shows to explain the new policy for stipulating nationwide use of AD syringes. The shows featured district personnel from the project districts, UNEPI officials, NDA, Ministry of Health (The Commissioner for Clinical Services and the Assistant Commissioner for Health Promotion) and the MMIS BCC Advisor.
- Training for village health teams (VHT) community drug distributors in Wakiso and Kayunga Districts was conducted. Wakiso continued to train VHTs in another 4 sub-counties while Kayunga has completed all of their training. Kayunga now has 273 members of the VHTs trained while the Wakiso training is on going. The VHT members have been sensitizing communities on the correct treatment procedures with special emphasis on treatment via oral medication.
- The communities of Isingiro, Mbarara, Manafwa, Mbale, Kabale, Hoima and Nebbi were sensitized on injection safety using radio talk show programs on local FM stations. The district focal persons, the district health educators and some local politicians participated in the shows. Communities responded to the shows well and raised a number of questions, which were answered by the panelists but are also being compiled into a question and answer booklet for other readers.
- Health education talks were conducted in the district primary and secondary schools in Nebbi (20 schools) and Mpigi (36 schools). This was done in conjunction with the district education offices and brought out a number of issues on injection safety that are being addressed by the district health teams. This initiative includes sensitization of the school nurses on injection safety and provision of some syringes to some of the larger boarding schools.
- Drama shows have been held in Kabale, Hoima, and Mpigi Districts. The groups have helped educate their communities on injection safety to reduce demand for injections. Drama groups have been identified in the Districts of Kabarole, Wakiso and Kayunga. Kayunga and training for all their drama groups has been completed, with the remaining districts currently preparing for their training.
- Brochures on the switch to AD syringes for the general community and other stakeholders were developed and produced. These are designed to raise the profile of injection safety and provide information on the switching process to the community and importers of syringes. They were distributed during the national launching of syringes in July 2007; others will be distributed by the National Medical Stores.
- Leaflets that provide information to the health workers on the switching process were developed and produced and distributed during the rapid training that was conducted by the MOH.
- The MMIS Regional BCC Advisor, as well as MMIS/HQ BCC Team, provided technical assistance to pilot the use of interactive group discussions to help prescribers gain insight into factors that affect the use of injections in communities. The approach will be used as an additional strategy to further reduce injection use in districts and sub-counties that continue to prescribe high rates of injections or where the demand for injections by the community is high.
- A problem solving sustainability tool was introduced to help service providers analyze and solve problems at their health facilities by choosing solutions available in their working environment.

The tool is still in its preliminary stages of development, but it is hoped that it will be ready for use by late fall 2007.

- Between August and December 2006, twelve radio stations broadcast five messages per day explaining the benefit of oral medications in the treatment of common conditions in MMIS's intervention districts. Anecdotal reports suggested a reduced desire for injections and followed the treatment schedules given especially for COARTEM (an oral alternative) in the treatment of malaria following the messaging.
- The BCC Advisor and the MOH Health Educationist participated in the National Health Assembly and Joint Review Mission (JRM) sponsored by the MOH. New injection devices were demonstrated to assembly participants, complemented by a video on injection safety and distribution of educational materials.
- MMIS/Uganda, in coordination with the MOH and MMIS/HQ, developed a creative brief and outlined a draft to be used in flip chart presentations for community education by the VHTs. The chart will be pre-tested among some VHTs in Mpigi and Wakiso Districts and will later be translated into 8 major local languages before distribution when funding becomes available.
- A wall chart showing the correct procedures in giving an injection has been finalized. The chart is intended to be a highly visible and readily available reference material for injection providers. The chart will be printed once funding becomes available.
- The Commissioner for Health Services and MOH's Senior Pharmacist conducted a phone-in talk show on Uganda Broadcasting Television in January 2007. The talk show educated viewers on plans for the national switch to syringes with re-use prevention features.
- In commemoration of World AIDS Day, articles on the success of injection safety interventions in Uganda were published in the New Vision and Daily Monitor (the country's leading English dailies). With these articles, communities were educated on the acceptability and use of auto-disable syringes in the curative sector.
- District civic leaders and Heads of Departments in Wakiso (30), Kayunga (20) and Kampala (11) were sensitized on injection safety. During the meetings, the leaders' roles in promoting injection safety were identified, and the district leaders committed themselves to support and promote injection safety interventions.
- MMIS/Uganda worked closely with the district medical officers to create awareness of the dangers of unsafe injections among Councilors and Heads of Departments in Kampala and Luwero Districts through council meetings. Most of the awareness sessions focused on agreeing to the leaders' roles, with total of 170 and 60 officials from Kampala and Luweero respectively attending the sessions.
- The MMIS/Uganda BCC Advisor and the acting District Health Educator (DHE) Mbale, participated in community film shows about injection safety in February and March 2007. Communities were educated on the advantages of oral treatment for common conditions and the need to demand new syringes when being given injections.
- A total of 600 and 1,200 members of the village health teams in Wakiso and Kiruhuura respectively were educated on the dangers of unsafe injection practices. The trainees from Wakiso were drawn from 6 sub-counties and also double as drug distributors. These are now available to educate communities on the value of tablets, and the benefits of seeking treatment early. Training teams included MMIS staff and members of the district health teams.

Task 4: Establishing a Standardized System for Proper Sharps Disposal

- A waste management review meeting involving health unit managers, in-charges of Health Sub-District (HSD), and environmental health staff at district and HSD levels was conducted in Kabale District to coordinate mechanisms to ensure timely distribution of waste management commodities. The role of immediate supervisors in enforcing proper waste management was emphasized, and participants were given refresher sessions on how to segregate and safely manage infectious waste. Reports on waste pit utilization were given by the environmental health staff and clarifications were made as to which waste should be disposed of in the medical waste pits.

- 278 waste handlers were trained at Health Sub District level in the Kampala District during July 2007. Issues addressed during the training included staff attrition and waste segregation, and the dangers of poor handling of health care waste were discussed in detail. That same month, 87 health care waste handlers were trained in Mbuya and Bombo military hospitals.

- Twenty health care waste pits were completed in the districts of Kayunga and Manafwa. The installation was supervised by the district Engineers and environmental officers. Segregation posters were distributed to all units where pit installation was completed as a strategy of enhancing segregation of waste and therefore appropriate utilization of the pits. In addition sixty new medical waste pits are now in place in 6 of the project districts (10 each). Waste handlers in these districts were oriented on how to safely handle infectious waste, including the proper maintenance of the medical waste pits.

- In order to make training of waste handlers sustainable, participants suggested that the contracted firms should routinely train hired staff before deploying them. Companies without training programs in the future will not qualify to bid.

- District HCWM and logistics review meetings were conducted in 5 districts (Kabale, Nebbi, Yumbe, Budaka and Manafwa). The roles and responsibilities of different health workers were discussed. Among the key issues discussed were, stock outs of commodities and how these can be eliminated, improving on the job training for newly recruited staff, submission of monthly and quarterly consumption forms, and using credit line funds to order injection and waste management commodities.

- Discussions continue with the AIDS Information Centre (AIC) and the Infectious Disease Institute (IDI) in Mulago, since limited progress has been made to support the units handling infectious waste in final disposal. IDI staff felt that since they treated patients on behalf of Mulago Hospital, the hospital should take care of the waste. IDI managers promised to hold joint HCWM Meetings with Mulago to improve the situation.

- USAID/Uganda is in discussion with MMIS to provide technical assistance to PEPFAR partners who generate infectious waste. Partners who generate infectious waste will be expected to devote a portion of their PEPFAR funds for HCWM activities.

- Between April and June 2007, 32 health care waste pits were completed (10 in Manafwa, 12 in Pallisa and 10 in Kiruhura). The close supervision conducted by the district health teams and the district engineers helped to ensure that the construction conformed to the required standards.

- The students of Ibanda nurses training school were trained in health care waste management in addition to routine training on injection safety.

- The 5 new districts (Kayunga, Kampala, Luwero, and Wakiso) received color-coded, foot-operated waste segregation bins. Local dealers in metals works who can do minor repairs on the waste bins have been identified. The project intends to link the dealers with district managers so that their services can be easily obtained if any of the waste bins happen to malfunction.

- Initially, over 300 needle cutters in the districts of Hoima, Kabale, Nebbi, and Yumbe were collected and serviced at their respective HSD office. Following this exercise, needle cutter servicing was extended to 8 districts (Bududa, Manafwa, Pallisa, Mpigi, Mbarara, Ibanda, Isingiro and Budaka). This exercise assisted in building the capacity of districts and HSDs on servicing needle cutters.

- During January to March 2007 health workers in 8 districts had refresher training in health care waste management as part of the Phase I injection safety training. Central trainers supported district training teams in training lower-level health workers. On-the-job trainings were conducted to shorten the time commitment of health workers and improve accessibility and relevance to their work environment.

- Twenty (20) health care waste pits were completed in Mbale and Kabale Districts. The final inspection of the pits was carried out by a joint team that included the district engineer and the MMIS waste management advisor. Additionally, ten new pits will be put in place in each of the districts of Kiruhura, Pallisa, Manafwa and Bududa.

Task 5: Private Providers and the Informal Health Sector

- MMIS/Uganda continued to work closely with private sector providers by offering free training courses for health workers in these institutions. Between October and December 2006 midwives in private practice in Kampala received training courses and manuals for prevention of disease transmission through unsafe injections.

- A literature review on the use of injections and of sharps' in procedures within the informal sector was finalized, and a review by the USAID mission in Uganda was completed. The final document will be submitted to USAID/Washington in late 2007. This literature review is intended to serve as a tool for planning interventions that improve practices in the informal sector.

Task 6: Policy Environment

- MMIS is working closely with the MOH to finalize the statute on immunization of health workers. The statute is awaiting approval by parliament.

- MMIS/Uganda is working with MOH and WHO to collect current data that will be used in the formulation of national work plans and guidelines on HCWM.

Task 7: Monitoring and Evaluation

- The project conducted joint supervision visits with MOH officials. Data for the midterm evaluation was collected in the Hoima, Kabale, Yumbe, and Mbale districts. Findings were disseminated in a stakeholders meeting in July 12, 2007. The recommendations from the meeting will be used as the basis for further planning. Findings at midterm showed a noticeable improvement in practices with the number of health workers reporting needle stick injuries falling from about 33% at baseline to 7% in all the participating districts, a finding which exceeded the midterm target of 10%. 93% of the health units had no loose infectious sharps in open or overflowing containers inside or outside the facility at the time of the supervision visits, a marked improvement over the 48% found at baseline. Stock outs of syringes are less prevalent and 100% of the injections observed were given with a new needle and syringe from a sealed sterile pack.

- The draft report by the local consultants on the Rational Injection Use (RIU) study was revised and sent to MMIS in October 2006. At that time, during the review, it was noted that the analysis of diagnostic groups was missing a large number of cases that had not been assigned to any group.

From January to February 2007, MMIS worked on developing a grouping system for a more robust analysis. This was completed at the end of February and sent to Uganda for local review and to USAID for approval. A consensus has emerged on the groups to use and the dataset has been updated accordingly. The process of adding the analysis of results by diagnostic group to the draft report is underway.

- MMIS/Uganda and the MOH have continued to offer on-the-job supportive supervision to health workers. Supervision reports show that there is progressive improvement in practices. Re-use of injection devices is no longer evident, and record reviews reveal a positive change in prescribers' practices, showing significant reductions in the number of injections prescribed. The practice of waste segregation has markedly improved, with smaller health units performing better than large hospitals. Among the larger hospitals, the NGO facilities show better performance compared to the government health units. Different departments within the large hospitals have different levels of performance that are closely related to the interest of the immediate supervisor in the injection safety initiative.
- Supportive supervision visits demonstrate safety has also improved, with 80% of health units reporting no stock outs of needles and syringes compared to 59% at baseline. In Kabale District, consumption rate for syringes was noted to be very low. This was also reported from most of the project districts in Western Uganda.
- MMIS participated in the supervision of the implementation of a mass measles campaigns with the aim of evaluating the safety of injections given during the exercise.
- MMIS also collaborated with ORC MACRO and the Mission in providing questions on injection safety for a Service Provision Assessment (SPA) which began in June 2007.

Challenges

As the project completed its third year of implementation, the specific injection safety needs of different health units have changed, making general planning at district level less effective in solving individual facility problems. For this reason, MMIS will be facilitating problem-solving meetings at individual health units focused on improving the capacity of these individual units to sustain improvements in safe practices.

The districts in the eastern part of the country suffered stock outs of commodities due to failure of National Medical Stores (NMS) to deliver the commodities on schedule. The project has had discussions with the general manager of NMS who has promised to take this up with the distribution unit. Apparently NMS is experiencing transport constraints as some of the vehicles were reported to be experiencing mechanical breakdowns.

Supervisors have reported an increasing number of new recruits in the initial districts who need to be trained. The high turnover of staff in the faith-based organizations is an issue of concern. Most of the health workers that were trained left and have been replaced with new staff. It has been agreed between MMIS and the districts that regular Continuing Medical Education be conducted as a way of bringing new recruits on board.

ANNEX I: JSI/MMIS ANNUAL FINANCIAL MONITORING REPORT AS OF 30 SEPTEMBER 2007

JSI/MMIS ANNUAL FINANCIAL MONITORING REPORT

Implementer: John Snow, Inc.
Contract Number: GHS-I-00-03-00026-00
Contract Period: February 26, 2004 – September 30, 2009
Approved Budget Ceiling: $56,824,216
Total Amount Obligated To-Date: $30,382,868
Cumulative Expenditures/Accruals To-Date (9/30/07): $25,962,535 (see table below)
Funds Remaining in Obligation (9/30/07): $4,420,333
Time Remaining in Contract: 24 months

Cumulative Expenditures/Accruals Report (9/30/07)

- Indirect cost total $952,353; Direct costs total $25,010,182

Line Item	Budget	Admin	Ethiopia	Mozambique	Nigeria	Uganda	Total
Workdays Ordered	$6,115,807	$1,106,049	$277,488	$721,770	$841,422	$571,357	$3,518,085
Other Direct Costs	$47,491,944	$3,819,902	$3,213,215	$2,453,747	$6,243,989	$5,244,020	$20,974,873
Fee	$3,216,465	$295,557	$209,442	$190,531	$425,125	$348,923	$1,469,577
Total	$56,824,216	$5,221,508	$3,700,145	$3,366,048	$7,510,535	$6,164,299	$25,962,535*

Summary of Program Activity Expenditures per Country (Oct 06 – Sept 07)

Program Activity Area	Ethiopia	Mozambique	Nigeria	Uganda
Commodity Supply Management	$237,121	$12,702	$96,178	$368,964
Capacity Building & Training	$257,852	$71,139	$389,823	$199,091
Advocacy/BCC	$11,170	$21,510	$79,699	$253,175
Waste Management	$21,289	$183,775	$22,116	$151,438
Informal Sector	$2,369	$11,074	$0	$332
Policy Environment	$0	$20,664	$3,930	$1,619
M&E	$4,389	$39,160	$23,879	$130,078
Commodity Procurement*	$1,022,792	$0	$1,342,986	$1,085,821

*Injection safety commodities are procured through our subcontractor, PATH, and shipped to the respective countries. All costs associated with in-country clearance and distribution of commodities are included in the Commodity Supply Management program activity line item.

Financial Status as of 9/30/07
Below is a table of obligation increases provided to MMIS through contract modifications since the beginning of the project.

Obligation	Obligated in USAID FY	Date of Modification	Amount
1st Obligation	FY04	February 26, 2004	$3,932,002
2nd Obligation	FY05	March 21, 2005	$2,153,439
3rd Obligation	FY05	July 25, 2005	$11,786,925
4th Obligation	FY06	May 1, 2006	$10,999,904
5th Obligation	FY07	July 10, 2007	$1,510,598
6th Obligation	FY08	May 08???	???
Cumulative Obligation			**$30,382,868**

The FY07 obligation was much lower than expected. The FY07 COPRS planning level was $11,342,317. JSI's FY07 obligation of $1,510,598 was roughly 13% of that COPRS planning level. We have been informed that the current funding (including the FY07 obligation) should last the project until the end of May, 2008, when FY08 funding is expected to become available.

Based on these funding constraints, we revised our country level and HQ budgets to stretch existing funding until May 08. This results in an estimated 80% cut in program activity at the country level. This affect has been reflected in the workplan revisions.

The remaining funds in our pipeline ($4,420,333) have been programmed at the HQ and country level through the end of May 2008. Should JSI not receive any notification of funding before then, we will be forced to consider closing out project activities.

Estimated Financial Needs for Next Year (FY08 funding)
The FY07 funding reduction has had, and will continue to have, a dramatic affect on the level of program implementation and achievement of results. We are hopeful that the level of FY08 funding will be sufficient to bring the project back to the pre-reduction level of implementation required to achieve the results and deliverables established in our original task order.

Based on the full level of annual funding received during FY06 ($10,999,904), MMIS roughly estimates a need of $14,666,539 to last the project until the contract end date of September 30, 2009. This assumes FY08 funding would become available June 1, 2008.

Plus Up Funding
Several USAID/Missions have committed financial resources through Plus Up funding. In Uganda, the Mission has committed $300,000 for program use in the area of waste management. In Nigeria, the Mission has also committed $1,433,291 in resources for MMIS in-country use. Field support through our Track 1 task order was possible because FY07 funding was lower than expected and the FY07 ceiling had not been reached.

ANNEX II: INVENTORY REPORT AS OF 30 SEPTEMBER 2007

John Snow, Inc.
Making Medical Injections Safer (MMIS) project
Contract #: GHS-I-00-03-00026-00

INVENTORY REPORT
as of 9/30/07

Item description	Model	Serial #	Manufacturer	Vendor	Purchase Date	Cost (US$)	Location	Condition
Ethiopia Office								
Conference Table	TS-CSD823	407	imported	Technostyle	Dec-06	$646	Addis Ababa, Ethiopia	Good
Desktop Computer	DELL optiplex GX 270	00043-513-428-473	DELL Inc.	Next Computer Technology	Jun-04	$1,561	Addis Ababa, Ethiopia	Good
Desktop Computer	DELL optiplex GX 270	00043-513428-475	DELL Inc.	Next Computer Technology	Jun-04	$1,561	Addis Ababa, Ethiopia	Good
Desktop Computer	DELL optiplex GX 270	00043-513-428-356	DELL Inc.	Next Computer Technology	Jun-04	$1,561	Addis Ababa, Ethiopia	Good
Desktop Computer	DELL optiplex GX 270	00043-516-761-017	DELL Inc.	Next Computer Technology	Jun-04	$1,561	Addis Ababa, Ethiopia	Good
Laptop Computer	PSA40E-08M7W-G3	24829614G	Toshiba	Next Computer Technology	May-04	$2,197	Addis Ababa, Ethiopia	Good
LCD Projector	300digital 12654937			Genius Trading	Jun-04	$2,162	Addis Ababa, Ethiopia	Good
Laptop Computer	PP10L	CN-OH2049-48643-4AR-2169	DELL Inc.	Alta Computec	Jan-05	$2,069	Addis Ababa, Ethiopia	Good
Laptop Computer	PP10L	CN-OH2049-48643-4c4-1996	DELL Inc.	Alta Computec	Mar-05	$1,788	Addis Ababa, Ethiopia	Good
Laptop Computer	PP10L	CN-OH2049-48643-4C4-1461	DELL Inc.	Alta Computec	Mar-05	$1,788	Addis Ababa, Ethiopia	Good
Printer	HP2460 Laserjet	CNFJF48739	HP	Snap Traiding & Plc	Mar-05	$965	Addis Ababa, Ethiopia	Good
Digital Camera	Powershot A95/PC1099	336331748	Canon	Gellatley Hankey Co.	Aug-05	$578	Addis Ababa, Ethiopia	Good
Desktop Computer	DELL Opliex GX280/ DHM	6MOPQ1J	DELL Inc.	Alta Coputec	Sep-05	$1,261	Addis Ababa, Ethiopia	Good
Laptop Computer	DELL Latitude 110L		DELL Inc.	Alta Computec PLC	Oct-05	$1,707	Addis Ababa, Ethiopia	Good
PhotoCopier	G225/F139800	USC07077	Canon	Gellatley Hankey Co.	Oct-05	$1,156	Addis Ababa, Ethiopia	Good
LCD Projector	Sony VPL-CS7		Sony	Jupiter Trading	Aug-06	$1,832	Addis Ababa, Ethiopia	Good
Desktop Computer	Dell Optplex	CN-0FC529-72872-64E-3JS	Dell	Alta Computec	Nov-06	$1,109	Addis Ababa, Ethiopia	Good
Laptop Computer	Dell Latitude 120c,PP21L	CN-ORJ272-70166-67H-00EH	Dell	Alta Computec	Jul-06	$1,629	Addis Ababa, Ethiopia	Good
Laptop Computer	Dell Latitude 120c,PP21L	CN-ORJ272-70166-67H-0052	Dell	Alta Computec	Jul-06	$1,629	Addis Ababa, Ethiopia	Good
Motor Vehicle	Toyota LandCruiser St. Wagon LWB	**VIN#:** JTECB01J00-1024111	Toyota	Red Sea Automotive SAZF (MOENCO)	Oct-05	$30,217	Addis Ababa, Ethiopia	Good
Mozambique Office								
LCD Projector	VPL-CS6	40814	Sony	Byte & Pieces	May-04	$2,369	Maputo, Mozambique	Broken
Photography Machine	5500 Digital		Fuji	Game	Nov-05	$673	Maputo, Mozambique	Good
New Server	Dell Power Edge 2800	9CVN22J	Dell	Bytes & Piece	Mar-06	$12,940	Maputo, Mozambique	Good
LCD Projector	VPL-CS20A	2000	Sony	Mediabit	Mar-06	$2,545	Maputo, Mozambique	Good
Photocopy Machine		IR 2000	Canon	Prodata	Jul-06	$3,444	Maputo, Mozambique	Good
Printer	HP LaserJet 1320n	CNCKF37359	HP	Sierna	Dec-06	$923	Maputo, Mozambique	Good
Desktop Computer		CN-0TC670-70821-595-G7M2	Dell	Byte & Pieces	Mar-06	$925	Maputo, Mozambique	Good
Laptop Computer	D 600	N/A	Dell	Byte & Pieces	May-04	$2,369	Maputo, Mozambique	Good
Laptop Computer	Dell 610	CN-0D4571-48643-5BB-3859	Dell	Byte & Pieces	Dec-05	$2,050	Maputo, Mozambique	Good
Desktop Computer		CN-0C5385-46633-544-111U	Dell	Byte & Pieces	July - 05	$986	Maputo, Mozambique	Good
Laptop Computer	Dell D 505	CN-0H2049-48643-431-1835	Dell	Byte & Pieces	May-04	$2,334	Maputo, Mozambique	Good
Laptop Computer	D 600	N/A	Dell	Byte & Pieces	May-04	$2,369	Maputo, Mozambique	Good
Motor Vehicle	ISUZU KB 280	**VIN#:** ADMTFS 55 DL	Isuzu	**Donated by:** HSDS PROJECT	Mar-04		Maputo, Mozambique	Good
Motor Vehicle	KIA SPORTAGE	**VIN#:** KNASE551577353104	Kia	Quality Cars	Feb-07	$40,190	Maputo, Mozambique	Good

Item description	Model	Serial #	Manufacturer	Vendor	Purchase Date	Cost (US$)	Location	Condition
Nigeria Office								
Laptop Computer	HP Compaq nx 9010	CNF41517PC	HP	WECO SYSTEMS	Jul-04	$1,846	Abuja, Nigeria	Broken
Laptop Computer	HP Compaq nx 9011	CNF41315DW	HP	WECO SYSTEMS	Jul-04	$1,846	Abuja, Nigeria	Good
Laptop Computer	HP Compaq nx 9012	CNF4170K2V	HP	WECO SYSTEMS	Jul-04	$1,846	Abuja, Nigeria	Good
Laptop Computer	HP Compaq nx 9013	CNF41517NK	HP	WECO SYSTEMS	Jul-04	$1,846	Abuja, Nigeria	Good
Laptop Computer	HP Compaq 6110	CNU52907FC	HP	WECO SYSTEMS	Sep-05	$1,692	Abuja, Nigeria	Good
Laptop Computer	Portege A200	S15082336H	TOSHIBA	Real Choice Systems	Jan-06	$1,923	Abuja, Nigeria	Good
Digital Camera	S400	7127504337	Canon	Futurenet	Jul-04	$546	Abuja, Nigeria	Good
LCD Projector	SP 10t	G4201655	Boxlight	Bonama Nig Ltd	Jul-04	$1,846	Abuja, Nigeria	Good
Photocopier	Gestetner Dsm 622	J832204279		NEET Nig Ltd	Jul-04	$5,702	Abuja, Nigeria	Good
PABX Telephone Exchange	KX- TA308	4BASC259354	Panasonic	NEET Nig Ltd	Jul-04	$1,059	Abuja, Nigeria	Good
Network Router			Linksys	Prime Connections	Jul-04	$500	Abuja, Nigeria	Good
Generator	EF2600	906437	Yamaha	John Holt Ltd	Aug-04	$892	Abuja, Nigeria	Good
Desktop Computer		CN-OP1457-46633-424-22-EL	DELL	Pime Connections	Jul-04	$1,500	Abuja, Nigeria	Good
Desktop Computer		CN-DC3153-70821-434-1144	DELL	Prime Connections	Jul-04	$1,500	Abuja, Nigeria	Good
Desktop Computer		00045-581-672-375	DELL	Chipset Technologies	Sep-05	$1,577	Abuja, Nigeria	Good
Conference Table				Help desk	Jul-04	$1,077	Abuja, Nigeria	Good
5 Executive Tables				Help Desk	Jul-04	$6,154	Abuja, Nigeria	Good
Security Safe	Ultimate 106	P2Z35390F	Ultimate	Help Desk	Jul-04	$831	Abuja, Nigeria	Good
Motor Vehicle	Ford Explorer XLT 2006	**VIN #:** IFMEU73E26UA14540	Ford	Coscharis Motors Ltd	Feb-06	$32,000	Abuja, Nigeria	Good
Uganda Office								
Desktop Computer	E173fpf	CN-OU4941-72872-531-19NL	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	T7570	XVM22-C7T2H-22BWQ-GVT6G	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	E173fpf	CN-0U4941-72872-531-49WL	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	T7570	VK2T0-XTJHP-4Y0X-6C97K-FKX0M	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	E173fpf	CN-OU4941-72872-531-1A3L	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	T7570	KJP7F-QP37KYTD6B-2GRPFKX8H3	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	E173fpf	CN-OU494172872531ORPL	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	BK650ML	PB0430133885	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Printer	1320	CNHJN77519	HP Laser jet	Computer Point		$1,500	Kampala, Uganda	Good
Desktop Computer	E173fpf	CN-OU494172872531OP2L	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	BK650ML	PB0430135520	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Fax Machine	L220	KPL07623	Canon	Computer Point		$500	Kampala, Uganda	Good
Printer	4250N	4098-7618	HP Laser jet	Computer Point		$1,500	Kampala, Uganda	Good
Laptop Computer	A70-S249	15215861K	Toshiba	MTA Computers	Dec-05	$1,900	Kampala, Uganda	Good
Laptop Computer	A70-S249	Z4353699K	Toshiba	MTA Computers	Dec-05	$1,900	Kampala, Uganda	Good
Desktop Computer	E173FPb	REV AO1	Dell	Computer Point	Aug-05	$1,200	Kampala, Uganda	Good
Desktop Computer	75G	L3A9226	IBM	Southern business solutions	Jul-06	$1,650	Kampala, Uganda	Good
Motor Vehicle	Toyota Landcruiser	**VIN #:** JTECBOIJ60-1008057	Toyota	**Donated by:** AIM Programme		Donated	Kampala, Uganda	Good
Motor Vehicle	Toyota Hilux	**VIN#:** JTFDE62680-0148198	Toyota	Lonrho Motors Uganda Ltd	Sep-05	$27,197	Kampala, Uganda	Good

Item description	Model	Serial #	Manufacturer	Vendor	Purchase Date	Cost (US$)	Location	Condition
HQ Office								
Laptop Computer	Latitude D610	CN-002125-48643-522-7020	Dell	Futurenet		$1,576	Arlington, VA	Good
Laptop Computer	Latitude D610	CN-OU8082-48643-59T-2565	Dell	Futurenet		$1,846	Arlington, VA	Good
Desktop Computer		00045 629 651 519	Dell	Futurenet		$2,853	Arlington, VA	Good
Laptop Computer	Latitude D610	CN-0D4571-48643-56K-7675	Dell	Futurenet		$1,384	Arlington, VA	Good
Laptop Computer	Latitude D600	CN-OG5152-48643-497-4402	Dell	Futurenet		$1,650	Arlington, VA	Good
Software	Arcview 9x	Registration #: UNK120443894	ArcView	CMC International		$1,269	Arlington, VA	Good
File Cabinet				Deskmate Office Products		$709	Arlington, VA	Good

* Missing information will be collected and updated in the next annual inventory report.

For more information, please visit www.mmis.jsi.com.

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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.

MEASURE

Task Order October-December Activity List

AFR-2TO	Workshop on M&E of HIV/AIDS (Anglophone Africa)
ANE-1TO	Workshop on M&E of PHN Programs (ANE)
ANE-11TO	Technical Assistance to SE Asia Regional Program: Infectious Disease
ANE-12TO	Technical Assistance to SE Asia Regional Program: Malaria
ANE-13TO	Technical Assistance to SE Asia Regional Program: Avian Influenza
CI-2TO	Technical Assistance to Cote d'Ivoire: MOH
CI-3TO	Technical Assistance to Cote d'Ivoire: CIPMS
CI-4TO	Technical Assistance to Cote d'Ivoire: MLS
CI-5TO	Technical Assistance to Cote d'Ivoire: OVC
CI-6TO	Technical Assistance to Cote d'Ivoire: HIV/AIDS Patient Monitoring Tools
CN-1TO	Technical Assistance to China: HIS
DO-2TO	Technical Assistance to the Dominican Republic
EAF-4TO	Workshop on M&E of PHN (Anglophone) 2008
GLB-1TO	General Data Demand & Data Use
GLB-3TO	General Coordination with OPRH and HIDN CA's
GLB-4TO	General Tools and Methodologies and Technical Assistance
GLB-8TO	Global HIV/AIDS Coordination Unit
GLB-9TO	Global PEPFAR Tools/Methodologies
GLB-10TO	Global PLACE
GLB-12TO	Global TB Technical Assistance
GLB-13TO	Health Metrics Network
GLB-14TO	HIS Inventory and Tool Development
GLB-15TO	RHINO
GLB-17TO	SAVVY: Vital Registration with Verbal Autopsy
GLB-27TO	Capacity Building Internet Based Tools
GLB-53TO	WHO ART Patient Tracking
GLB-57TO	SI Field Technical Assistance: Focus Countries
GLB-58TO	Indicator Guidelines for Focus & Non-Focus Countries
GLB-61TO	Data Use Guidelines, Case Studies and Training Materials
GLB-63TO	Health Facility Data Collection Working Group
GLB-64TO	PEPFAR OVC SI Support
GLB-70TO	Technical Assistance to Non-Focus Countries
GLB-72TO	Creating Partner Demand for Quality SI Data through Facilitating Local Use
GLB-89TO	Community Level Program Information Reporting (CLPIR)
GLB-90TO	GIS OVC Program Mapping
GLB-91TO	Standards & Guidelines for Data Quality: Double Counting
GLB-102TO	Distance Learning Modules
GLB-103TO	Population-Health-Environment M&E Technical Assistance
GLB-104TO	Child Status Index
GLB-105TO	Technical Assistance to PEPFAR GIS
GLB-106TO	MARP Manual
GLB-107TO	M&E Support for MCH
GY-3TO	Technical Assistance to Guyana: DHS
HN-2TO	Technical Assistance to Honduras: PMP 2008
HN-3TO	Technical Assistance to Honduras: Special Study of Decentralized Health Services
HT-1TO	Technical Assistance to Haiti: SI Support
HT-2TO	Technical Assistance to Haiti: PEPFAR non-Facility Interventions

HT-3TO	Technical Assistance to Haiti: DQA
HT-4TO	Technical Assistance to Haiti: MOH
LAC-2TO	Workshop on Impact Evaluation of PHN Programs (INSP Mexico)
LAC-10TO	Technical Assistance to LAC: HIS
LR-2TO	Technical Assistance to Liberia: Malaria
MZ-4TO	Technical Assistance to Mozambique: SAVVY
MZ-6TO	Technical Assistance to Mozambique: AB Process Evaluation
NG-3TO	Technical Assistance to Nigeria: NNRIMS
NG-5TO	Technical Assistance and Capacity Development for Nigeria in M&E
NG-7TO	Technical Assistance to Nigeria: DDIU
NG-9TO	Technical Assistance to Nigeria: OVC
RW-1TO	Technical Assistance to Rwanda: PEPFAR
RW-3TO	Technical Assistance to Rwanda: Data Collection Systems
RW-4TO	Technical Assistance to Rwanda: DDIU
SAF-2TO	Master's Degree Training (Pretoria)
TZ-2TO	Technical Assistance to Tanzania: SAM
TZ-4TO	Technical Assistance to Tanzania: USG SI Support
TZ-6TO	Technical Assistance to Tanzania: Database Support
TZ-7TO	Technical Assistance to Tanzania: DDIU
TZ-8TO	Technical Assistance to Tanzania: GIS
TZ-9TO	Technical Assistance to Tanzania: Partner Capacity Building
TZ-12TO	Technical Assistance to Tanzania: OVC
VN-4TO	Technical Assistance to Vietnam: Avian Influenza
WAF-4TO	Workshop on M&E of HIV/AIDS (Francophone) 2008
WAF-8TO	West Africa CB Working Group
WAF-9TO	Workshop on RHIS (Francophone)
ZM-1TO	Technical Assistance to Zambia: SBS
ZM-4TO	Technical Assistance to Zambia: DHS

AFR-2TO: Workshop on M&E of HIV/AIDS (Anglophone Africa)

Lead: Sohail Agha (Tulane University)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to increase individual and institutional capacity for M&E of HIV/AIDS programs in Anglophone Africa region.

Description:
This activity includes working with the University of Pretoria on the ongoing development and implementation of a two-week workshop on M&E of HIV/AIDS programs for mid-level professionals in the Anglophone Africa region. Up to five MEASURE Evaluation TO fellowships will be offered to qualified candidates from USAID assisted countries. The workshop will train 25-30 professionals in M&E fundamentals, strategic information in decision making, development of M&E plans, and tools for M&E of HIV/AIDS programs. Opportunities for collaboration with MEASURE partners, such as participation of DHS, BuCen, and CDC experts as instructors will be further explored. Opportunities for collaboration with the South Africa Ministry of Health and other South African organizations will also be explored.

Tasks:
1. Conduct planning activities for workshop, including venue, agenda, budget, logistics, and timeline, in collaboration with partner institution faculty.
2. Begin discussing and planning with University of Pretoria partners to prepare them to offer the workshop on their own in 2009.
3. Prepare and disseminate recruitment material for 2008 workshop.
4. Finalize agenda and identify MEASURE Evaluation TO and partner instructors.
5. Conduct workshop.
6. Prepare Activity Report for 2008 workshop.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation on October 1, 2007.

* Finalize workshop dates.

* Begin initial planning for workshop.

* Draft and finalize workshop brochure and application materials for release in early January.

Task Order October-December Activity Sheets

Progress:
During this quarter, MEASURE Evaluation TO staff finalized the workshop dates for the next workshop: March 3-14, 2008. Staff began planning for the upcoming workshop with partners at the University of Pretoria, including: fine-tuning the workshop agenda and curriculum, finalizing the brochure and application materials, conducting the initial workshop announcement/dissemination, and facilitating the workshop recruitment.

Year 1 Quarter January, February, March

Plans:
* Continue the workshop recruitment.

* Select the workshop participants and fellowship recipients.

* Finalize the workshop agenda, curriculum, and materials.

* Conduct the workshop.

* Begin activity close-out activities.

ANE-1TO: Workshop on M&E of PHN Programs (ANE)

Lead: Bates Buckner (University of North Carolina at Chapel Hill)

Technical Advisor: Lisa Maniscalco (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to increase individual and institutional capacity for M&E in the ANE and Eurasia regions.

Description:
This activity includes the implementation of a three week workshop on M&E of Population, Health, and Nutrition Programs for mid-level professionals from the ANE and Eurasia regions, in collaboration with a training partner institution in the Asia region. In early 2008, MEASURE Evaluation TO staff will select a training partner institution in Asia that will collaborate to offer the workshop in late 2008/early 2009. Technical, administrative, and logistical support will be provided to the training partner institution, as required, in preparation for the workshop. A limited number of MEASURE Evaluation TO fellowships will be offered to qualified participants from USAID assisted countries.

Tasks:
1. Select a training partner institution in Asia that will collaborate to offer the 2008 workshop.
2. Provide technical, administrative, and logistical support to the selected training partner institution, as required.
3. Prepare and disseminate recruiting material for the 2008 workshop.
4. Review applications and select MEASURE Evaluation TO fellowship recipients.
5. Conduct workshop providing technical, administrative, and logistical support as needed.
6. Prepare Activity Report for the 2008 workshop.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Identify technical and administrative criteria required for the training partner institution in Asia that will collaborate to offer the PHN workshop in late 2008/early 2009.

* Identify a short list of 2-3 potential partner institutions and determine their interest in exploring a training partnership with MEASURE Evaluation Task Order.

* Plan site visits to assess the suitability of potential training partner institutions, with the aim of selecting a partner in early 2008.

Task Order October-December Activity Sheets

Progress:
A timeline for the site selection process was developed. A preliminary list of potential training partner institutions in Asia was compiled in December 2007. Based on identified basic, technical, and logistical criteria required for the partnership, an initial short list of 8 sites was prepared. Additional information on these potential candidate sites will be gathered via the internet and from key regional contacts, with a view to generating a short list of 3-5 potential sites by the end of January, 2008. Following initial contacts with 2-3 priority sites to assess interest and basic capacity, MEASURE Evaluation TO staff will make visits to these sites, with the aim of making a final selection in May 2008. MEASURE Evaluation TO staff will then begin working with the new partner site to plan for a Regional PHN workshop to take place in late 2008.

Year 1 Quarter January, February, March

Plans:
* Continue the search for a new training partner site according to the time frame outlined above.

* Prepare the short list of potential candidates.

* Make initial contact with these sites, followed by field visits to assess technical and administrative capacity to offer M&E workshops.

ANE-11TO: Technical Assistance to SE Asia Regional Program: Infectious Disease

Lead: Ravi Goud (Macro International Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Other Public Health Threats (OPHT))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to provide technical assistance in the development of the RDM/A PMP for the Infectious Disease (ID) program, and to develop a database for reporting of ID and AI indicators.

Description:
Development of the Infections Disease (ID) PMP will occur through consultations with RDM/A regional partners and RDM/A ID staff. Staff on the MEASURE Evaluation TO will work with RDM/A partners in Bangkok to identify and operationalize ID indicators, develop data collection forms and guidance on the indicators, and train them on the data collection forms. Infectious diseases to be included in the ID PMP are for Malaria, Tuberculosis, Dengue, and possibly other neglected infectious diseases. While the period of performance for this work is October 2007 through September 2008, much of this work will be done in the early part of the fiscal year. Once the ID indicators for the PMP have been finalized, staff on the MEASURE Evaluation TO will develop an ID reporting database for the RDM/A office. The ID data system should be compatible with the existing HIV/AIDS On-line Reporting Tool (ORT) for developing an integrated health reporting data system in the near future.

Tasks:
1. Develop the ID PMP.
2. Develop database for ID indicators.
3. Develop reporting guidance and train partners.

Year 1 Quarter October, November, December

Plans:
* Travel to Bangkok to meet with RDM/A Mission and partners to begin work on the ID PMP in October.

Progress:
Eckert and Goud traveled to Bangkok and met with the RDM/A mission. They received materials detailing various projects within the region, and met with David Payne of PAHI Vietnam, an NGO fostering communication and collaboration between NGOs and donor organizations. In coordination with the RDM/A mission, Eckert and Goud determined a rough time line for the development of the PMPs, and have completed an initial draft of the narrative, which is being finalized in collaboration with RDM/A.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Solicit feedback on the PMP from the RDM/A Mission and partners.

* Finalize the PMP.

* Start developing the database.

* Plan a meeting to train partners during the following quarter.

ANE-12TO: Technical Assistance to SE Asia Regional Program: Malaria

Lead: Ravi Goud (Macro International Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Malaria)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
To strengthen M&E of malaria programs among regional malaria partners in SE Asia.

Description:
This activity will start with the MEASURE Evaluation Task Order team reviewing the 'Kunming' indicator list, which is being used to monitor the WHO Mekong Malaria Program and National Malaria Control Program. A member of the team will then attend RDM/A's malaria partners meeting in Thailand on 29-31 October 2007, meet with partners, and discuss M&E priorities as well as strengths and weaknesses of the Kunming indicators. The MEASURE Evaluation TO team will then revise the indicators and produce a mini-guidance document on monitoring and evaluation of malaria programs in the region. This guidance document will be produced in collaboration with USAID partners, local governments, and international agencies working in the region. MEASURE Evaluation TO staff will develop a M&E training curriculum and conduct training(s) for government officials and other implementers on the Regional M&E Strategy, perhaps in conjunction with ACT Malaria. This activity will also include some travel to meet with regional partners and country programs as funding allows.

Tasks:
1. Develop the guidance document on malaria indicators for the Mekong Region.
2. Provide TA to regional partners on M&E.

Year 1 Quarter October, November, December

Plans:
* Travel to RDM/A regional malaria partners meeting in October.

* Develop scopes of work for TA to partners.

* Begin a review of the regional indicators.

Progress:
Eckert and Goud attended the USAID Mekong Malaria Programme Core Partners' Meeting in order to meet partners and start groundwork for the regional M&E plan. Eckert developed and presented the MEASURE Evaluation TO workplan for FY 07 to partners. Eckert and Goud reviewed the partners' workplans, identifying themes and potential synergies. These workplans will be used to construct two malaria deliverables: an internal PMP for USAID/RDM/A's ID portfolio, and a larger M&E Framework for the Mekong

Malaria Program headed by WHO. Eckert and Goud inquired as to the difference between the USAID partners' malaria PMP and the regional WHO plan, but further clarification is necessary. An initial draft was completed of the narrative for the RDM/A ID PMP, portions of which will contribute to the regional Malaria M&E plan.

Year 1 Quarter January, February, March

Plans:

* Clarify MEASURE Evaluation TO's role and expectations with WHO.

* Clarify the difference between RDM/A USAID partners Malaria PMP and RDM/A PMP by obtaining other partner workplans from WHO.

* Complete the review of the Kunming Indicators.

* Conduct a strategy development meeting with partners to start developing a regional strategy.

ANE-13TO: Technical Assistance to SE Asia Regional Program: Avian Influenza

Lead: Denise Johnson (Macro International Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Avian Influenza (AI))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
To support the development of a database for AI indicators and to provide training on reporting and M&E to RDM/A AI partners in the region.

Description:
This work is an extension of the technical assistance provided by MEASURE Evaluation TO staff in developing indicators and M&E guidance for avian influenza programs in the region, resulting in the development of the Guide for the Monitoring and Evaluation of Avian Influenza Programs in SE Asia.

MEASURE Evaluation TO staff will participate in semi-annual AI partner's meetings to help inform workplan development and enhance coordination with partners. MEASURE Evaluation TO staff will develop a M&E training curriculum and conduct training(s) for government officials and other implementers on the Regional M&E Strategy in two countries in the region (TBD). This could include an overall presentation, in-depth meetings with individual government staff or other implementers, and/or M&E workshops specific to AI.

MEASURE Evaluation TO staff will work with RDM/A and its AI Partners to develop an AI indicators database. The database will initially be for internal RDM/A use to track their programs, but it will be designed for eventual linkage with the Washington-based AIMEBA reporting system. In addition, this database should be compatible with the ORT HIV/AIDS database. However, given funding constraints, the priority is to develop a database for RDM/A to input the information and display key results.

RDM/A anticipates one final round of revisions for the regional AI Guide. MEASURE Evaluation TO staff will incorporate the revisions as detailed by RDM/A into the regional guide, perform an internal peer review and will deliver a printer-ready PDF of the regional guide to RDM/A.

Tasks:
1. Conduct final revision, peer review, and delivery of printer-ready PDF of the regional AI guide.
2. Develop and deliver internal RDM/A database for AI programs.
3. Provide TA to two countries to improve AI reporting.
4. Participate in semi-annual AI partners meeting.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* Receive recommended revisions for the regional AI guide from RDM/A.

* Incorporate revisions, conduct a peer review and deliver a pinter-ready PDF of the regional guide to RDM/A.

* Conduct a requirements analysis of the database needs for the AI database.

* Program, test, and deliver the AI database.

Progress:

The MEASURE Evaluation TO team conducted a requirements analysis for the Avian Influenza M&E database in consultation with the staff at RDM/A. The analysis identified both short-term, immediate needs, and long-term goals for the system. It also provided priorities to guide the identification of a technical solution. The information was documented in the AI/ID Database Description.

The MEASURE Evaluation TO team considered multiple technical approaches and explored the adaptation of an existing web-based relational database management system (USAID/Washington's AIMEBA system) to meet the mission's short-term and long-term goals. This adaptation proved infeasible given constraints of the schedule and funding. Instead, MEASURE Evaluation TO will use an Excel-based approach to meet the mission's priorities. This solution will be delivered in the first quarter of 2008.

The revisions for the regional guide were not received from RDM/A during this quarter. This task will occur during the first quarter of 2008.

Year 1 Quarter January, February, March

Plans:

* Receive recommended revisions for the regional AI guide from RDM/A.

* Incorporate revisions, conduct a peer review, and deliver a printer-ready PDF of the regional guide to RDM/A.

* Program, test, and deliver the AI database.

CI-2TO: Technical Assistance to Cote d'Ivoire: MOH

Lead: Mounkaila Abdou Billo (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
Provide technical and material assistance in standardizing and strengthening the collection, management, utilization, and dissemination of HIV/AIDS monitoring and indicator data.

Description:
With FY07 funds, the MEASURE Evaluation TO will work closely with the USG team, WHO, UNAIDS, Global Fund, and the MOH to: (1) strengthen coordination of HIV/AIDS M&E activities; (2) build capacity in and scale-up the HMIS; (3) provide IT support to the MOH; and (4) coordinate supportive supervision at the district level. The specific tasks are described below.

Tasks:
1. Organize one meeting per month for eight months among Emergency Plan partners and MOH directorates and programs (DIPE, PNPEC, PSP, and PNLT).
2. Support (financially and technically) the development of an HIV/AIDS Monitoring and Evaluation Plan for the health sector.
3. Organize two training sessions for 25 data managers each in the use of HIV/AIDS data-management software developed by ACONDA.
4. Provide technical assistance to the Cote d'Ivoire SI technical committee in the development of maps to monitor the coverage of PMTCT and care and treatment sites, as well as community-based interventions based on digital maps purchased by the USG team in 2004.
5. Support national authorities in the scale up of the implementation of HIV/AIDS data-collection tools by documenting scale up progress.
6. Provide financial support for one staff member (with relevant responsibility for supporting the PNPEC) to attend the CESAG M&E workshop.
7. Assist the MOH in the revision of the national supervision guidelines to include HIV/AIDS activities.
8. Organize a three day training for a pool of 10 health personnel on the revised national supervision methods and guidelines including HIV/AIDS data collection tools.
9. Assist the MOH to conduct at least two supportive and formative supervisions on HIV/AIDS data management at the district level.
10. Provide both financial and technical support to the MOH to assess the feasibility of internet connection at the facility level.
11. Implement the recommendations in at least one region, as appropriate, by providing internet connection to one health region, district office, and 5 HIV/AIDS care and treatment clinics.
12. Provide Internet connection to five district health offices and two regional offices.
13. Provide two computers to two HIV/AIDS care and treatment sites.
14. Continue to provide internet connection to the DIPE.

15. Provide a high speed internet connection to the PNPEC.
16. Attend PEPFAR meetings and all other national workshops and meetings.

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from activity CI-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Organize one meeting per month among Emergency Plan partners and MOH directorates and programs (DIPE, PNPEC, PSP, and PNLT).

* Support (financially and technically) the development of an HIV/AIDS Monitoring and Evaluation Plan for the health sector.

* Organize two training sessions for 25 data managers each in the use of HIV/AIDS data-management software developed by ACONDA.

* Provide TA to the Cote d'Ivoire SI technical committee in the development of maps to monitor the coverage of PMTCT and care and treatment sites, as well as community-based interventions, based on digital maps purchased by the USG team in 2004.

* Assist the MOH in the revision of the national supervision guidelines to include HIV/AIDS activities.

* Provide both financial and technical support to the MOH to assess the feasibility of internet connection at the facility level.

Progress:

Two coordination meetings were held during this quarter. On October 29, 2007, eight PEPFAR partners, including MEASURE Evaluation TO, met to discuss progress made in the development of the electronic medical record system for HIV patients by ACONDA.

On November 26, 2007 MEASURE Evaluation TO organized and hosted the SI coordination meeting. The objectives of the meeting included: (1) to present all the action plans for the deployment of the integrated HIV/AIDS tools (printing, supervision, and equipment); (2) to harmonize the tools to be printed (CD, registers, tally sheets, periodic report forms); (3) to discuss the mechanisms of storage and distribution of the tools reproduced; (4) to identify additional sources of funding; and (5) to identify the next steps.

The outcome of the meeting was that each partner will have to print the national tools according to the specifications worked out by the DIPE. The printer identified by the partner should reproduce the entire set of data collection tools. The tools reproduced by the partners should be given to the DIPE to be stored in the premises of the PSP.

A new resident advisor, Moussa Traore, was hired in November 2007 as a data analyst and use specialist to replace Eby Pascal. Therefore, the supervision activities for the HMIS scaling up plan were not carry out.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Organize and carry out an evaluation of the HMIS Cote d'Ivoire using the PRISM methodology and tools.

* Organize at least three coordination meetings of PEPFAR partners.

* Organize a meeting with Solutions Informatques, the local consultation firm that developed SIGVision, to evaluate the software and propose solutions to improve data entry and reporting.

* Propose strategies to improve the data transmission among the levels of the health systems.

CI-3TO: Technical Assistance to Cote d'Ivoire: CIPMS

Lead: David Boone (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to support the PEPFAR reporting process in Cote d'Ivoire, CDC Retro CI, and its implementing partners through the implementation of the CIPMS data management, analysis, and reporting system.

Description:
The Cote d'Ivoire HIV/AIDS Program Monitoring System (CIPMS) is a Microsoft Access based indicator monitoring database for use in the management, monitoring and evaluation of HIV/AIDS treatment, and care and prevention programs supported by PEPFAR. It is designed to operate at the level of in-country implementing partners (IPs) who manage program specific data and forward it to the national level where it is aggregated automatically for USG program managers. The CIPMS can reduce the burden of reporting and improve the quality of data by standardizing the collection of data. The CIPMS also allows partners to monitor their own performance and make decisions informed by the data.

CIPMS was implemented in Cote d'Ivoire in 2006 at the national level. Due to staff turn-over at CDC - Retro CI, the activity was never rolled out to the IPs. In the fall of 2007, Retro CI again expressed interest in the program and began active testing of the application preparatory to the PEPFAR Annual Report. Retro CI intends to roll out the application to IPs in subsequent quarters.

Tasks:
1. Train and support the USG team in CI to use the CIPMS database and administer reporting from Implementing Partners.
2. Train Implementing Partners to collect, analyze, and report program data using CIPMS.
3. Work with USG SI Team to ensure high quality reporting and data use using CIPMS.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity CI-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Work with the USG SI Team in Cote d'Ivoire to implement the CIPMS for the PEPFAR Annual Report 2007.

* Assist the SI Team to enable USG implementing partners to report data and results for PEPFAR activities using CIPMS.

Task Order October-December Activity Sheets

* Assist the SI Team and its implementing partners to analyze and appropriately use PEFPAR activity data and results using CIPMS.

* Respond to other needs related to CIPMS, data management, analysis, and reporting as needed.

Progress:
The CIPMS was successfully piloted during the PEPFAR annual reporting period. USG was able to use CIPMS to enter implementing partner data to produce automated reports and conduct analysis using the decision support system.

As a result of the experience in 2007 with CIPMS, USAID/Cote d'Ivoire has requested revisions and upgrades to the software system before distributing it to partners in 2008. A report of their experience, including a list of revisions to be made, was prepared and submitted to MEASURE Evaluation TO.

Year 1 Quarter January, February, March

Plans:
* Conduct a conference call with USAID/Cote d'Ivoire to finalize modifications to the CIPMS to meet the needs of implementing partners in Cote d'Ivoire.

* Make adjustments or edits to the software system as needed.

* Test the application prior to implementation for the PEPFAR Semi-annual report in April-May 2008.

* Conduct training of PEPFAR implementing partners on CIPMS.

CI-4TO: Technical Assistance to Cote d'Ivoire: MLS

Lead: Arnaud Bah Kouadio (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
Provide technical and financial assistance to MLS to Implement the National M&E Plan.

Description:
The MLS is charged with coordinating the overall fight against HIV/AIDS in Cote d'Ivoire, including its M&E strategy. The MLS is specifically responsible for community-based (non-facility-based) HIV/AIDS data collection and processing. The NGO Alliance Cote d'Ivoire, a PEPFAR implementing partner, supports the MLS in collecting and managing community-based program data, including data for HIV prevention, care, and treatment-literacy programs. In July 2006, the MLS developed a five-year strategic plan, with technical assistance from MEASURE Evaluation regarding M&E and defining intervention areas. With FY07 funds, MEASURE Evaluation TO will carry out the tasks described below.

Tasks:
1. Assist the MLS in conducting four quarterly formative supervisions in four decentralized committees.
2. Provide technical assistance to the MLS to use the CRIS (selected as the national M&E software) to exchange and retrieve data with other national software (SIGvision, Alliance Cote d'Ivoire) by developing a module that will facilitate data exchange and retrieval.
3. Train at least four MLS staff and partners in the use of this software.
4. Provide financial support for one DPPSE/MLS staff member to attend the CESAG M&E of PHN programs workshop, pending acceptance of the participant into the course.
5. Provide two computers to two decentralized committees to better manage and analyze HIV/AIDS data, and lead to improved data timeliness and completeness.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity CI-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Develop a module that will facilitate data exchange and retrieval for the MLS.

* Assist the MLS in conducting one supportive and formative supervision in one decentralized committee.

Task Order October-December Activity Sheets

* Provide one computer to one decentralized committee to better mange and analyze HIV/AIDS data, and improved data timeliness and completeness.

Progress:
A module was developed and tested to identify programming bugs. The next steps are to write a user manual, install the module on the MSL data server, and train the MLS staff on its usage. One supervision visit was conducted in Abidjan District from December 27-28, 2007. During this visit, three NGOs and three local organizations (decentralized MLS committees) were visited to discuss data management and collection tools. Because the MLS did not identify one decentralized committee, no computer was given.

In addition to the activities planned, MEASURE Evaluation TO conducted the following: (1) TA for the production the HIV annual report 2006 and 2007 by analyzing data and generating tables and graphics; (2) supervised HIV data entry at the community level; and (3) finalized the terms of reference to relocate the MLS website. The draft can be viewed at: www.sida.gouv.ci. Seven people from five NGOs were trained on using the PDA for data transmission (as part of the SCMS project for strengthening the data transmission).

Year 1 Quarter January, February, March

Plans:
* Organize one meeting to present the module for data exchange.

* Train four MLS staff members on the module administration.

* Install the module on the MLS data server.

* Continue the 2007 data entry for the HIV National Report.

* Control the data quality of the HIV National Report.

* Print the HIV annual report for 2006 and 2007.

* Train three MLS staff on the web site management.

* Update and maintain the web site.

* Assist the MLS to conduct a formative supervision in decentralized committee.

* Provide TA to the MLS to strengthen data transmission by using PDA in collaboration with SCMS.

* Provide one computer to one sectorial committee to improve data management.

CI-5TO: Technical Assistance to Cote d'Ivoire: OVC

Lead: Leontine Gnassou (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
Provide technical and financial assistance to the National OVC program for the strengthening of the OVC Community-Based Information System (PNOEV).

Description:
The USG funds Alliance CI to manage community-based program reporting carried out by NGOs, CBOs, and FBOs. Cote d'Ivoire also has a national OVC program (PNOEV), under the Ministry of Family and Social Affairs, which is in charge of coordinating all OVC activities in the country. In collaboration with FHI, MEASURE Evaluation TO will provide technical assistance to the PNOEV to implement an OVC M&E system linked to the overall MLS-supported M&E system. With FY07 funds, MEASURE Evaluation TO will carry out the tasks listed below.

Tasks:
1. Assist the PNOEV in the design of the midterm evaluation of data collection tools.
2. Assist the PNOEV in the training of 15 staff of its partners in both M&E and the use of data collection tools.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity CI-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Organize a meeting with the M&E Staff of the National OVC program to discuss the planning of a midterm evaluation of data-collection tools.

* Collaborate with the OVC program staff to develop a draft of the scope of work for the data-collection tools that were developed and implemented in 2005.

* Validate the scope of work of the data-collection tools that were developed and implemented in 2005 with the PNOEV partners.

Progress:
A meeting with the National OVC Program M&E staff was held on October 31, 2007 to discuss the MEASURE Evaluation TO planned activities and the plan for the midterm evaluation on the use of the data-collection tools. The next steps and the methodology were identified, and a draft of the Terms of References (TOR) of the process was written. Then, the TOR was finalized and validated by the OVC program partners (PEPFAR, UNICEF). The selection of the consultant that will conduct the evaluation is ongoing.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Assist the PNOEV in the training of 15 partner staff in both M&E and the use of data collection tools.

CI-6TO: Technical Assistance to Cote d'Ivoire: HIV/AIDS Patient Monitoring Tools

Lead: Leontine Gnassou (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to ensure the deployment and roll out of the HIV/AIDS Patient Monitoring tools.

Description:
With FY06 funds, PEPFAR has provided TA to the MOH to adapt the WHO HIV/AIDS patient longitudinal monitoring data collection tools based on revised national HIV/AIDS indicators. A training of trainers was conducted with a pool of 18 health workers, data managers, central-level staff, and other EP partners. For the integrated HMIS, restitution of the pilot phase was completed, and the data collection forms and procedures have been validated. Indicators for the integrated system were revised in January 2006 to take into account information needs of the various partners involved in HIV/AIDS activities (MOH, WHO, UNAIDS, Global Fund, and PEPFAR). Under Phase II of the MEASURE Evaluation Project, appropriate data-collection tools were developed in collaboration with other partners. MEASURE Evaluation TO will build on this work with FY07 funds by implementing the tasks described below.

Tasks:
1. Organize a validation workshop of the HIV/AIDS patient monitoring training materials and guidelines.
2. Train 150 health workers on HIV/AIDS patient longitudinal monitoring data collection.
3. Conduct supervision and provide monthly updates.
4. Conduct a rapid evaluation of the use of HIV/AIDS patient longitudinal monitoring data-collection tools.
5. Write up and disseminate the results of the evaluation of data collection tools.
6. Revise training materials and data collection tools based on the evaluation results during a workshop with 20 participants for 6 days.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity CI-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Train at least 20 health workers in the use of data collection on longitudinal HIV/AIDS patient management.

* Select one printing house from three options.

Task Order October-December Activity Sheets

* Print the HIV/AIDS paper forms for 20 HIV/AIDS Care and Treatment sites.

* Distribute the paper form tools during training sessions and workshops.

Progress:
Two trainings took place; one in Yamoussokro (October 22-26, 2007) and one in Adzope (December 3-7, 2007). The aim of those two trainings was to strengthen health workers (ART care givers and data managers at the district level) in the use of the ART patient monitoring data collection tools. Thirty-five Health workers attended those two trainings; 19 in Yamoussokro and 16 in Adzope. During these trainings, important recommendations were made by the participants to improve the use of the data collection tools in the field. For the second training, each HIV Care and Treatment clinic that was represented received three months provision of data collection tools. The first training targeted districts that already have data collection tools provided by other partners (Belgium cooperation, ESTHER and WHO).

In addition to the above mentioned activities, MEASURE Evaluation TO facilitated the organization of a coordination meeting to review the level of contribution of each partner to support the deployment of the ART patient monitoring tools. As a result, the number of health workers to be trained in the use of the tools and the quantity of data collection tools, to be printed by some of the partners ACONDA-VS, ICAP (Colombia University, EGPAF, ESTHER) have been identified.

Year 1 Quarter January, February, March

Plans:
*Organize a validation workshop of the HIV/AIDS patient monitoring training materials and guidelines.

* Revise the HIV/AIDS patient monitoring training materials by integrating all past trainings comments.

* Elaborate the terms of references of the workshop.

* Conduct the validation workshop.

* Train 150 health workers on the use of HIV/AIDS patient longitudinal monitoring data collection.

* Conduct supervision and provide monthly updates.

CN-1TO: Technical Assistance to China: HIS

Lead: Anwer Aqil (John Snow, Inc.)

Technical Advisor: ThuVan Dinh (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to improve routine health information systems for HIV/AIDS programs in the Yunnan and GuangXi provinces in China.

Description:
Starting in October 2006, discussions took place with representatives of various Chinese government agencies involved in the collection and use of the national HIV/AIDS information system to agree on a two year workplan on HMIS strengthening. MEASURE Evaluation proposed to use the PRISM conceptual framework which emphasizes defining the performance of routine health information systems (RHIS) while incorporating behavioral, organizational, and technical determinants. The work started in April 2007 with the organization of a HMIS assessment study using the PRISM tools. Based on the findings of the assessment study, consensus-building workshops took place in June in both provinces for stakeholders to agree on HMIS strengthening interventions. Using this workplan agreed upon by all stakeholders, MEASURE Evaluation TO will assist the Yunnan and GuangXi implementing partners in implementing a series of technical, organizational, and behavioral interventions in the coming year. Part of these interventions will focus on the coordination of PEPFAR reporting in both provinces.

Tasks:
1. Share baseline preliminary results in dissemination and intervention planning workshop in Guangxi.
2. Complete final baseline HMIS assessment reports of Gunagxi and Yunnan.
3. Finalize the selected HMIS interventions in Guangxi.
4. Share baseline preliminary results in dissemination and intervention planning workshop in Yunnan.
5. Implement the HMIS interventions Guangxi.
6. Select and implement the HMIS interventions in Yunnan.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Conduct the Yunnan HMIS strengthening workshop.

* Prepare the Yunnan HMIS strengthening workshop report.

* Prepare and pretest the HMIS intervention training manual in both Guangxi and Yunnan.

Task Order October-December Activity Sheets

* Conduct a training of master trainers in December in both Guangxi and Yunnan.

* Facilitate one training workshop of county and facility staff by master trainers in both Guangxi and Yunnan.

* Publish the China HMIS assessment results in a peer reviewed journal.

Progress:
During this quarter, the Guangxi CDC office completed a survey of the USAID supported counties. Yunnan CDC organized the baseline result sharing and intervention development workshop on November 8-9, 2007. A training curriculum on the use of information feedback was developed for improving the competence of the CDC officer and staff at the provincial, county and facility levels. The CDC China central office was consulted on the development of the training manual, which was approved by both CDC offices. All planned activities and deliverables were achieved. These include: (1) approved Baseline HMIS Survey Reports for Guangxi and Yunnan Provinces were made available; (2) training manual on the Continuous Improvement of HMIS Performance: Quality and Information Use, Focus on HIV/AIDS Services was made available; and (3) the Yunnan HMIS baseline assessment results sharing and intervention development workshop was conducted and the report is available.

A total of 26 and 16 master trainers were trained in Guangxi and Yunnan provinces respectively. Training workshop reports for Master trainers in Guangxi and Yunnan are available, in addition to a detailed implementation plan for training, feedback, and sharing success stories in Guangxi and Yunnan provinces. A peer review publication is being discussed with CDC officials, and after approval, will be sent for publication.

Year 1 Quarter January, February, March

Plans:
* Conduct a training of the county and facility staff by Guangxi and Yunnan CDC. A total of 340 persons will be trained in six counties of each province.

* Supervise the training and act as a one of the trainers.

* Monitor data quality and information use during field visits.

* Conduct a supervisory visit in late February or early March to monitor project progress.

* Submit a peer review publication by the end of March.

DO-2TO: Technical Assistance to the Dominican Republic

Lead: Silvia Alayon (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this scope of work is to strengthen the ability of NGOs, CBOs, and FBOs that provide HIV/AIDS services to monitor and evaluate their programs while meeting donor reporting requirements and supporting the use of HIV/AIDS information for policy making and program planning.

Description:
The MEASURE Evaluation TO will strengthen monitoring and evaluation skills in NGOs, FBOs and CBOs and provide USAID/DR with quality, accurate, and valid information consolidated in a bi-annual M&E report. These reports will be shared with the GODR, as well. This will be achieved through the tasks described below.

The work will be accomplished by either hiring a local consultant or contracting a local firm to help with planning and logistics for the two workshops, serve as a technical resource to partners following the workshop, coordinate data collection at the end of the fiscal year, and draft the report. During the first visit, MEASURE Evaluation TO will explore the possibility of identifying a local firm instead of a consultant. The decision on whether to engage a local firm will be made by balancing cost considerations with the longer term objective of building institutional capacity in M&E. US-based staff will backstop the local firm or consultant and provide assistance to facilitate the workshops, design the M&E system, train implementing partners, process and analyze data, and draft the report.

Tasks:
1. Hire local consultant.
2. Conduct planning workshop: obtain input from USG partners on the design of the M&E System.
3. Develop a plan for an M&E system.
4. Train FBOs, CBOs, and NGOs on the new M&E system.
5. Provide support to FBOs, CBOs, and NGOs and serve as a technical resource to USG partners to implement the new M&E system.
6. Coordinate HIV/AIDS data collection among USG partners.
7. Provide USAID/DR with the first bi-annual M&E report.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* Begin work with the awardee of a bid to manage sub-grants to NGOs, FBOs, and CBOs for the implementation of HIV/AIDS activities, to design the M&E system for USAID-funded HIV/AIDS activities.

* Maintain communications with the mission and draft the terms of reference for the local consultant who will be hired in January 2008.

* Obtain mission approval on the TOR.

* Begin recruitment.

Progress:

During this quarter, Deshpande and Alayon maintained communications with the USAID mission in the Dominican Republic. Terms of reference for a local consultant were drafted and submitted to the mission for their approval, which is pending.

Year 1 Quarter January, February, March

Plans:

* Obtain mission approval on the TOR for the consultant.

* Make an initial trip to the Dominican Republic to interview and hire a local consultant.

* Conduct a planning workshop with local stakeholders and HIV/AIDS implementing partners.

EAF-4TO: Workshop on M&E of PHN (Anglophone) 2008

Lead: Anastasia Gage (Tulane University)

Technical Advisor: Lisa Maniscalco (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to increase individual and institutional capacity for M&E in Anglophone Africa.

Description:
This activity includes the development and implementation of a three week workshop on M&E of population, health, and nutrition programs for mid-level professionals from the Anglophone countries of Africa, in collaboration with Addis Ababa University in Ethiopia. The workshop will be offered in mid-2008. A limited number of MEASURE Evaluation TO fellowships (up to 5) will be offered to qualified participants from USAID-assisted countries. The design, organization, and implementation of the workshop will be done by a joint team of AAU faculty and MEASURE Evaluation TO staff.

Tasks:
1. Finalize planning for the 2008 workshop including agenda, instructors, budget, logistics, and timeline.
2. Provide logistical support for the workshop as needed.
3. Conduct workshop.
4. Prepare Activity Report.
5. Conduct follow-up of trainees.
6. Close out activity.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Re-new the agreements with AAU, EPHA, DCH/SPH, and PSRC.

* Develop a workshop budget.

* Plan for the 2008 workshop including agenda, instructors, budget, logistics, and timeline.

Progress:
During this quarter, staff finalized the activity report and all close-out activities for the 2007 workshop, and began discussing the new partnership agreement with our partners at AAU. Further progress was delayed due to multiple transition issues arising from the transfer from MEASURE Evaluation to the MEASURE Evaluation Task Order.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Re-new the agreements with AAU, EPHA, DCH/SPH, and PSRC.

* Develop a workshop budget.

* Plan for the 2008 workshop, including agenda, instructors, budget, logistics, and timeline.

* Develop the workshop brochure, application, and announcement materials.

* Announce the workshop and begin dissemination.

GLB-1TO: General Data Demand & Data Use

Lead: Scott Moreland (Constella Futures)

Technical Advisor: Bamikale Feyisetan (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to promote the expanded implementation of data demand and information utilization (DDIU) strategies throughout task order activities.

Description:
This activity supports overall coordination, technical leadership, and management of DDIU within the task order. This includes integration of the DDIU conceptual framework into task order data activities, participation in collaborative networks for DDIU such as the MEASURE partners group and the CDC/WHO/UNAIDS data use group, leadership of technical meetings with task order partners to keep them informed on DDIU strategies and approaches, and documenting results in improved data use.

Tasks:
1. Continue collaborations with MEASURE partners and with CDC, WHO, HMN, UNAIDS, and the World Bank on approaches to facilitating data use. Specific focus will be on collaborating with the World Bank GAMET to incorporate DDIU activities into national M&E programs in Eastern Africa.
2. Provide DDIU technical assistance to global activities and other CAs and partners as required.
3. Function as an internal technical resource to support and add value to core and field activities with DDIU components.
4. Work with activity leads to formulate Task 1 results.
5. Conduct a regional DDIU Information Sharing Conference in Africa with national M&E managers and directors from countries in the region to share DDIU techniques and experiences.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Continue to disseminate the DDIU conceptual framework, guidelines, and tools and the DDIU case study documents.

* Provide DDIU TA to global activities and other CAs and partners.

* Communicate with WHO and HMN with a view to developing joint DDIU activities and strategies.

Task Order October-December Activity Sheets

* Utilize the MEASURE Evaluation Compendium of DDIU activities to monitor progress towards achievement of DDIU-related results.

Progress:
DDIU staff attended a meeting organized by USAID/Washington that focused on DDIU. The meeting's purpose was to begin to develop a DDIU resource guide for countries that would help to develop DDIU activities and find an appropriate USAID project for assistance, including MEASURE Evaluation TO. MEASURE Evaluation TO will take the lead in developing this guide.

Plans for a DDIU case study on the use of Health Facility Assessment (HFA) data were discussed with the HFA working group/network.

MEASURE Evaluation TO DDIU staff discussed with MEASURE DHS and with Health Policy Initiative, the possibilities for collaboration in the DDIU area. DDIU staff continued to monitor DDIU activities by partners on MEASURE Evaluation TO.

Year 1 Quarter January, February, March

Plans:
* Continue to disseminate the DDIU conceptual framework, guidelines, and tools and the DDIU case study documents.

* Continue to utilize the MEASURE Evaluation Compendium of DDIU activities to monitor progress towards the achievement of DDIU-related results.

* Update the DDIU component of the MEASURE Evaluation workgroup.

* Complete the DDIU guide for USAID/Washington.

* Plan for an anticipated DDIU International Workshop for the April-June quarter or the July-September quarter.

* Communicate with WHO and HMN with a view to developing joint DDIU activities and strategies.

* Provide assistance to the PHE for OVCs in terms of DDIU strategies and eventual activities when the results are ready for discussion.

GLB-3TO: General Coordination with OPRH and HIDN CA's

Lead: Sian Curtis (University of North Carolina at Chapel Hill)

Technical Advisor: Lisa Maniscalco (Elements: Maternal and Child Health (MCH), Family Planning and Reproductive Health (FP/RH))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen coordination and collaboration with USAID BGH CAs and international partners in M&E of population, reproductive health, maternal, and child health programs.

Description:
This activity covers attending USG and global technical meetings, reviewing M&E components of documents, and providing M&E advice to BGH CAs and other international partners in population, reproductive health, maternal health, and child health programs outside of the context of specific activity codes.

Tasks:
1. Respond to TA and meeting requests on an as needed basis.
2. Provide M&E consulting support to OPRH CAs as needed.
3. Participate in IGWG TAG.
4. Participate in CORE M&E Working Group.
5. Participate in PMNCH M&E Working Group.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Attend the UN expert group meeting on indicators to measure violence against women from 8-10 October, 2007 in Geneva.

* Participate in an IGWG GBV Task Force meeting on monitoring and evaluation of GBV initiatives. Speizer will present on the findings from the recent Haiti youth study and on the GBV M&E curriculum and Curtis will moderate a panel discussion on evaluations of GBV interventions.

* Attend other technical and coordination meetings that arise in the quarter, as needed.

* Participate in IGWG and CORE M&E working group meetings, as needed.

Progress:
Bloom attended the UN Expert group meeting on indicators to measure violence against women in October in Geneva. The meeting provided an opportunity to share the work

Task Order October-December Activity Sheets

MEASURE Evaluation TO is doing to develop the compendium of indicators on violence against women and to coordinate that work with the work of the expert group. Curtis and Speizer attended the IGWG GBV Task Force meeting on M&E of GBV initiatives. Speizer presented findings from the recent PLACE study of youth reproductive risk behaviors in Haiti and Curtis moderated a panel discussion on evaluations of GBV interventions.

Year 1 Quarter January, February, March

Plans:

* Participate in technical and coordination meetings as needed.

GLB-4TO: General Tools and Methodologies and Technical Assistance

Lead: Sian Curtis (University of North Carolina at Chapel Hill)

Technical Advisor: Bamikale Feyisetan (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to respond to ad hoc and emerging technical needs.

Description:
This activity allows the project to respond to emerging non-PEPFAR technical priorities in M&E and HIS. These needs may include conducting secondary analysis to address specific emerging questions, conducting emerging small-scale technical activities, preliminary technical work for potential new activities that arise between funding cycles, additions to scopes of work of existing activities in response to evolving needs, revisions to academic papers, and small-scale follow up to earlier MEASURE Evaluation activities that are no longer active.

Tasks:
1. Respond to technical requests for new work or follow on to previously completed activities, as needed.
2. Prepare journal articles based on previous MEASURE Evaluation work, as appropriate.
3. Provide sampling support for MEASURE Evaluation TO data collection activities.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Respond to new requests that arise, as appropriate.

* Provide sampling support for MEASURE Evaluation TO activities, as needed.

Progress:
There are no specific activities to report this quarter.

Year 1 Quarter January, February, March

Plans:
* Respond to new requests as needed and appropriate.

GLB-8TO: Global HIV/AIDS Coordination Unit

Lead: Svetlana Negroustoueva (Macro International Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to increase collaboration and coordination of global HIV/AIDS M&E efforts.

Description:
This activity includes supporting the UNAIDS Monitoring and Evaluation Reference Group (MERG) and its working groups: Indicator Harmonization, Coverage, and Evaluation. MEASURE Evaluation TO will contribute technical expertise in UNAIDS MERG activities, participate in other national and international HIV/AIDS technical meetings on behalf of the project, and review relevant documents by partner organizations, as appropriate.

Tasks:
1. Work with the Indicator Harmonization and Registry Technical Working Group on further harmonization and technical guidance of indicators. Complete work on populating the Indicator registry with indicator definitions and meta-data associated with indicators.
2. Continue to coordinate and collaborate in global level meetings, conference calls, and communications, including monthly multi-agency conference calls (MACC).
3. Participate in the Indicator Harmonization, Coverage, and Evaluation working groups, including meeting attendance.
4. Continue ongoing work to coordinate and monitor technical assistance requests as needed.
5. Support and coordinate USG participation in global indicators meetings.
6. Attend the MERG meetings.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Attend the MERG meeting including the first MARP International Thematic Working Group (ITWG) meeting.

* Participate in the Indicator Harmonization, Coverage, MARP, and Evaluation working groups.

* Work with the Registry Technical Working Group on the Review Indicator registry with indicator definitions and meta-data associated with indicators, including key-words.

Task Order October-December Activity Sheets

* Prepare the Registry for the first release for the MERG meeting in December 2007.

Progress:
Noone, from the MEASURE Evaluation TO team, attended the MERG meeting. In preparation for the meeting, Curtis reviewed Evaluation working group materials which were presented at the MERG. The HIV/AIDS Indicator Registry was also presented at the MERG meeting and members were given until the end of January ,2008 to submit comments. Negroustoueva reviewed the Registry and submitted comments to the Registry Working Group chair. The National Core Indicators, an outcome of the Indicator Harmonization Working Group, was released at the MERG meeting as well.

Year 1 Quarter January, February, March

Plans:
* Participate in the bi-weekly MACC calls.

* Provide TA to the HIV/AIDS Registry development.

* Provide TA to the HIV/AIDS Indicators Harmonization Working Group.

* Attend the UNAIDS Monitoring and Evaluation Reference Group meeting.

GLB-9TO: Global PEPFAR Tools/Methodologies

Lead: Sian Curtis (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to support emerging tools and methods development relevant to PEPFAR SI needs that arise between funding cycles.

Description:
This activity allows the project to respond quickly to emerging technical needs to support central PEPFAR SI priorities that arise between funding cycles and to collaborate with global partners on manuals, guidelines, and other tools that are relevant to PEPFAR. Such needs include supporting and attending technical meetings for PEPFAR, initial technical work for emerging tools, methods and guideline development, reviewing PEPFAR technical documents, and additions to existing centrally-funded SI scopes of work in response to evolving priorities.

Tasks:
1. Attend and support technical meetings relevant to PEPFAR SI, as needed.
2. Participate in document review groups and other advisory groups relevant to PEPFAR SI, as needed.
3. Respond to emerging technical needs and ad hoc technical requests relevant to PEPFAR SI.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Participate in relevant PEPFAR technical meetings, as appropriate.

* Respond to emerging technical needs for PEPFAR, as appropriate.

Progress:
No specific activities to report this quarter.

Year 1 Quarter January, February, March

Plans:
* Respond to emerging needs related to PEPFAR as needed.

GLB-10TO: Global PLACE

Lead: Sharon Weir (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to provide technical leadership, coordination, and dissemination of the PLACE method as well as PLACE extensions for most at risk populations.

Description:
In the MEASURE Evaluation TO, this activity shifts from the development and implementation of new PLACE activities to publication and dissemination of PLACE results, increasing access to PLACE data and indicators, and critical review of lessons learned and recommendations to improve data use. Publication and dissemination activities will strategically focus on reaching specific key populations: M&E sub-committees of national AIDS control programs; the prevention science research community; and potential users of the PLACE method.

Tasks:
1. Prepare and submit a peer reviewed article on biomarkers and PLACE data and present findings at an international meeting.
2. Provide access to PLACE Indicators on the DHS website.
3. Prepare and submit an article to a peer review journal comparing PLACE indicators from several countries.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Resubmit the PLACE article using biomarker data from the PLACE Kinshasa study to validate the PLACE method.

* Submit an article on PLACE in Madagascar to the Journal of AIDS (JAIDS).

* Initiate an article comparing PLACE data from several countries with Khan as a co-author.

* Meet with high-level social science researchers working in China who are engaged in HIV research and describe the PLACE method to them.

* Determine whether it is feasible to publish a compendium of PLACE articles or if publisher restrictions make a compendium of pdfs not feasible.

Task Order October-December Activity Sheets

Progress:
The paper on the Kinshasa PLACE study findings was resubmitted. The article on PLACE in Madagascar was submitted and rejected. It will be resubmitted to another journal, not yet identified. Khan and Weir identified two paper topics that would compare DHS and PLACE data across several countries. One paper is on the characteristics of men with high rates of partner acquisition and the other is on the characteristics of women with high rates of partner acquisition. The focus will be an exploration of concurrency, commercial sex, and sexual mixing. Weir met with researchers from China and reviewed the PLACE protocol with them. Much discussion was held regarding the PLACE compendium and the decision was made to do a MEASURE Evaluation Monitor e-newsletter issue on PLACE instead with a target date of July, 2008.

Year 1 Quarter January, February, March

Plans:
* Make progress on the comparative PLACE paper.

* Make progress on the MEASURE Evaluation Monitor issue dedicated to PLACE.

* Submit the paper summarizing the results of the Jamaica PLACE RCT to a journal.

* Develop a plan for adding the PLACE indicators to the DHS website.

GLB-12TO: Global TB Technical Assistance

Lead: Stephanie Mullen (John Snow, Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Tuberculosis (TB))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objectives of this activity are to: increase collaboration and coordination of global TB monitoring and evaluation efforts in priority USAID countries; increase collaboration and coordination to obtain and communicate TB data to ensure that the information generated is used for program decision-making and policy setting; and improve the design and implementation of the TB information gathering process including tools, methodologies, and technical guidance to meet user's needs.

Description:
In December 2002, with USAID core funding, MEASURE Evaluation, in collaboration with WHO/STOP TB, established a M&E TB working group to ensure collaboration on TB indicators and share expertise in this field. The working group consists of members from STOP TB/WHO, KNCV, CDC, USAID, the Union, Global Drug Facility, MSH, and the World Bank. The first product of this working group was a compendium of TB indicators to enable monitoring and evaluation of the National TB Programs. In Years 3 and 4 of MEASURE Evaluation Phase II, staff conducted four regional TB M&E workshops to build capacity for M&E and the TB compendium. Activities under the MEASURE Evaluation Task Order will build on this existing work to further strengthen the M&E capacity of national TB programs. Specifically, this activity will cover the tasks listed below as well as overall technical management and coordination of MEASURE Evaluation TO TB activities.

Tasks:
1. Provide general management and oversight for TB activities.
2. Coordinate with TB partners such as the Core Group and the STOP TB Partnership.
3. Conduct TA to countries as requested.

Year 1 Quarter January, February, March

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on January 1, 2008.

* Develop survey instruments for TB lab partners.

* Conduct a TB lab partner survey.

GLB-13TO: Health Metrics Network

Lead: Philip Setel (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to collaborate and coordinate with the Health Metrics Network (HMN) by providing technical leadership to the HMN Technical Advisory Group and participating in the production of high-profile outputs that advocate and set standards for increasing demand, production, quality, and use of health information in resource-constrained countries.

Description:
The HMN has become a global change agent in strengthening health information systems and methods. Since the inception of the HMN, the JSI/UNC Consortium implementing the MEASURE Evaluation TO has been a key collaborator, helping to shape its strategic vision, operational priorities, and technical standards.

The collaboration will focus on participation in the HMN Technical Advisory Group (TAG), which provides guidance on technical issues to the HMN Board and relevant Task Groups. The areas of expertise sought from the MEASURE Evaluation TO include routine health information systems and vital events data. Staff will also participate in the meetings of the Monitoring of Vital Events Task Group (MoVE), which works to sustainably strengthen the demand, production, and use of vital statistics, including causes of death. If resources allow, staff will also make contributions to the HMN Data Use Task Group (to be formed in 2007) and to standards for assessing and strengthening routine health information systems.

Tasks:
1. Participate in TAG and provide guidance to HMN Board of Directors in the form of substantive contributions in TAG reports and recommendations.
2. Collaborate in production of training materials for certifying underlying causes of death, and applying ICD-10 to facility-based and non-facility based death certificates in developing country settings (if resources allow).
3. Provide input into updating and revisions of HMN country HIS assessment procedures (if resources allow).
4. Provide input into HMN materials and advocacy on data demand and information use (if resources allow).

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Participate in TAG meeting.

* Participate in the launch of MoVE Stepping Stones Resource Kit at GFHR.

* Begin work on the WHO Technical Report on the Standard VA publication.

* Increase the level of collaboration on expanding the use of ICD in developing countries.

* Increase the level of input into DDIU issues.

Progress:

Lippeveld and Setel attended the sixth TAG meeting held in Geneva on November 15-16, 2007. At this meeting, the TAG hosted an informal and optional pre-TAG day of free-ranging discussions on November 14. These meetings centered on brief updates on the status of HMN tools and existing Task Forces, but devoted most its agenda to discussions regarding plans and progress from the newly proposed working groups from TAG-5.

Lippeveld also had discussions with HMN on a joint RHINO-HMN project to develop enterprise architecture for RHIS. It was agreed that in the coming months a proposal will be prepared jointly between RHINO and HMN (see also GLB-15TO).

Setel, Mikkelsen, and AbouZahr reported on progress of Monitoring of Vital Events (MoVE) task group and discussed priorities for 2008. Setel provided extensive comments on the proposed M&E plans and framework for HMN in advance of the HMN Board meeting.

Year 1 Quarter January, February, March

Plans:

* Attend a technical meeting on the refining of the HMN Planning Tool, January 24-25, 2008 in Geneva. (Lippeveld)

* Attend the seventh TAG meeting on April 21 in Cambodia. (Lippeveld and Setel)

* Provide input on priorities for MoVE activities in 2008. (Setel)

GLB-14TO: HIS Inventory and Tool Development

Lead: Anwer Aqil (John Snow, Inc.)

Technical Advisor: John Novak (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to share research findings, experiences, and lessons learned from using PRISM tools with decision makers and key stakeholders.

Description:
MEASURE Evaluation TO will publish a peer reviewed journal article on application of the PRISM framework and its tools in Uganda, Pakistan, Mexico, Paraguay, and other countries. The purpose of the article will be to show how the PRISM framework and its tools have been used to improve RHIS performance. This activity will also include developing an operational guidance on the use of PRISM tools.

Tasks:
1. Collect all relevant data and materials from Pakistan, Uganda, South Africa, Mexico, Honduras, and Paraguay.
2. Complete the operational guidance on the use of PRISM tools and publish.
3. Analyze and present the data from the countries as examples of PRISM tool use.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Finalize and publish PRISM case studies.

* Finalize and publish PRISM Tools User's Guidelines.

Progress:
The Health Policy and Planning Journal accepted the revisions by the authors and the paper has been sent to external reviewers. The work on the PRISM Case studies and PRISM Tools User's Guidelines was delayed due to priority work in the China and Haiti HMIS evaluations. It will be completed in the next quarter.

Year 1 Quarter January, February, March

Plans:
* Finalize and publish the PRISM Case Studies describing experiences from Pakistan, Uganda, South Africa, and Mexico.

* Finalize and publish the PRISM Tools User's Guidelines by the end of March.

GLB-15TO: RHINO

Lead: Theo Lippeveld (John Snow, Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to promote high quality and practical approaches to the collection and use of routine health information in developing countries.

Description:
Comprised of health and information professionals from developing country governments, donor agencies, technical groups, universities, and private volunteer organizations (PVOs), RHINO seeks to strengthen the role of routine health information systems for evidence based decision making in least developed countries (LDC) health systems and improve overall planning and management of the health services. Under Phase II of the MEASURE Evaluation Project, RHINO was established as an independent NGO registered in Massachusetts. An application has been submitted to IRS to qualify for 501(c)3 status. A board of Directors will be created to monitor the overall functioning of the network. The RHINO Steering Committee sets priorities and agenda items to improve responsiveness to its members. RHINO uses a website, email list server, and electronic forums to maintain continuous contact with its members. In addition, RHINO participates in conferences where it can contribute to knowledge and use of routine health information.

Under MEASURE Evaluation TO, the intention is to strengthen RHINO as an independent NGO, both financially and administratively. An incorporated RHINO will also have greater flexibility in diversifying its activities as well as forming strategic alliances. The activity lead and the RHINO manager are in contact with various organizations to join the Board of Directors and provide financial contributions to allow for an expanded number of activities and long term sustainability. Potential strategic alliances could be established with international aid agencies such as USAID, WHO, World Bank, Asian Development Bank, and European aid agencies, with private foundations such as Gates, Rockefeller, and Soros Open Society Institute, with government Health Ministries, with academic institutions and non-government organizations, and with corporations with commercial interests in the field of health information such as IBM, Oracle, Hewlett-Packard, Intel, and others. Finally, RHINO will continue to strengthen as an advocacy network and the activities in the MEASURE Evaluation TO will be based partially on the findings of a formative evaluation of the listserv and website undertaken during MEASURE Evaluation Phase II.

Tasks:
1. Further strengthen RHINO as a private non-profit organization through the development of a set of administrative and financial procedures, as well as fund raising activities.
2. Maintain close relationships with the Health Metrics Network.
3. Raise the visibility of RHINO through the establishment of other strategic alliances with a variety of public and private partners.

4. Organize and manage the RHINO Board of Directors meetings as well as Steering Committee meetings.
5. Organize RHINO panel presentations at APHA, Global Health Council or other appropriate conferences.
6. Strengthen the technical content and format of the RHINO website/listserv based on the findings of a formative evaluation undertaken by UNC public health students under MEASURE Evaluation Phase II.
7. Provide leadership and content to the RHINO listserv, including the organization of RHINO forums.

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Further strengthen RHINO as a private non-profit organization through the development of a set of administrative and financial procedures, as well as fund raising activities.

* Maintain close relationships with the Health Metrics Network.

* Raise the visibility of RHINO through the establishment of other strategic alliances with a variety of public and private partners.

* Organize the first RHINO Board of Directors.

* Recruit and train an Executive Director.

* Strengthen the technical content and format of the RHINO website/listserv based on the findings of a formative evaluation undertaken by UNC business students in MEASURE Evaluation Phase II.

Progress:

During this quarter, a pre-Board meeting was organized on November 3rd in DC, inviting potential future Directors of the Board, including Sally Stansfield, executive secretary of HMN. During this meeting, the Articles of Organization and the By-laws of RHINO, including the criteria for election to the Board, were discussed in detail and updated where necessary. It was also planned that RHINO and HMN would prepare a proposal to develop an enterprise architecture for a Routine Health Information System (RHIS) and submit it for funding.

The founding Directors (Lamstein, Lippeveld, and Spohr) decided in December by written consent to expand the Board of Directors with six new Directors, representing the following organizations: Abt Associates, AEDES, HISP, HMN, UNC and URC. They also approved the revised Bylaws.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Organize a Board Meeting in February to appoint the Executive Director and nominate the Technical Advisory Committee.

* Develop the (RHIS) Enterprise Architecture proposal and submit it to the funding agency.

* Revise the technical content and format of the RHINO website and listserv.

GLB-17TO: SAVVY: Vital Registration with Verbal Autopsy

Lead: Dan Williams (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to provide technical leadership in the use of demographic surveillance, verbal autopsy, medical records, the International Classification of Disease (ICD-10) system, and other mortality data sources to improve the monitoring and measurement of vital events and causes of death in low-resource settings.

Description:
In continued collaboration with the US Census Bureau, the focus for SAVVY at the global level will be on the continued development and promotion of internationally-standardized mortality surveillance tools and methods as a central piece of long-term population impact evaluation. The focus is on HIV/AIDS, malaria mortality, improving information on births and birth outcomes, and other key components of disease burdens in resource-constrained countries. This information is used in priority-setting, planning and impact evaluation and is not available from other sources.

Collaboration will continue with other international stakeholders (e.g. WHO; WHO-Family of International Classifications Network; CDC-NCHS; Health Metrics Network; and the Institute for Population Health Metrics and Evaluation) on setting global standards in sample vital registration, verbal autopsy, improving the quality of medical death certification data, and seeking ways of diversifying streams of support for the long-term central-level technical assistance and local capacity investment needed to establish and maintain relevant systems within countries. New, valid, and innovative methods will be explored for the local use of population denominator, fertility, and household poverty status data and for providing direct measures of total and cause-specific mortality with a focus on HIV/AIDS, malaria, TB, and newborn and child health.

The US-based SAVVY Team will serve as a resource for some specified country level activities. The bulk of SAVVY-based methods of cause-specific mortality measurement will be implemented in PEPFAR and PMI countries where field support funds have been allocated.

Tasks:
1. Provide global technical leadership in development, validation, coordination, and collaboration on methods to produce and use high quality mortality and cause-of-death data.
2. Provide technical assistance to USG, Missions, PEPFAR SI and PMI teams, country health ministries, and statistics offices to explore and plan SAVVY methodologies.
3. Collaborate with international partners to improve medical death certification and ICD-10 mortality coding in developing countries with a focus on AIDS, malaria, and birth outcomes.

4. Publish reports and scientific papers to demonstrate validity of methods for planning and evaluation of health programs, with a focus on HIV/AIDS, malaria, and neonatal mortality.
5. Promote demand for and use of newly available mortality data sets based on medical records and standardized verbal autopsy methods through primary and secondary analysis activities in collaboration with international partners and country institutions.

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Attend and support the HMN/WHO-sponsored launch of the consensus international standard verbal autopsy (VA) forms at the Global Forum for Health Research in Beijing from October 29 to November 2.

* Launch the SAVVY Resource Kit, using the consensus VA forms, after the WHO VA forms are released. The Resource Kit will be announced by the November issue of the MEASURE Evaluation Monitor e-newsletter, and CDs containing the entire Resource Kit will be distributed to a selected group of collaborators and stakeholders. The CDs will also be available upon request on the MEASURE Evaluation web site.

* Present the Mozambique INCAM mortality survey methodology at a WHO-sponsored workshop on the measurement of maternal mortality during the 2010 Census round, and discuss the feasibility of incorporating verbal autopsy methodologies into future Censuses.

* Continue to collaborate with PMI and PEPFAR countries to improve cause-specific mortality information in areas where it is not available.

Progress:

The WHO international standard verbal autopsy (VA) forms were launched at the Global Forum for Health Research in Beijing, China from October 29 - November 2, 2007. The SAVVY team, which was heavily involved in the development of these forms, attended and presented on the application of these forms in Mozambique's post-census mortality survey (INCAM). In addition, the SAVVY team presented the methodology used during INCAM at a WHO-sponsored workshop in Geneva on the measurement of maternal mortality during the 2010 Census.

The SAVVY Resource Kit was launched via the MEASURE Evaluation Monitor e-newsletter immediately following the launch of the WHO VA forms.

These high-profile international events are part of a WHO/HMN strategy, supported by MEASURE Evaluation TO, to emphasize the importance of civil and vital registration data as an input to evidence-based public health policy. MEASURE Evaluation TO continues to support PEPFAR and PMI countries in their quests to improve the availability of civil/vital registration data, as well as cause-specific mortality information.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Lead the development of a validation study of the WHO international standard VA tool.

* Continue research to identify the most appropriate methods of certifying and coding death certificates using VA data.

* Continue to support PMI and PEPFAR countries to improve cause-specific mortality information where it is not available.

GLB-27TO: Capacity Building Internet Based Tools

Lead: Melissa Dunn (University of North Carolina at Chapel Hill)

Technical Advisor: Lisa Maniscalco (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to facilitate global capacity building in M&E through the tracking of and communication with MEASURE Evaluation and MEASURE Evaluation TO trainees.

Description:
This activity involves the further development and implementation of a M&E trainee tracking system to follow-up with participants of the regional M&E workshops and graduates from the Master's programs to determine how they are using their new M&E skills, to obtain feedback on the relevance of the topics included in the workshops and master programs, and to find opportunities for collaboration in M&E activities. The trainee database, which is the base of the tracking system, also facilitates communication with and among MEASURE Evaluation and MEASURE Evaluation TO alumni, provides a directory of human resources trained in M&E, and facilitates announcements of MEASURE Evaluation TO workshops, masters degree programs and other M&E related activities.

Tasks:
1. Maintain and upgrade training database.
2. Conduct routine follow-up of former trainees and masters graduates.
3. Compile success stories and lessons learned from trainee follow-up responses.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Refine and develop the training database by editing its structure and function, as well as adding trainees to the database.

* Compile, update, and disseminate trainees success stories pamphlets.

Progress:
Staff continued to add recent trainees and trainers to the training database. During this quarter, staff sent 155 six-month and/or 1-year follow-up questionnaires. Of those emails sent, 44 former trainees completed and returned the follow-up questionnaire resulting in an overall response rate of 28% for the quarter. Staff are actively exploring different approaches to increase response rates. Some examples of success stories received from former workshop participants during this quarter include:

Task Order October-December Activity Sheets

"Yes it has helped, but I have no specific "story" to share. But I have recommended the course to others, if they can find the funding." Thailand PHN Workshop Participant. 2007-10-19

"I have been working for Reproductive health project monitoring and evaluation in my country. I applied to my work what I have learned in M&E workshop. It was very easy to understand and applied easily." Thailand PHN Workshop Participant.2007-10-19

"Sharing the knowledge with the district Directors has improved the quality of reports on the various public health interventions to the Regional level." Ethiopia PHN Workshop Participant. 2007-09-17

"Developing the overall M&E module for the Nutrition Program of the Ministry of Health as a part of the overall health M&E framework. I was part of the Nutrition Group during the group assignment in Ethiopia. I am adopting the approach used in the group assignment to develop the M&E plan for Nutrition in Southern Sudan. It is only yesterday, September 27, 2007, that I convened a meeting with the Nutrition Technical Working Group and we have formed a small task force of five member institutions (MoH/UNICEF/WFP/Tearfund/ACF-USA) to look closely into the module we developed in Ethiopia and work out which components/tools will be adopted. Once this is done, the task force will draw out the plan of how to engage stakeholders in a planning process that follows some of the tools selected then develop indicators based on the processes stipulated. This is to ensure we contribute practical indicators to the overall health M&E framework. I will provide an update of the progress of this adoption process once we make some breakthroughs." Ethiopia PHN Workshop Participant. 2007-10-01

"The M&E Workshop has improved my knowledge on M & E issues and this has stimulated me to start M.PH program with the University of Liverpool(Online). I make use of the workshop materials a lot in the M.PH Programme. I am now an M&E guru." South Africa HIV Workshop Participant. 2007-10-08

"From the time I attended the workshop, my M&E skills improved greatly. I had great inputs in the formulation of baseline survey tools for safety nets for HIV infected and affected households. I was the co-investigator in the research. I am now critical thinker than before. However, I still have problems in SPSS." South Africa HIV Workshop Participant. 2007-09-21

"At that stage we were in the process of finalizing our nation M&E plan, which I realized at the workshop needed some revising. Therefore after the workshop, I have reviewed the national M&E framework and plan for my country to be in line with what I have learned at the workshop. Most importantly, the workshop assisted me to build up an M&E network of friends, with whom we share documents, advice, comments on any M&E related activities." South Africa HIV Workshop Participant. 2007-05-17

Year 1 Quarter January, February, March

Plans:

* Refine and develop the training database by editing its structure and function, as well as adding trainees to the database.

GLB-53TO: WHO ART Patient Tracking

Lead: Renee Fiorentino (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to support the adaptation and implementation of the patient monitoring guidelines for HIV care and ART in PEPFAR focus countries.

Description:
In the MEASURE Evaluation TO, this activity will continue to adapt, implement, revise, review, and strengthen the basic patient monitoring tools in PEPFAR countries. This will be carried out through direct technical assistance to countries and through country and regional trainings. An operationalization guide will be developed to facilitate these activities, along with improved training materials. Important linkages to PMTCT, TB, and under-5 care programs will be made to create comprehensive facility-based information systems. Finally, a scientific publication will be done to provide written evidence for simplified patient monitoring systems.

Tasks:
1. Conduct country and regional trainings.
2. Develop operationalization guide.
3. Improve training materials.
4. Draft HIV-adapted tools for PMTCT monitoring.
5. Publish scientific paper.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Co-facilitate the WHO/EMRO HIV care and ART Patient Monitoring workshop, November 7-8, 2007 in Sana'a, Yemen.

* Continue to work with WHO on the operationalization guide (including the annual review monitoring tool) with preparation for field testing in January 2008 being a priority.

* Continue to improve the patient monitoring training materials, with an emphasis on updating and harmonizing the French materials.

* Participate in the validation of the HIV-adapted tools for PMTCT monitoring, with a view to pilot testing these tools in January 2008.

* Continue to work on development of a scientific paper for publication, with an emphasis on demonstrating reportability of outcome and impact information from the routine HIV care and ART patient monitoring system.

Task Order October-December Activity Sheets

Progress:
During the past quarter, Fiorentino co-facilitated the WHO/EMRO HIV Care and ART Patient Monitoring workshop, November 7-8, 2007 in Sana'a, Yemen where 14 countries were represented by National AIDS Program managers and WHO HIV/AIDS focal points.

Work continued with WHO on the Operations Manual for Delivery for HIV Prevention, Care, and Treatment at Primary Health Centres in High-Prevalence Resource-Constrained Settings and other related documents and tools, such as the Basic HIV Service Elements (district level) Manual and the Annual Monitoring Review. The card sorts portion of the Annual Monitoring Review was pre-tested in January 2008 in Ethiopia. Fiorentino also updated the WHO's draft integrated patient monitoring tools suite for presentation at the PMTCT IATT M&E sub-committee's meeting in Washington DC.

Fiorentino participated in the WHO -sponsored Global Health Data Standards workshop held in Nairobi, Kenya, December 4-7, 2007 on behalf of WHO.

Lastly, Fiorentino continued to field countries' patient monitoring TA requests. Work continued on the development of a scientific paper for publication, with an emphasis on demonstrating reportability of outcome and impact information from the routine HIV care and ART patient monitoring system.

Year 1 Quarter January, February, March

Plans:
* Continue to work with WHO on the patient monitoring and quality improvement sections of the Operations Manual for Delivery for HIV Prevention, Care, and Treatment at Primary Health Centres in High-Prevalence Resource-Constrained Settings.

* Continue to work with WHO on other related documents and tools, such as the Basic HIV Service Elements (district level) Manual, and the Annual Monitoring Review.

* Continue to improve the patient monitoring training materials, with an emphasis on updating them to include the integrated patient monitoring system.

* Participate in the validation of the WHO IMPAC modules, including the PMTCT portion of the integrated patient monitoring systems, scheduled for February 25-27, 2008.

* Continue to field and respond to countries' patient monitoring TA requests, including proactive follow-up of countries that participated in AFRO francophone and EMRO regional trainings.

* Liaise with the WHO knowledge management team (and partners) on the development of electronic tools around the minimum patient monitoring data set.

* Continue to work on the development of a scientific paper for publication, with an emphasis on demonstrating reportability of outcome and impact information from the routine HIV care and ART patient monitoring system.

GLB-57TO: SI Field Technical Assistance: Focus Countries

Lead: Silvia Alayon (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen the capacity of USG SI teams in focus countries to respond to PEPFAR reporting requirements and other PEPFAR SI needs.

Description:
MEASURE Evaluation TO will provide as-needed technical assistance to USG SI teams in up to two focus countries, depending on the level of effort required, with an emphasis on supporting implementation of tools and guidelines produced during Phase II of the MEASURE Evaluation Project (e.g. Indicator Guidance, MARP Guide, etc.). The exact nature of the technical assistance will vary according to need but may include short trainings or tailored assistance for the USG SI team or for country partners. Assistance for implementation of DQA tools is not included (see GLB-55TO).

Tasks:
1. Respond to technical assistance requests, as needed.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Respond to requests for TA from focus countries as requested, with an emphasis on supporting implementation of tools and guidelines produced during MEASURE Evaluation Phase II.

Progress:
During this quarter, MEASURE Evaluation TO did not receive any requests for TA from focus countries. During meetings with USAID and OGAC, the USG was reminded of this mechanism for country support.

Year 1 Quarter January, February, March

Plans:
* Respond to requests for TA from focus countries as requested, with an emphasis on supporting implementation of tools and guidelines produced during MEASURE Evaluation Phase II.

GLB-58TO: Indicator Guidelines for Focus & Non-Focus Countries

Lead: Silvia Alayon (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to provide support to the Planning & Reporting subcommittee of the central PEPFAR M&E working group and the OGAC SI unit.

Description:
MEASURE Evaluation TO will continue its support to the Planning & Reporting subcommittee through participation in meetings, providing technical guidance related to indicators, including support of indicator refinement process (PEPFAR and global level indicators), and distributing guidance to the field for planning, target setting, and reporting. MEASURE Evaluation TO will also continue to provide technical guidance and support to USAID and OGAC during the PEPFAR annual results reporting process for other bilateral countries. Finally, MEASURE Evaluation TO will participate in multilateral meetings on global indicators as they relate to PEPFAR indicators.

Tasks:
1. Work with the P&R subcommittee to respond to questions related to the indicator reference guide issued July 2007.
2. Participate regularly in the P&R subcommittee meetings and phone calls.
3. Participate in up to 2 multilateral meetings on PEPFAR indicators, as requested.
4. Provide assistance, with the P&R subcommittee, to other bilateral countries for annual PEFPAR reporting.
5. Collate annual PEPFAR report data from other bilateral countries.
6. Continue annual updating of the Indicator Reference Guide.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Continue to support the Planning & Reporting subcommittee monthly meetings.

* Continue to provide technical guidance and support to USAID and OGAC during the PEPFAR annual results reporting process for bilateral countries. Annual results reporting will begin in November and December, and be completed sometime in January or February.

* Participate in the process for review and revision of indicators for PEPFAR Phase II. This activity is already underway and will be ongoing for the next 6 months.

Task Order October-December Activity Sheets

Progress:
During this quarter, Rose continued to support the PEFPAR Planning and Reporting working group by participating in monthly meetings. Rose participated in the planning of the Next Generation PEPFAR Indicators Launch meeting. This year, OGAC decided not to collect annual results data from other bilateral countries.

Year 1 Quarter January, February, March

Plans:
* Continue to provide support to the Planning and Reporting working group.

* Identify a new liaison to the Planning and Reporting working group. This person will attend regular working group meetings and support the coordination of the Next Generation of PEPFAR Indicators as requested by the working group.

* Participate in the January launch meeting for the Next Generation of PEPFAR Indicators.

* Volunteer to sit on some indicator working groups that are responsible for developing the new indicators for the next phase of PEPFAR. Participation may be limited to reviewing documents produced by the working group as space on the working group for implementing partners is limited.

GLB-61TO: Data Use Guidelines, Case Studies and Training Materials

Lead: Scott Moreland (Constella Futures)

Technical Advisor: Bamikale Feyisetan (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to expand the use of tools and approaches for facilitating increased use of data and information for decision-making.

Description:
The main goal of this activity is to expand the use of DDIU tools and approaches through documenting best practices and providing guidelines on the use of M&E data and health information. Specific activities include: documenting the application of DDIU tools and approaches that are being used in the field; developing additional case studies on innovative and effective approaches for strengthening demand for quality health data and for facilitating evidence-based decision-making; enhancing, revising, and disseminating curriculum materials on data use; and translating the DDIU tools into Spanish and French.

Tasks:
1. Document the application of DDIU tools and approaches that are being used in the field.
2. Prepare additional analytical case studies of innovative and effective data use.
3. Enhance, revise, and disseminate DDIU curriculum materials.
4. Work closely with the MEASURE Evaluation Capacity Building team to integrate the DDIU curriculum into the regional training programs.
5. Translate DDIU tools and training materials into Spanish and French.
6. Revise and adapt existing DDIU curriculum materials in collaboration with the Capacity Building Team to develop a web-based distance learning DDIU module to complement MEASURE Evaluation's existing M&E distance learning course (MENTOR).

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Continue to finalize a series of case studies documenting examples of data use as well as the DDIU curriculum, which has already been tested in several countries.

* Translate the DDIU Conceptual Framework into French.

* Continue to work with the Capacity-Building Team to ensure that DDIU materials, presentations, and tools are integrated into all regional training programs.

Task Order October-December Activity Sheets

Progress:
Work continued on updating and finalizing the case studies, but was delayed due to lack of available DDIU staff time. Work also continued on developing DDIU curriculum materials, including a MENTOR component. Final versions of these should be ready in early 2008.

Year 1 Quarter January, February, March

Plans:
* Translate the DDIU Conceptual Framework into French.

* Complete final versions of the case studies and submit them to the MEASURE Evaluation TO publications unit.

* Develop three to four additional case studies that are drawn from non-MEASURE Evaluation TO activities, such as other USAID or USG projects (AIDS Relief, DHS, HPI).

* Complete the curriculum materials.

GLB-63TO: Health Facility Data Collection Working Group

Lead: Bolaji Fapohunda (John Snow, Inc.)

Technical Advisor: Lisa Maniscalco (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objectives of this activity are 1) to improve communication, coordination, and collaboration around HFA tools, indicators, data availability, and quality (at the global level); 2) to improve the knowledge of types of HFA approaches to data collection and their application for management decisions (at the global and national levels); 3) to establish and promote best practices around the design, implementation, and dissemination of HFA, including tools, methodologies, and guidance in developing HFAs (at the global and national levels); and 4) to expand the use of HFA data for program management and health policies (at the national level).

Description:
The International Health Facility Assessment Network (IHFAN, formerly known as HFATWG) was established in 2005 to strengthen health facility-based data collection, analysis, and use through improved communication, coordination, networking, and dissemination around tools, indicators, data collection, and data utilization. Since then the IHFAN has raised the visibility of health facility data collection and use in international discussions, produced several products, and conducted four capacity building workshops on HFA. This work plan supports implementation of the recommendations of the IHFAN 5th Technical Meeting held in April of 2007.

The specific tasks in the work plan can be grouped into 3 broad categories: 1) IHFAN coordination (Tasks 1-4 below), 2) Issues Paper Series (Tasks 5-8 below), and 3) IHFAN tools development (Tasks 9-11 below).

Tasks:
1. Maintain and moderate the members listserv, webpage, and workgroup.
2. Continue to lead the development of the IHFAN as an umbrella organization for improving HFA.
3. Revise the IHFAN strategy paper and develop communication strategies to reach country levels.
4. Conduct the 6th Technical meeting of the IHFAN including a 2-day capacity building workshop in HFA data collection and use.
5. Prepare a flow chart of HFA implementation: a step by step description of how to implement HFA, including how to navigate the HFA resources developed for collecting the core indicators.
6. Profile HFA sampling methods and produce a paper on the comparative analysis of HFA approaches.
7. Conduct and prepare two case studies of HFA data use in two countries to elaborate the underlying levers and pathways to HFA information use.
8. Develop profiles of world heath systems using the core indicators.

9. Develop an IHFAN HFA questionnaire repository to provide a one-stop-shop for all recommended survey tools and associated guidance, mainly to assist with IHFAN capacity building strategies and the promotion of widespread use of HFA for program monitoring.
10. Collaborate with HMN to build a logbook of country level HF surveys and censuses for coordinating data collection work within and across countries.
11. Develop standardized training curriculum for core content on HFA.

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Create a flow chart of HFA implementation including how to navigate the HFA resources developed for collecting the core indicators.

* Maintain and moderate the HFA listserv: IHFAN@who.int.

* Conduct a background review and develop an outline for the comparative analysis of HFA approaches.

* Begin tool collection and the preparation of an indicator reference sheet with regard to the Questionnaire bank.

* Produced revised IHFAN strategy paper.

Progress:

Per the workplan, IHFAN drafted the flow chart of HFA that provides a step-by-step description of how to implement HFA. The flow chart is instructive for non-HFA specialists and USAID desk officers who want to support their Program HF-based data collection. It revised the strategy paper and produced the IHFAN Brief. The Brief is the primary tool for communicating on IHFAN and getting buy-in of donors, CAs, and countries. The Brief is developed for widespread use by IHFAN and other technical members.

On the Profiles of HFA Methods, IHFAN revised the current version of the guide and added four new methodologies to it. The revised guide is undergoing a PI review and will be reissued before the end of January. The relevant technical inputs have been finalized in preparation for the launch of the IHFAN LISTSERV. However, the process has been delayed due to internal processes at the WHO. The LISTSERV is designed to sit on a WHO computer. Every effort will be made to enable a functional LISTSERV before the end of this quarter.

IHFAN made significant progress on the development of the IHFAN Questionnaire Bank this quarter. It is finalizing arrangements with the International Household Survey Network, the World Bank, and DFID to collaborate on developing the HFA Questionnaire Bank. When developed, this will be a good example of a collaboration brokered by

MEASURE Evaluation TO that resulted in a specific output. This output will have more widespread use than if MEASURE Evaluation TO had developed it on its own.

Preliminary efforts to define criteria for linking questions across the approaches yielded the Questionnaire Reference Sheet.

Year 1 Quarter January, February, March

Plans:

* Continue to provide technical leadership and coordination to IHFAN by organizing and/or responding to relevant inquiries and meetings on HF data collection and use.

* Represent IHFAN and organize panel presentations at program, national, regional, and global meetings, and maintain a liaison with HMN and other strategic partners.

* Maintain and update the technical content of the IHFAN webpage and workgroup.

* Launch and moderate the LISTSERV.

* Travel to Kenya and Uganda to conduct preliminary arrangements in regards to the upcoming 6th Technical HFA Meeting & CB Workshop.

* Collaborate with the EAC Health Desk to develop curriculum for building the capacity of developing country nationals in the HFA, including developing an agenda and obtaining input of countries and IHFAN.

* Collaborate with IHSN, World Bank, and DFID to develop the HFA questionnaire pilot and workplan for a full fledged database.

* Issue Paper series.

* Collaborate with the JHU School of Public Health to initiate development for comparative analysis of HFA methodologies.

GLB-64TO: PEPFAR OVC SI Support

Lead: Florence Nyangara (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to harmonize and strengthen M&E for OVC programs by increasing the collaboration and coordination among PEPFAR OVC implementing partners in collecting and reporting M&E data, increasing availability of M&E tools including the CSI, and facilitation of use of the OVC M&E data.

Description:
This activity will build on the momentum gained under Phase II of MEASURE Evaluation to harmonize and strengthen M&E for OVC through increased collaboration and coordination among OVC program implementing partners in PEPFAR countries. MEASURE Evaluation TO will continue to assist USAID Mission teams to find ways of supporting and promoting systematic monitoring processes of OVC programs through increased availability of relevant M&E tools and guidelines and promoting the use of OVC data. MEASURE Evaluation TO will provide TA in 2-3 countries (depending on the nature of the TA required). The exact nature of the TA will depend on local needs but may include M&E plan development, providing technical guidance on OVC situation analysis through review and implementation of tools including the CSI tool in surveys or programs, and conducting workshops on general M&E, implementation of new tools, and/or the use of OVC data. Opportunities for MEASURE Evaluation TO to collaborate with Duke University and Missions to bridge the divide between the government ministries overseeing children's departments, UNICEF, World Food Programs, and other partners supporting children in M&E for OVC programs will be prioritized.

Tasks:
1. Work with USG partners in 2-3 countries to establish systematic and consistent processes of monitoring progress for programs.
2. Conduct workshops on M&E tools used including the CSI tool, and sharing best practices.
3. Respond to TA requests to support USG and their OVC program implementing partners in M&E related activities including presenting and attending interagency meetings, as requested.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity GLB-64 under MEASURE Evaluation Phase II on October 1, 2007. Please also see GLB-104TO.

* Provide TA to 1-2 PEPFAR countries on harmonizing M&E tools and processes.

Task Order October-December Activity Sheets

* Attend and present at interagency meetings and conferences about M&E for OVC programs.

* Conduct a workshop with OVC program staff on monitoring child well-being including how to use the CSI and other instruments to collect and use data.

Progress:
MEASURE Evaluation TO presented at the PL-1095-USG intergency working group meeting on the challenges with M&E for OVC and the opportunities available to support local implementing partners. The CSI tool was also presented as one of the available tools that could be adapted to monitor progress of child wellbeing across USG agencies working with children under difficult circumstances.

During the quarter, MEASURE Evaluation TO staff attended and presented at the Track 1 OVC implementing partners' meeting in October, 2007 in Washington, DC. In addition, MEASURE Evaluation TO was invited to attend and present at the AVSI/Italian Embassy co-sponsored seminar on November 27, on M&E/OVC issues including evaluation challenges, methods, and tools. The CSI documents were completed and are under review by USG.

Year 1 Quarter January, February, March

Plans:
* Lead the OVC Technical working group under the PEPFAR Next Generation Indicator in developing a logical M&E framework for reporting and using data.

* Develop indicators that include outputs, outcomes, and impact through a participatory approach with other USG implementing partners.

* Finalize the CSI publications.

GLB-70TO: Technical Assistance to Non-Focus Countries

Lead: Silvia Alayon (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen the capacity of USG partners in non-focus countries to respond to new reporting requirements under PEPFAR.

Description:
This activity will support a one to two week course on M&E for HIV/AIDS programs in Southern Sudan, tentatively scheduled for October 2007. Mullen, along with two trainers from the Addis Ababa University, will work to modify the existing HIV/AIDS M&E curriculum for use in Southern Sudan. MEASURE Evaluation TO will provide three trainers and all materials for the course.

In addition, this activity will allow MEASURE Evaluation TO to respond quickly to additional requests for technical assistance to meet the PEPFAR SI needs of non-focus countries. The budget will support short term technical assistance (i.e. two weeks of in-country TA) to two non-focus countries as requested by USAID. Depending on the needs expressed by the field missions, technical assistance may include support to USG SI teams and PEPFAR implementing partners for SI strategic planning, annual reporting to OGAC, M&E training, improving data quality, or promoting data use.

Tasks:
1. Participate in one to two non-focus country visits depending on LOE required for each visit and travel costs.
2. Plan and conduct a short course on M&E of HIV/AIDS programs in Southern Sudan.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Modify the existing HIV/AIDS M&E curriculum for use in Southern Sudan.

* Conduct a workshop on M&E for HIV/AIDS programs in Southern Sudan October 29 - November 9, 2007. Workshop participants will include staff from the Southern Sudan National AIDS Commission, Ministry of Health and from USG-sponsored HIV implementing partners.

* Respond to requests for TA to meet the PEPFAR SI needs of non-focus countries.

Task Order October-December Activity Sheets

Progress:
From October 29 - November 8, 2007, MEASURE Evaluation TO conducted a two week workshop on monitoring and evaluation of HIV/AIDS Programs in Southern Sudan with the support of USAID, OGAC, CDC, UNDP/Global Fund, Southern Sudan Ministry of Health and the Southern Sudan AIDS Commission (SSAC). The workshop was facilitated by MEASURE Evaluation TO, the University of Pretoria and the University of Addis Ababa. Logistical support was also provided by CDC and SSAC. The primary objective of the workshop was to introduce participants to M&E plans by developing frameworks, selecting indicators and identifying data systems, and to provide state-of-the-art tools and methods used in the M&E of HIV/AIDS programs. A total of 28 participants including SSAC staff, Ministry of Health staff, and USG implementing partners attended the workshop.

Year 1 Quarter January, February, March

Plans:
* Remain available to respond to requests for TA to meet the PEPFAR SI needs of non-focus countries.

GLB-72TO: Creating Partner Demand for Quality SI Data through Facilitating Local Use

Lead: Nicole Judice (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to facilitate and expand the use of HIV/AIDS data and information by providing M&E units and program managers at the national and local levels, PEPFAR officers, and implementing partners, with guidance for using commonly collected HIV/AIDS data.

Description:
Under Phase II, MEASURE Evaluation conducted a data use assessment that addressed key questions related to the current use of HIV/AIDS information in Kenya and Nigeria, and developed a country-specific "Guide to Expanding the Use of HIV and AIDS Information." Under the MEASURE Evaluation TO, staff will make revisions to a general guide based on feedback received by users in Kenya and Nigeria. In addition, MEASURE Evaluation TO proposes to conduct a data use assessment and develop country-specific compendiums for expanding the use of HIV/AIDS information in two additional countries.

Tasks:
1. Finalize the existing guide by making any necessary revisions based on feedback from Kenya and Nigeria examples.
2. Conduct data use assessments and develop and disseminate for use in two additional countries.
3. Make additions to the general guide based on the country-specific guides developed under task 2 above.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Finalize and publish the 'Guide to Expanding the Use of HIV and AIDS Information'.

* Identify the two countries where MEASURE Evaluation TO will conduct an assessment and develop country-specific compendiums. Countries being considered for this include Tanzania, Vietnam, Rwanda, and others.

Progress:
The "Guide to Expanding the Use of HIV and AIDS Information" was submitted to OGAC for review and approval. As of the end of 2007, the guide is still awaiting final approval. The team has not made any steps in further planning on country-specific compendiums until final approval from OGAC is received.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Receive final approval from OGAC on the Guide and publish the guide during this quarter.

* Identify two countries where MEASURE Evaluation TO will conduct an assessment and develop country-specific compendiums. Countries being considered for this include Tanzania, Vietnam, Rwanda, and others.

GLB-89TO: Community Level Program Information Reporting (CLPIR)

Lead: Ryoko Yokoyama (John Snow, Inc.)

Technical Advisor: Aisha Talib (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to support a monitoring and reporting enhancement system designed to capture non-facility community level indicators that are essential to the management of direct service provision programs and indicative of the quality of service being provided and, which facilitates the reporting of consistent and reliable program performance data to higher levels such as PEPFAR and Host Country National Governments.

Description:
The CLPIR Toolkit was drafted under Phase II of the MEASURE Evaluation project. In the process, the team consulted with a range of stakeholders in Kenya, Nigeria, Tanzania, Zambia, and the US, including USG country teams, national HIV managers, and other experts in the HIV/AIDS field to develop the Community Level HIV/AIDS Program Information Reporting Systems Toolkit. This Toolkit provides resources for harmonizing reporting, strengthening community level data collection, and encouraging information use. As part of the toolkit development, some components of the toolkit have been applied to date in Haiti (Diagnostic tool, Indicator Harmonization Process Guide Proposed minimum set of indicators and Proposed data collection tools) and in Kenya (Harmonization Process Guide and Engagement process for capacity building). Activities under the MEASURE Evaluation TO will finalize and pilot test various components of the CLPIR Toolkit in at least three more countries and further refine the Toolkit.

Tasks:
1. Finalize the first draft of the Stakeholder Engagement Tool.
2. Identify the pilot test sites in coordination with MEASURE Evaluation TO country teams, USG partners and host-governments.
3. Pilot test the diagnostic tool to identify which CLPIR elements are necessary for a successful non-facility community level program information reporting system in the country and their relative ability to contribute to the system.
4. Hold an indicator harmonization workshop in one of the pilot countries.
5. Pilot test the stakeholder engagement tool to build the capacity of service providers at the lowest level and facilitate the adaptation of the indicators and forms to meet their reporting as well as management needs. This will also create opportunities to test the training curriculum.
6. Refine and print the CLPIR Toolkit based on the results of the pilot tests.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Complete the draft of the Stakeholder Engagement Tool.

* Coordinate input from PEPFAR with the core technical working groups (OVC, Palliative Care, and Prevention) to finalize the minimum set of indicators, data collection forms/registers, user guidelines, and indicator reference sheets.

Progress:

The Stakeholder Engagement, User Guide, and Indicator Reference Sheet sections of the toolkit were completed. The draft CLPIR toolkit was thoroughly reviewed by internal MEASURE Evaluation TO staff. The draft CLPIR toolkit was then shared with USAID and OGAC for their comments.

Year 1 Quarter January, February, March

Plans:

* Incorporate feedback from USAID and OGAC into the CLPIR toolkit.

* Finalize the timeline of the CLPIR pilot test.

GLB-90TO: GIS OVC Program Mapping

Lead: John Spencer (University of North Carolina at Chapel Hill)

Technical Advisor: Catherine Schenck-Yglesias (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen OVC mapping by implementing the strategy, methods, and techniques developed as a result of the OVC Mapping Activity undertaken by MEASURE Evaluation in Year 4.

Description:
OVC data focuses on two elements: the services provided and the population in need. A better understanding of the geographic relationship between these two elements can lead to improved OVC programs and identification of areas of underservice as well as overservice. This activity under the MEASURE Evaluation TO will build on the work conducted under Phase II of the MEASURE Evaluation Project by developing a curriculum for USAID SOTA training for OVC Mapping and by providing TA to target countries. TA will seek to strengthen the data infrastructure for OVC mapping by implementing the methods and techniques developed in previous activities and by coordinating data sharing and communication between USG personnel.

GLB-90TO will run concurrently with the MEASURE Evaluation Phase II activity GLB-90.

Tasks:
1. Identify target countries for TA.
2. Develop USAID SOTA Workplan.
3. Develop a TA strategy for target countries customized for each country.
4. Conduct TA in 3-4 target countries.

Year 1 Quarter October, November, December

Plans:
* This activity will run concurrently with MEASURE Evaluation Phase II activity GLB-90 beginning October 1, 2007. Please also see GLB-105TO.

* Work with USG team members in the countries that participated in the original OVC Mapping Activity, as well as with USAID and PEPFAR staff to identify target countries for OVC Mapping TA.

* Contact USG personnel in country to coordinate a TA visit.

* Develop a workplan for upcoming SOTA training on OVC Mapping.

Task Order October-December Activity Sheets

Progress:
MEASURE Evaluation TO staff have been communicating with USAID and OGAC personnel to identify the scope, goals, and possible locations for OVC Mapping TA. A conference call was held on December 17, 2007 to identify possible goals and suitable countries. While no decision was finalized, the countries of Uganda, Cote d'Ivoire and Nigeria were strong candidates. Final decisions will be made in January or early February of 2008 in preparation for a visit in March.

Specifics on the SOTA training had not been finalized by USAID, so no progress has been made regarding SOTA training by MEASURE Evaluation TO staff.

Year 1 Quarter January, February, March

Plans:
* Work with USAID, OGAC, and target countries to identify locations, scopes of work, and goals for OVC Mapping TA.

* Conduct OVC Mapping TA, if SOW and countries have been identified.

* Develop a workplan for SOTA traning on OVC Mapping, if details are finalized about USAID SOTA.

GLB-91TO: Standards & Guidelines for Data Quality: Double Counting

Lead: Walter Obiero (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objectives of this activity are to derive quantitative estimates of the scope and magnitude of double counting in key areas of results reporting under PEPFAR, and to develop a double counting tool or guide to assist USG teams as they aggregate implementing partner results for submission as part of the Semi-Annual and Annual Program Reports to OGAC.

Description:
Through a rapid survey of USG team needs, and a one day expert meeting on double counting, MEASURE Evaluation TO will develop a research protocol to help OGAC better understand and address the highest priority program areas subject to double counting. Once the program areas and countries are identified, the protocol will be implemented in 1-2 countries to quantify the problem of double counting.

Tasks:
1. Meet with OGAC to decide on final design.
2. Modify study proposal.
3. Implement study design in 1-2 countries.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Re-start meetings and discussions with OGAC.

* Modify the study proposal (as per discussions with OGAC).

* Implement the study design in 1-2 countries.

Progress:
The Oct-Dec plans were developed before staff changes on the activity. During discussions with MEASURE Evaluation TO project management in November, it was agreed that resumption of double-counting activities would be postponed until new staff were on board. In preparation for that, MEASURE Evaluation TO was able to confirm with USAID and OGAC that the original USG managers would once again be overseeing this activity. The activity has now transitioned to a new activity lead, Walter Obiero of Constella Futures.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Meet with OGAC and USAID to review the original concept paper and scope of work.

* Modify or draft a new scope of work to meet the current needs and establish an activity time line.

* Begin activities as per agreed-upon scope of work and time line.

GLB-102TO: Distance Learning Modules

Lead: Melissa Dunn (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen the M&E capacity of SI Officers and other professionals that work on M&E of HIV/AIDS programs globally by expanding existing and developing new M&E distance learning interactive courses and online resources and tools.

Description:
MEASURE Evaluation TO staff will participate in the USAID/OGAC/CDC PEPFAR eLearning Initiative Working Group. Through this USG working group, MEASURE Evaluation TO staff will serve in a reviewer/technical expert capacity in helping the working group conceptualize, develop, pilot, and launch two interactive online courses. These courses will include a course on data quality and a course covering M&E of HIV/AIDS Programs.

Since there is interest in including the existing MENTOR-based mini-course on M&E fundamentals as part of the SI officers orientation materials, MEASURE Evaluation TO will continue to support, expand, and promote MENTOR (Monitoring & Evaluation Network of Training Online Resources) through expanding the downloadable materials on HIV/AIDS program M&E available through this resource, and continuing to monitor and expand the interactive mini-course on M&E fundamentals. In addition, staff will continue to explore new and innovative ways to expand and improve the resources available through the MENTOR page on the MEASURE Evaluation website.

Tasks:
1. Assist the eLearning Initiative Working Group by supplying resources for creation of the courses (e.g. documents, graphics, illustrations, charts, reference citations, and glossary terms).
2. Provide technical expertise to the eLearning Initiative Working Group in developing course outlines and modules for the data quality and the M&E of HIV modules.
3. Participate in the USAID/OGAC/CDC PEPFAR eLearning Initiative Working Group.
4. Review, edit, and beta-test/pilot both course modules, as needed pre and/or post launch.
5. Support, monitor, promote, and expand the M&E Fundamentals Interactive Mini-Course available on the MENTOR site.
6. Support, monitor, promote, and expand the downloadable workshop curriculum modules and other resources available on the MENTOR site.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* Participate in the USAID/OGAC/CDC PEPFAR eLearning Initiative Working Group.

* Assist the eLearning Initiative Working Group by supplying resources for creation of the courses (e.g. documents, graphics, illustrations, charts, reference citations, and glossary terms).

* Provide technical expertise to the eLearning Initiative Working Group in developing course outlines and modules for the data quality and the M&E of HIV modules.

* Prepare the curriculum modules from the PHN workshop in Mexico (INSP) for posting to the MENTOR site under downloadable material.

* Provide ongoing support to monitor, promote, and expand the M&E Fundamentals Interactive Mini-Course available on the MENTOR site.

Progress:

During this quarter, staff participated in the USAID/OGAC/CDC PEPFAR eLearning Initiative Working Group, and collaborated on the development of two interactive, distance learning modules (one module on M&E and a second on Data Quality). Staff assisted the eLearning Initiative Working Group by supplying resources for creation of the courses (e.g. documents, graphics, illustrations, charts, reference citations, and glossary terms), and provided technical expertise to the eLearning Initiative Working Group in developing course outlines and modules for the data quality and the M&E of HIV modules.

Staff also worked with activity leads to prepare the curriculum modules from the PHN workshop in Mexico (INSP) for posting to the MENTOR site under 'downloadable material' and provided ongoing support to monitor, promote, and expand the M&E Fundamentals Interactive Mini-Course available on the MENTOR site.

Year 1 Quarter January, February, March

Plans:

* Participate in the USAID/OGAC/CDC PEPFAR eLearning Initiative Working Group.

* Assist the eLearning Initiative Working Group by supplying resources for creation of the courses (e.g. documents, graphics, illustrations, charts, reference citations, and glossary terms).

* Provide technical expertise to the eLearning Initiative Working Group in developing course outlines and modules for the data quality and the M&E of HIV modules.

* Prepare the curriculum modules from the PHN workshop in Mexico (INSP) for posting to the MENTOR site under downloadable material.

* Provide ongoing support to monitor, promote, and expand the M&E Fundamentals Interactive Mini-Course available on the MENTOR site.

GLB-103TO: Population-Health-Environment M&E Technical Assistance

Lead: Melissa Dunn (University of North Carolina at Chapel Hill)

Technical Advisor: Bamikale Feyisetan (Elements: Family Planning and Reproductive Health (FP/RH))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen the monitoring and evaluation capacity of the population-health-environment field.

Description:
The population-health-environment (PHE) field continues to need assistance in capacity building for monitoring and evaluation, with a focus on conservation organizations involved in implementing integrated activities and policy-related organizations working in PHE. MEASURE Evaluation Task Order will work with one PHE cooperating agency, most likely World Wildlife Fund (WWF), to conduct an M&E capacity assessment and develop an M&E capacity building plan based on the assessment. The assessment will likely focus on one of WWF's country programs, to be decided. MEASURE Evaluation TO will then provide technical assistance to implement the M&E capacity building plan. The exact nature of the technical assistance will depend on the findings of the capacity assessment and available resources.

Tasks:
1. Hold discussions with the WWF on capacity assessment and determine country program to be included in the assessment.
2. Conduct capacity assessment.
3. Develop M&E capacity building plan based on the assessment.
4. Provide TA to implement the capacity building plan, as appropriate.

Year 1 Quarter October, November, December

Plans:
* This activity is follow-on work from activity GLB-39 under MEASURE Evaluation Phase II.

* Begin discussions with the World Wildlife Fund on an M&E capacity assessment.

Progress:
During this quarter, staff initiated some preliminary discussions with the World Wildlife Fund regarding their M&E needs and conducting an M&E capacity assessment. WWF expressed interest in assistance with their PMP but further discussions are needed to clarify their wider M&E capacity building needs.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Hold discussions with WWF (or another PHE partner if the WWF is no longer interested).

* Develop a scope of work to build M&E capacity.

GLB-104TO: Child Status Index

Lead: Florence Nyangara (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to develop and test a protocol to apply the Child Status Index (CSI) at the National and Program Levels.

Description:
The initial mission of the CSI activity was to develop, field test, and implement a tool that is child centered, rapid, and simple to administer, and can be used routinely to track the wellbeing of orphans and vulnerable children receiving services and resources from programs. The resulting CSI guide provides information and advice for using the tool to gather information that measures child wellbeing at the level of the individual child. It includes guidance on information gathering from caregivers and how to use the information to improve service delivery to the child.

This activity builds on the previous work but will focus on developing a systematic approach for using the CSI to monitor the OVC populations served by national or by specific programs. This will provide a regular and systematic monitoring protocol that can serve as a dash board for how OVC programs are doing in terms of the welfare areas captured by the CSI. Use of the CSI at the program or national level will involve developing a protocol or system for collecting the data systematically, aggregating the data, and using it for policy and program decisions. The protocol will include a database that can be incorporated into routine OVC data collection systems to accommodate the CSI information. The protocol will be piloted in 1-2 country OVC programs (TBD).

Tasks:
1. Develop a systematic protocol for using the CSI tool to monitor programs.
2. Assist 1-2 country programs (TBD) to implement the systematic protocol and database.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity GLB-64 under MEASURE Evaluation Phase II on October 1, 2007. Please also see GLB-64TO.

* Train OVC program staff and pilot-test the CSI tool for program use and reporting results in two countries (TBD).

* Draft a protocol for using the CSI to monitor the OVC population served by national and by specific programs.

Task Order October-December Activity Sheets

Progress:
In October, Save the Children Ethiopia requested TA to their Positive Change: Children, Communities, and Care (PC3) Program. The request was to help train the PC3 program staff on how to use the Child Status Index tool to monitor child wellbeing and assess program progress for improvement. A training workshop was conducted from October 29 - November 2, 2007, for 36 PC3 program staff, mainly those charged with M&E and program management. A participatory approach was used to map-out how the CSI could be practically adapted to the program and perhaps national levels. As a result, the PC3 partners developed a number of next steps and an approach to implementing the CSI at the program level. They have translated the CSI to Amharic, developed an OVC sampling frame, and they are guiding a draft of the protocol for CSI adaptation at the program level. A draft of the guide on program level use of the CSI was started. A poster titled "How Are The Children? A community-based approach to monitoring and evaluation of child well-being in Sub-Saharan Africa" was presented at the UASP conference in Arusha, Tanzania.

Year 1 Quarter January, February, March

Plans:
* Visit Ethiopia to find out how the CSI implementation process is going and provide further guidelines on training of the trainers for the CSI, especially in the community.

* Write the guidelines of how to use the CSI for program assessment.

GLB-105TO: Technical Assistance to PEPFAR GIS

Lead: John Spencer (University of North Carolina at Chapel Hill)

Technical Advisor: Catherine Schenck-Yglesias (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to provide support to PEPFAR as it builds and strengthens GIS and spatial analysis capacity.

Description:
Many PEPFAR activities have benefited from spatial analysis and mapping. The increasing use of Geographic Information Systems (GIS) and other spatial methods and techniques require robust tools, mature data infrastructures, and viable training. MEASURE Evaluation TO staff will provide support to PEPFAR as it develops a training course encouraging the use of GIS with PEPFAR reporting data. Additionally, MEASURE Evaluation TO staff will provide support to the PEPFAR Spatial Data Repository through consultation with PEPFAR staff and partners. MEASURE Evaluation TO staff will also provided other limited support to strengthen PEPFAR's GIS and spatial analysis efforts as needed.

Tasks:
1. Provide consultation in support of the development of the ESRI PEPFAR course.
2. Provide consultation in support of the PEPFAR Spatial Data Repository.
3. Provide other support as appropriate in support of PEPFAR GIS and spatial analysis efforts.

Year 1 Quarter October, November, December

Plans:
* This activity is a follow on activity from GLB-90 under MEASURE Evaluation Phase II. Please also see GLB-90TO.

* Respond to PEPFAR requests as needed.

Progress:
PEPFAR and USAID had no activity related to the PEPFAR Spatial Data Repository or ESRI Course during this period, therefore MEASURE Evaluation TO had no activity during Oct-Dec 07.

Year 1 Quarter January, February, March

Plans:
* Continue to respond to PEPFAR requests for activities related to the Spatial Data Repository, PEPFAR ESRI Course, and other general GIS related activities.

GLB-106TO: MARP Manual

Lead: Ruth Bessinger (Macro International Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to improve collection, analysis, and presentation of data to promote better use of data in planning, policy making, managing, monitoring, and evaluating HIV/AIDS prevention programs for most-at-risk populations.

Description:
Under Phase II, MEASURE Evaluation in collaboration with USAID, CDC, UNAIDS, WHO, UNICEF, and FHI, led the development of global guidance aimed at strengthening the M&E of HIV prevention programs for most-at-risk populations (MARP). The guide was published by UNAIDS in early 2007. The multi-agency technical working group (TWG) that developed the guide also drafted plans to pilot test the guide's framework as part of a strategic planning exercise in three to four countries. Workshops were held in India and Russia in 2006 with program managers and M&E staff. Plans for workshops in Indonesia and Honduras were put on hold at the end of 2006 at the request of USAID/Washington. These two workshops will be completed under Phase II of MEASURE Evaluation.

Under the MEASURE Evaluation Task Order, staff will continue to work closely with the international partners to identify opportunities to strengthen M&E of MARP programs at both the global and national levels. This will include the identification of technical areas that require further development and the development of a strategy to provide technical assistance to the field. MEASURE Evaluation TO will take the lead on further advancing one technical area to strengthen the M&E of MARP programs.

Tasks:
1. Develop a workplan with partners to moderate the global agenda on strengthening the M&E of MARP.
2. Participate in a MARP TWG meeting in Geneva.
3. Coordinate a review of current data collection practices on behavioral and/or coverage data and make recommendations for improvements.

Year 1 Quarter October, November, December

Plans:
* This activity is a follow-on from activity GLB-50 under MEASURE Evaluation Phase II.

* Participate in a MERG TWG meeting.

* Develop a workplan with international partners (UNAIDS, WHO, CDC, etc) to moderate the global agenda in strengthening M&E of HIV prevention programs targeting MARP.

Task Order October-December Activity Sheets

Progress:
MEASURE Evaluation TO participated in conference calls with UNAIDS, CDC, and USAID to discuss potential activities that would be conducted jointly. The formation of a formal international TWG for M&E of MARP to finalize and implement such a plan, however, requires approval by the MERG. The proposal for the iTWG was presented at the December MERG meeting by a UNAIDS colleague and was approved.

Year 1 Quarter January, February, March

Plans:
* Collaborate with partners on the development and implementation of a workplan for 2008.

GLB-107TO: M&E Support for MCH

Lead: Kavita Singh (University of North Carolina at Chapel Hill)

Technical Advisor: Lisa Maniscalco (Elements: Maternal and Child Health (MCH))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen the M&E of MCH programs.

Description:
This activity will most likely focus on providing technical assistance for the monitoring of MCH outcomes. In 2006, USAID held an expert meeting to discuss methodological options for measuring outcomes for MCH programs that could be implemented relatively inexpensively and on an annual or biannual basis. MEASURE Evaluation prepared a briefing paper for that meeting that compared several approaches for collecting common MCH outcome indicators. Since then, GH Tech has conducted two evaluations of promising methods for monitoring MCH outcomes in Guatemala and Madagascar. The results of these evaluations are expected shortly. Based on the results of those evaluations, it is expected that MEASURE Evaluation TO will provide technical assistance to two countries to collect MCH outcome indicators. However, the exact role for MEASURE Evaluation TO will be determined when the evaluation results are available.

Tasks:
1. Finalize detailed scope of work and tasks with USAID.
2. Identify two countries that require TA.
3. Finalize the specific scope of TA in the selected countries.
4. Provide TA as agreed upon in the scope of work.

Year 1 Quarter October, November, December

Plans:
* Hold discussions with USAID to finalize details of the scope of work when Guatemala and Madagascar evaluation results are released.

Progress:
Discussions were scheduled for January.

Year 1 Quarter January, February, March

Plans:
* Hold discussions with USAID and DHS about this activity.

* Outline the role of MEASURE Evaluation TO in this activity.

GY-3TO: Technical Assistance to Guyana: DHS

Lead: Luis Ochoa (Macro International Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Maternal and Child Health (MCH), Family Planning and Reproductive Health (FP/RH))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to support the initial stages of the Guyana DHS. Funding to continue and complete the Guyana DHS will be made available through the MEASURE DHS project.

Description:
Through the MEASURE Evaluation TO, a contractor will provide TA to complete the initial stages of the Guyana DHS survey. Local costs for the Guyana DHS will not be covered by this Task Order, but through a separate funding mechanism. Work is expected to begin in January 2008 with an initial visit to recruit and select a local organization and key staff with which the project can collaborate. Once the implementing organization and key staff are in place, staff will provide TA as required, in consultation with the MoH and the implementing agency. Activities to be completed under the MEASURE Evaluation TO will include: (1) Form Technical Advisory Committee; (2) Identify Survey Director; (3) Identify key staff; (4) Survey design; (5) Sample selection; (6) Finalizing questionnaires/manuals; (7) Staff training; (8) Data collection and quality control (initial stage of fieldwork); and (9) Establishing initial data processing procedures.

Tasks:
1. Conduct initial country visit for recruitment of implementing organization.
2. Recruit a project director and principle investigator.
3. Design the survey.
4. Complete sample selection.
5. Finalize questionnaires and manuals.
6. Provide TA during household listing and mapping.
7. Provide TA during pretesting of questionnaires.
8. Provide TA during main training for fieldwork.
9. Provide TA during beginning of fieldwork.
10. Provide TA to establish data processing procedures.

Year 1 Quarter October, November, December

Plans:
* Conduct an initial country visit to Guyana in mid-November to negotiate survey implementation with the Bureau of Statistics.

* Attend the meeting with the Ministry of Health on November 19th to review the status and availability of sampling materials and discuss the sampling design.

Task Order October-December Activity Sheets

* Submit draft questionnaires to USAID/Guyana for consideration.

* Harmonize the questionnaires with those used in the 2005 Guyana AIS.

Progress:
Draft questionnaires have been prepared and sent to Guyana. Following discussions with the Mission, the questionnaires include the OVC and Malaria modules. In the coming months, the questionnaires will be harmonized with those used in the 2005 Guyana AIS.

A visit to Guyana by Ochoa and Alfredo Aliaga took place November 25 - December 1, 2007. Implementation of the survey was negotiated with the Ministry of Health (overall) and the Bureau of Statistics (fieldwork). A draft sub-agreement was prepared for review by the MoH and the BoS. Decisions were made on sample design, including the sample sizes and sample domains. The basic document with the sample design was drafted by Aliaga during the visit and revised in December 2008. Ochoa held meetings with staff from the MoH, CDC, PAHO, FHI (GHARP project) and USAID/Guyana to discuss the contents of the DHS. An agreement was reached.

During a visit, a Technical Advisory Committee was created and Ochoa participated in the first meeting. Copies of the proposed questionnaires and the tab plan were shared with the participants. Other details of the visit are included in the trip report.

Year 1 Quarter January, February, March

Plans:
* Finalize the sub-agreement with the Ministry of Health and the Bureau of Statistics (including the budget for local costs).

* Finalize the sample selection of 6,600 households in 300 clusters.

* Provide assistance for the preparation of training for field work and participate in training activities.

HN-2TO: Technical Assistance to Honduras: PMP 2008

Lead: Veronica Betancourt (Constella Futures)

Technical Advisor: Lisa Maniscalco (Elements: Maternal and Child Health (MCH))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
A performance monitoring plan (PMP) was designed in order to assess USAID/Honduras progress towards achieving the missions intermediate results. The PMP is to be considered as a tool to guide data collection activities and annual report production during the life of the agreement between USAID and GOH. Annual reports will be prepared to evaluate the advances made towards the intermediate results by measuring the indicators included in the PMP, indicators provided by USAID/Washington on OP (Operational Plan) preparation and additional indicators agreed upon at a coordinating meeting of USAID-funded implementing mechanisms in May 2006. During 2007, forms were prepared to collect information from the MOH and other USAID implementing agencies that work in the health sector. People were trained to fill out these forms and a program was designed to manipulate the information in an easier way. USAID/Honduras is the primary audience for the results of this activity. The mission has invested large amounts of money in support of health related activities with the goal of significantly improving health status of the Honduran population and reducing poverty. Study results will provide evidence of impact of these investments and input to decisions on future levels and types of support.

Description:
During the last trimester in 2007, MEASURE Evaluation TO will systematize the process of collecting information to prepare annual reports and describe the system that has been established for that purpose. This will include: (1) a guide to collect information, (2) computer program, and (3) training for those who collect information, etc. In early 2008, once the structure of the 2008 PMP Annual Report has been agreed upon, MEASURE Evaluation TO, with the assistance of implementing agencies and the MoH, will collect data on indicators covering the period from September 2007 to August 2008 and prepare tables showing data.

Tasks:
1. Prepare a draft of the systematization document.
2. Prepare and print the final version of the systematization document.
3. Prepare a draft of the 2008 PMP Annual Report and discuss it with the Mission.
4. Follow up with CAs and the MOH on collection of data for the PMP report.
5. Collect information for the 2008 PMP Annual Report.
6. Analyze and prepare tables with information for the 2008 PMP Annual Report.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from activity HN-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Systematize the process of collecting information to prepare annual PMP reports and describe the system that MEASURE Evaluation TO in Honduras has established for that purpose.

* Prepare 2008 PMP report.

Progress:

The MEASURE Evaluation TO local consultant began preparing the document which systematizes the process for monitoring the PMP.

Year 1 Quarter January, February, March

Plans:

* Hold meeting on January 2-4 among the different implementing mechanisms to discuss some health indicators and their definitions, as well as provide some valuable indications for the collection of data for the 2008 PMP annual report. This will also include a few hours of training on data cleaning and generation of summary tables with the data.

* Monitor collection of data by the implementing mechanisms (CAs) and present to MEASURE Evaluation TO at the end of January on some of the indicators previously identified and agreed upon.

* Revise precise definitions for all indicators, as well as the formats to adjust codes, periodicity, and dates.

* Adjust the PMP indicators matrix to incorporate new indicators currently under discussion.

HN-3TO: Technical Assistance to Honduras: Special Study of Decentralized Health Services

Lead: Veronica Betancourt (Constella Futures)

Technical Advisor: Lisa Maniscalco (Elements: Maternal and Child Health (MCH))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to evaluate the performance and cost of initiatives taken under the health sector reform efforts in Honduras. Specifically, this study aims to determine how an alternative (also called decentralized) model of health care provision in Honduras compares to the traditional model.

Description:
The results of this study are expected to inform the ongoing debate over the utility of changing from the old way of doing business in the health sector to new modalities. Decision makers in the Honduran government, and particularly in the MOH, are the primary audience for the results of this study. USAID and other development partners supporting health sector reform in Honduras are another primary audience for the results. Study results will provide evidence of impact of donor investments and input to decisions on future levels and types of support.

The MEASURE Evaluation Task Order will implement the first phase of this study. The first round of data collection will take place at the six sites which are already functioning as alternative models and at least six sites which are currently functioning as traditional models but which may convert to alternative model sites in the next round of contract extension. The data collection will be multi-pronged, and will consist of: (1) Household surveys in which we will collect basic demographic information and information on health service uptake and health outcomes; (2) Summaries and analyses of service statistics, representing production; (3) Documentation of the process by which these sites were turned into alternative sites; and (4) Collection of cost information, building on the World Bank methodology developed over the past two years in Honduras, but including the additional costs for decentralizing health service provision at the regional and central level.

The analysis will provide cross-sectional information on various indicators (detailed in the full proposal), and we will be able to evaluate how the indicators compare across the intervened sites (different alternative models) as well as how the intervened sites compare to the non-intervened, or traditional model, sites. Data collected during this first round of data collection at sites which are scheduled to convert to alternative service provision at a later date will serve as a baseline to be compared to findings from a second round of data collection (to be undertaken in the future).

Tasks:
1. Award local subcontract for data collection.
2. Design and implement household survey.

Task Order October-December Activity Sheets

3. Design and implement cost study.
4. Collection of service statistics.
5. Data analysis and report writing.
6. Conduct dissemination of findings.

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from activity HN-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Negotiate with the finalist for the local subcontractor (final SOW and budget).

* Make final selection of a local subcontractor.

* Develop data collection instruments with local the subcontractor.

* Begin data collection.

Progress:

This activity was delayed as there were not enough funds to carry it out as initially planned. Therefore, a decision was made (with the mission's approval) to conduct the special study in two phases. The first of which will begin in January. During this period the budget was analyzed and conversations were held with the mission and consultants to agree on the next steps.

Year 1 Quarter January, February, March

Plans:

* Revise the study's terms of reference to include only two components: cost effectiveness study and service statistics compilation.

* Invite companies to present proposals.

* Analyze proposals and select the best company to conduct the study.

* Hold meetings with the selected company to discuss the next steps and provide some support and guidance.

HT-1TO: Technical Assistance to Haiti: SI Support

Lead: Mounkaila Abdou Billo (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen the M&E capacity of the Mission's Investing in People (IP) Objective Team.

Description:
This activity involves the provision of a resident, long-term monitoring and evaluation technical advisor to provide direct support to the Haiti Missions IP Objective Team and training and supervision activities for improving monitoring and evaluation skills and systems of implementing organizations.

The long-term technical advisor will be a resident in Port-au-Prince to support the USAID/Haiti health and education technical staff on monitoring and evaluation of the USAID/Haiti technical strategy that supports the achievement of the USGs IP Objective under the new Foreign Assistance Framework. The strategy consists of two primary components - health and education - with HIV/AIDS development assistance under PEPFAR integrated into both. In addition, the USAID Title II food program activities are integrated, where applicable, with the health and education activities.

The health component of the strategy has one primary bilateral implementing partner and seven HIV/AIDS-specific implementing partners. The education component has one basic education implementing partner.

The long-term technical advisor has the responsibility for four focus areas that are linked: (1) to build monitoring and evaluation capacity (through mentoring, seminars etc.) of the USAID/Haiti health and education technical staff; (2) to provide technical assistance to the health and education implementing partners to enable them to have an adequate system for, and capacity to, monitor their respective program performance; (3) provide technical assistance to both the USAID technical staff and the implementing partners on jointly monitoring overall strategy performance towards achieving end of year and end of strategy results; 4) provide technical assistance and strategic technical direction to the PEPFAR Haiti Program and 5) develop a data management system (simple database or Excel spreadsheet to keep track and allow easy retrieval of raw data, presentations and important documents of Health and Education program activities) for all implementing partner reporting data for the Health and Education Office.

Tasks:
1. Recruit an M&E advisor.
2. Meet regularly with USAID health and education technical staff and the M&E specialist.
3. Support the SI functions of the USAID/Haiti health and education unit.
4. Establish a data management system for all USAID health and education partner data.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from activity HT-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Recruit a new resident technical advisor.

* Meet with the Mission to determine their new priorities.

Progress:

A trip was organized from October 21 to 26 to Port-au-Prince, Haiti to meet with the mission to determine their new priorities. The next steps identified were the following: (1) organize and carry out a consensus meeting (November 27 - 29, 2007) to validate the CLPIR's pilot-test results and recommendations, and to agree on plan for revision and finalization of data collection forms; (2) hire a Resident Technical Advisor by February 2008; (3) organize a visit to Haiti to continue the discussions with IHE, UCC/MOH and Directorate General/ MOH (November 26 - 29, 2007); (4) keep USAID fully informed of progress and needs related to all planned activities; and (5) organize and carry out an evaluation of the national health management information system in Haiti (first quarter 2008), including determination of the evaluation objectives, team, tools to be used, outputs, and timeline.

The overall goal of the evaluation is to obtain information on the strengths and existing gaps in the system which need to be solved to strengthen its performance. This will be done by: (1) determining whether the information system (recording and reporting) is capable of providing the data needed for decision-making towards improving the health programs, including HIV/AIDS; (2) assessing timeliness, completeness, and accuracy of reporting as well as the use of data at all levels of the system; (3) assessing shortcomings of the above and reasons for gaps, including technical, organizational, and behavioral issues ("PRISM lite"); and (4) making recommendations for improvements.

One candidate has been offered the new resident advisor position. The hiring process is almost finalized.

Year 1 Quarter January, February, March

Plans:

* Introduce the new resident technical advisor to USAID/Haiti and MOH.

* Meet regularly with the USAID/Haiti mission.

* Support the SI functions of the USAID/Haiti Health and Education Unit.

HT-2TO: Technical Assistance to Haiti: PEPFAR non-Facility Interventions

Lead: David Boone (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of the community based information system for PEPFAR partners in Haiti is to improve reporting performance and data quality through increased appreciation of the value and use of data, harmonization of indicators, and standardization of the reporting process.

Description:
The community based activity reporting system began in 2006 as a USG Implementing Partner reporting system for PEPFAR indicators related to community-based programs. Indicators were harmonized among IPs in October 2006 and standardized forms and reports were created in March 2007. Pilot testing of the new forms and reports was conducted from June - August 2007. Training will be conducted for community level staff in 2007-2008. Under the MEASURE Evaluation TO, the emphasis will be on the comprehensive roll-out of the system to all USG implementing partners. Supportive supervision and mentoring will be provided to data managers and decision makers at the community level to ensure appropriate evidence-based decision making, use of data for program management, and reporting of quality data. The community level activities reporting system will provide a cornerstone in the harmonization of indicators and reporting systems for community based activities among the Haitian National AIDS Control Program and programs supported by other international donors (e.g. the Global Fund, UNICEF).

Tasks:
1. Complete and distribute the M&E Plan and Data Quality Assurance methods and tools.
2. Complete and distribute the CLPIR System Users Guide.
3. Prepare and conduct a national training of trainers (ToT) for USAID Prime partners (umbrella organizations) on the new system.
4. Prepare and conduct a national workshop to train users on the new tools and system two sessions (Jacmel & Cap Haitien).
5. Conduct follow-up, trouble shooting, and evaluation of new system.
6. Monitor usage of the new data collection and reporting tools.
7. Monitor data quality and respond to data quality issues as they arise.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity HT-1 under MEASURE Evaluation Phase II on October 1, 2007.

Task Order October-December Activity Sheets

* Conduct a review of findings from the pilot phase of the reporting system.

* Make modifications to the reporting protocols and/or the new reporting forms and tools, if necessary.

* Conduct training for the new system for USG implementing partners engaged in PEPFAR funded community based activities.

* Conduct on-going monitoring of system performance (i.e. timeliness, completeness, accuracy).

Progress:
A pre-test of the new forms was conducted and completed in October 2007. A standardized feedback form was prepared and circulated. Site visits were also conducted to determine the acceptability of the new reporting forms.

The experiences using the new forms were compiled and presented at a consensus building workshop held in Port au Prince in November, 2007. Small revisions to the forms were recommended by the assembly. These changes were subsequently integrated into the final version of the new forms.

A user's guide for the new system was prepared.

Work on an M&E plan for the new community based activities information system was begun.

Year 1 Quarter January, February, March

Plans:
* Make final edits to the forms and distribute them to USG and implementing partners.

* Plan and prepare a budget for regional trainings of community level program staff on the new forms.

* Prepare the curriculum for the regional training of community level staff on the new forms.

* Conduct six regional trainings on the new reporting forms.

* Begin work on a data quality assurance plan for the community level activity reporting system.

* Monitor the use of the new reporting system during the PEPFAR Semi-Annual reporting period.

HT-3TO: Technical Assistance to Haiti: DQA

Lead: Mounkaila Abdou Billo (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen data quality assurance for all reporting on PEFAR interventions in conjunction with the Haitian Child Institute (IHE).

Description:
The work to be accomplished under the MEASURE Evaluation Task Order for USAID/Haiti (with TA from US) involves providing technical assistance to PEPFAR partners on implementing the M&E system strengthening and data quality assurance tools developed by the MEASURE Evaluation Phase II Project in collaboration with the Global Fund. The work also involves performing independent data quality assessments of the monitoring information collection of implementing partners, in collaboration with the Child Health Institution (IHE).

Tasks:
1. Provide TA to PEPFAR partners on M&E system strengthening and DQA.
2. Perform data quality assessments of implementing partners data collection and reporting systems.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity HT-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Organize at least one field visit in collaboration with IHE to build capacity in data quality assurance.

* Plan one workshop on M&E system strengthening and DQA tools for PEPFAR partners in Haiti.

Progress:
Two meetings were held with the Haitian Child Institute (IHE) to discuss and share tools on DQA tools. MEASURE Evaluation TO has also developed a collaboration approach to planning and field visits to improve data quality for PEPFAR reporting. The workshop on MESST and RDQA will be organized in the next quarter after the resident advisor has been installed.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Organize and carry out one workshop on the M&E system strengthening and DQA tools for PEPFAR partners in Haiti.

* Organize a least one field visit in collaboration with IHE to build capacity in data quality assurance.

HT-4TO: Technical Assistance to Haiti: MOH

Lead: Mounkaila Abdou Billo (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objectives of this activity are to provide TA to the Ministry of Health (MoH) to improve the quality and promote the use of national HIV/AIDS data for decision making, and to move toward a national health information system, which incorporates HIV/AIDS data.

Description:
The MOH has collected a lot of HIV/AIDS data through the various HIV/AIDS initiatives in Haiti. However, little of these data have been used for decision making and program improvement. The work to be accomplished under the MEASURE Evaluation Task Order for USAID/Haiti (with TA from US) involves: (1) improving data demand and information utilization (DDIU). Organize at least two workshops on HIV/AIDS data review, use, and dissemination with MOH staff at all levels; (2) printing of data collection forms and registers; and (3) assisting in the production and printing of the MOH annual report on HIV/AIDS.

The MEASURE Evaluation Phase II project provided support to the MOH to establish the national health information system (HIS) at all levels of the Haiti health system. Under the MEASURE Evaluation TO the mandate will be to provide targeted assistance to continue to strengthen the HMIS and support the integration of the HIV/AIDS information system, currently a separate reporting system, into the national HMIS. The following will be accomplished by a resident advisor with TA from US-based staff in close collaboration with MSH/Haiti: (1) in collaboration with the USAID main health bilateral partner (MSH/Haiti) to provide targeted TA as needed (e.g.conduct training sessions, assist with the validation of data in the MOH annual reports, assist with the compiling of the national report.); (2) assisting the MOH in the implementation of the strategic plan that has already been developed to achieve the integration of PEPFAR information systems with the other service information systems (e.g., PMTCT data as part of prenatal care records); (3) providing assistance to the MOH so that the short-term reporting requirements for initiatives such as PEPFAR and the Global Fund are met, as well as the long-term institutional requirements of the MOH; (4) supporting the MOH so that the HIS produces quality data and regularly produces reports that incorporate PEPFAR and Global Fund program data; and (5) providing technical assistance to the ten regional health department offices to strengthen their ability to validate, analyze and use data.

Tasks:
1. Facilitate DDIU workshop.
2. Support the MOH in printing data collection tools and the production of the HIV/AIDS annual report.
3. Provide TA to the ten regions in strengthening their capacity to collect, analyze, and use

data for decision making.

4. Organize a consensus building workshop to integrate PEPFAR information systems into the existing information systems.

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from activity HT-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Meet with the mission to determine their priorities.

* Meet with the mission and MSH/Haiti to determine MEASURE Evaluation TO's responsibilities in the HMIS strengthening activities.

* Plan DDIU and HMIS consensus workshops as well as supervision visits.

Progress:

One meeting was organized with MSH in October, 2007 to determine MEASURE Evaluation TO responsibilities in the new HMIS strengthening project lead by MSH. It was concluded that MSH will not reinvent the wheel and MEASURE Evaluation TO should continue strengthening systems through training at the department level.

During the meeting with USAID/Haiti in November, the mission decided to hold the activities of HT-4TO until the HMIS in Haiti is evaluated. Therefore, the month of December, 2007 was devoted to the preparation of the evaluation.

Year 1 Quarter January, February, March

Plans:

* Organize and carry out an evaluation of the health information system in Haiti.

* Develop an action plan to strengthen the HMIS in Haiti based on the conclusions/recommendations of the evaluation.

* Organize and carry out (with the agreement of the Mission) a DDIU workshop.

LAC-2TO: Workshop on Impact Evaluation of PHN Programs (INSP Mexico)

Lead: Gustavo Angeles (University of North Carolina at Chapel Hill)

Technical Advisor: Lisa Maniscalco (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to increase capacity for program M&E in the LAC region.

Description:
This activity includes the development and implementation of a three week workshop on the fundamentals of M&E and evaluation of the impact of population, health and nutrition programs for mid-level professionals from the LAC region, in collaboration with INSP, Mexico, and CDC's Division of Reproductive Health. The workshop will be offered as part of INSP's Summer Institute in July/August 2008. A limited number of MEASURE Evaluation TO fellowships (up to 4) will be offered to facilitate the participation of qualified government or local NGO M&E staff from USAID-assisted countries.

Tasks:
1. Prepare and execute an agreement between INSP and the MEASURE Evaluation TO.
2. Conduct planning for the 2008 workshop including content, instructors, budget, logistics and timeline.
3. Prepare and disseminate recruiting material for the 2008 workshop.
4. Review applications and select 2008 workshop participants and fellowship recipients.
5. Conduct 2008 workshop, providing administrative and instructional support as needed.
6. Prepare the Activity Report for the 2008 workshop.
7. Conduct follow-up of trainees.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Begin preliminary planning for 2008 Impact Evaluation workshop.

* Prepare the new agreement between INSP and MEASURE Evaluation Task Order.

Progress:
The dates for the 2008 workshop have been set for July 21 - August 8. Angeles and Kulatilaka have communicated with the INSP team about the preliminary planning for the workshop. Angeles and Deshpande from MEASURE Evaluation, and Paul Stupp from CDC, are expected to provide instructional support for the workshop.

Task Order October-December Activity Sheets

The scope of work for the new sub-agreement covering the 2008 workshop has been drafted and forwarded to INSP for review. INSP is preparing the draft budget for the workshop.

Year 1 Quarter January, February, March

Plans:

* Finalize the scope of work and budget and execute the new sub-agreement covering the 2008 workshop.

* Prepare the brochure and application form for the workshop and disseminate the announcement in February and March 2008.

* Continue working with the INSP team on the workshop agenda, curriculum, and logistics.

* Respond to information requests from potential workshop applicants.

LAC-10TO: Technical Assistance to LAC: HIS

Lead: Beatriz Plaza (University of North Carolina at Chapel Hill)

Technical Advisor: Lisa Maniscalco (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen HIS in the LAC Region.

Description:
This activity builds on the past work carried out through collaboration between Phase II of the MEASURE Evaluation Project and the Pan American Health Organization (PAHO). This collaboration supported the implementation of the Health Information Systems performance monitoring process in countries of the region of the Americas. The MEASURE Evaluation TO will continue the collaboration with PAHO in order to: (1) Extend the technical assistance for HIS assessment and strengthening provided under the previous collaboration to two new countries (subject to mission approval). (At the moment Peru and El Salvador have been proposed.); (2) To facilitate the establishment of a regional network of countries for strengthening their health information systems; (3) To apply the standardized assessment and monitoring process developed over the past three years (namely, the Health Metrics Network (HMN) framework and the Performance of Routine Information Systems Management (PRISM) framework); and (4) To disseminate successful experiences, key processes and lessons learned.

Given the available time and resources, efforts of this collaboration will be focused on pilot tests in the two countries; one or two departments or provinces will be chosen in each.

Success of the activity will be contingent on the strong communication and coordination plan that is established between MEASURE Evaluation TO, PAHO, USAID LAC Bureau, USAID and PAHO field offices. This will assist in overcoming delays and late starts of the consultative meetings and work plans for each country. The synergy created among this collaboration will be determinant in motivating the national health authorities, stakeholders, other international agencies, and donors in moving the work plan forward.

Tasks:
1. Conduct a consensus building process involving USAID/LAC/RSD, proposed country missions, PAHO field offices and National Health Authorities in order to guarantee acceptance of proposed project.
2. Establish HIS teams in each of the two target countries; Undertake an extensive assessment study of existing HIS using the HMN and PRISM framework and tools; Conduct HIS strengthening workshop with all stakeholders to discuss findings.
3. Determine interventions for both countries based on the strengths and weaknesses identified in the assessments; main emphasis will be on those gaps identified which are easy to bridge given the time frame.
4. Implement components of the interventions which may involve a) individual and institutional capacity building; b) mobilization of required resources; c) development of standard procedures and guidelines and d) monitoring and evaluation.

5. Disseminate the successful experiences, lessons learned, key processes, and best practices through a formalized Open Website.
6. Continue to promote networking and collaboration among national HIS teams, partners, and technical groups at the regional level.

Year 1 Quarter October, November, December

Plans:

* Conduct a consensus building process involving USAID/LAC/RSD, proposed country missions, PAHO field offices, and National Health Authorities in order to guarantee acceptance of proposed project.

* Conduct an initial two week consultative visit by Plaza and Martinez (PAHO).

* Prepare an HIS development plan to be shared with principal stakeholders for their comments based on findings from the visit.

* Obtain consensus on the HIS development plan by all principal stakeholders.

* Establish HIS teams in each of the two target countries.

Progress:

The last four of the planned activities listed above were not accomplished in the last quarter of 2007. This was primarily due to internal disagreements within the Pan American Health Organization (PAHO). Initial conversations did take place with the USAID mission offices in both Peru and the Dominican Republic. There is a definite buy-in on behalf of the national health authorities in Peru. Formal consensus building with the national health authorities in the Dominican Republic have not taken place.

Year 1 Quarter January, February, March

Plans:

* Meet with USAID and PAHO in mid-January to redefine and adjust the activity plan.

* Plan February visits to Peru and the Dominican Republic and officially transfer project responsibility from Ramon Martinez to Alejandro Giusti.

* Resume proposed activities mentioned for the October-December period.

LR-2TO: Technical Assistance to Liberia: Malaria

Lead: Michel Pacque (Macro International Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Malaria)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
To assess and improve the M&E system used by the National Malaria Control Program of Liberia.

Description:
MEASURE Evaluation TO will provide technical assistance to the Liberia National Malaria Control Program to improve its M&E systems. The MEASURE Evaluation TO will conduct a three day workshop in Liberia with the National Malaria Control Program and other relevant partners using the new Roll Back Malaria tool - Monitoring and Evaluation System Strengthening Tool (MESST) to contribute towards the development of a Malaria M&E plan. Following the workshop, the team will do an initial assessment of the current Malaria M&E system within the context of the overall health management information system and make recommendations for critical initial upgrades and further assessments as needed. This assessment will be an outgrowth of the workshop discussed above and will use a standardized protocol developed for PMI assessments conducted by the MEASURE Evaluation TO in five PMI countries. The assessment will target key intervention areas (such as sites of major spray or bednet campaigns) and the health facilities located in those areas. The number of sites will be limited to two to three to provide rapid results to the MOH. Using the results of activities 1 and 2 above, the team will make recommendations on the establishment of initial sentinel sites based on PMI and/or RBM definitions of sentinel sites, provide guidance on site selection, and recommended M&E or strategic information activities to be implemented in sentinel sites.

Tasks:
1. Conduct a three day MESST workshop with Liberia NMCP.
2. Conduct a site assessment of the NMCP monitoring system.
3. Provide TA to Liberia NMCP and PMI to identify sentinel sites and to improve M&E systems.

Year 1 Quarter October, November, December

Plans:
* Conduct initial conference call with USAID/Liberia and begin planning a trip for early 2008.

Progress:
This activity was put on hold by USAID/Washington per conversation with Misun Choi.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Follow up with USAID/Washington and if given the green light, proceed with the planning process.

MZ-4TO: Technical Assistance to Mozambique: SAVVY

Lead: Dan Williams (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to improve the collection and availability of cause of death data nationally through technical assistance to the Mozambican Instituto Nacional de Estatisticas (INE) and Ministry of Health (MISAU) in preparation for a post-census mortality survey (INCAM, in Portuguese).

Description:
The INCAM will be the first survey of its kind in Africa and will provide provincial-level estimates of the proportions and levels of mortality due to HIV/AIDS, malaria, and other leading causes. Statistics will be available for the entire country for all ages, by sex. Additional information about the use of health services in the period before death will also be available. Working in collaboration with the US Census Bureau, CDC/Mozambique, INE, MISAU, UNICEF, and the Manhica demographic surveillance site, MEASURE Evaluation TO will assist in the preparation and launch of the INCAM in October 2007, after the national census of population and housing in August. The INCAM survey, piloted in 2006, will follow-up with a provincially-representative sample of approximately 17,000 households reporting death events during the 2007 national census. A verbal autopsy (VA) interview will be administered to caregivers of the deceased person. The verbal autopsy procedures used will be those that are recommended for mortality surveillance through Sample Vital Registration with Verbal Autopsy (SAVVY), including the WHO core VA questionnaires.

Tasks:
1. Continue planning and preparations for INCAM (e.g. make appropriate adaptations to training materials, procurement, documentation and survey, and data processing procedures).
2. Continue identification of appropriate training partners, dates, and locations for supervisors, verbal autopsy interviewers, and VA certifiers/coders.
3. Launch INCAM fieldwork in October 2007, in all 11 provinces, using a total of 46 interview teams and 196 verbal autopsy interviewers.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Continue data entry and cleaning of mortality information from the census forms returning from the field (death frame compilation).

Task Order October-December Activity Sheets

* Finalize the INCAM sampling procedures and identify the selected primary sampling units (PSUs) in each province, as census forms return from the field.

* INE to conduct 5-day verbal autopsy interviewer trainings in all 11 provinces, and begin fieldwork immediately thereafter. SAVVY TA team to assist with training and fieldwork supervision.

* Complete fieldwork in 7 provinces by the end of December, with 4 additional northern provinces scheduled to complete data collection in early 2008.

* Work with the Ministry of Health (MISAU) on the identification of MDs for ICD-10 verbal autopsy certification and coding training/retraining in early 2008.

Progress:
The SAVVY team assisted INE and the Ministry of Health with the finalization of the verbal autopsy (VA) forms and the VA interviewer training for Maputo City and Province from October 15-19. On October 22, INCAM fieldwork launched in these first two areas. In general, the first 10 weeks of fieldwork have gone well, with few logistical concerns. One field issue that has arisen is that many deaths enumerated during the census actually occurred outside the 12-month reference frame, resulting in smaller actual sample sizes than anticipated. The INCAM team is reporting result codes by province biweekly, in order to track the magnitude of this problem. Fieldwork has now completed in 6 provinces and is nearly complete in Tete.

Year 1 Quarter January, February, March

Plans:
* Identify, on a rolling basis, the selected primary sampling units (PSUs) in each province, and continue/complete fieldwork in the northern provinces by the end of March.

* Continue working with the Census and INCAM teams on the monitoring of fieldwork results and operational issues.

* Assist BUCEN and INE with data processing, data entry, and weighting procedures as needed.

* Work with the Ministry of Health (MISAU) on the identification of MDs for ICD-10 verbal autopsy certification and coding training/retraining in April and May 2008.

MZ-6TO: Technical Assistance to Mozambique: AB Process Evaluation

Lead: Ilene Speizer (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objectives of this activity are to: (1) identify and document promising practices in the AB program area in Mozambique; (2) undertake a formal assessment of AB approaches and recommend improvements in quality and performance; and (3) undertake an end-of-project program assessment of the Project Hope AB program that was completed September 30, 2007.

Description:
MEASURE Evaluation TO will work closely with the USG Mozambique PEPFAR team and the Prevention Working group to undertake two main activities. First, MEASURE Evaluation TO will undertake a portfolio review of USG PEPFAR AB partners with the objectives of identifying promising practices and providing recommendations for improvement in quality and performance. In particular, this will involve working closely with the selected USG PEPFAR partners to determine the types of activities being undertaken and how they are expected to influence youth sexual risk-taking, the quality of peer education activities, linkages and referrals to other programs, program reach and targeting, strengths and challenges of program approaches, and whether data exist and the quality of data available. Two programs of particular interest for program review are the Peace Corps REDES and JOMA programs to determine their contribution to youth programming. The review will also incorporate the AB partners that are using abstinence pledges to determine how abstinence pledges are being implemented differently by World Relief, Food for the Hungry, and World Vision. Finally, the review will examine a sample of the Embassy's Quick Impact and PAO grants to determine the strengths and challenges of this additional funding mechanism.

Providing specific program recommendations for delivery of services is beyond the scope of the MEASURE Evaluation TO. Therefore, staff will accomplish the requirement of the SOW to recommend improvements in quality and performance of AB activities through the application of a focused Data Demand and Information Use (DDIU) workshop with USG stakeholders and AB partners. Starting with a preliminary meeting with USG stakeholders, input will be elicited on plans for using the findings from this program assessment. This will permit MEASURE Evaluation TO to ensure that the assessment is programmatically relevant and can be used to generate evidence-based recommendations for program improvement. At the DDIU workshop at the completion of the assessment, MEASURE Evaluation TO will present findings to the key USG stakeholders and AB partners, obtain input from them on interpretation, and ensure that delegates from USG and AB partners provide direct input into the final report sections dealing with recommendations for program improvement. Involving USG stakeholders and AB partners in this manner is one

of the primary purposes for holding a DDIU workshop, and will permit MEASURE Evaluation TO to include programmatic and policy recommendations into the deliverables.

Tasks:

1. Design assessments.
2. Conduct site visit to obtain materials for targeted programs and meet with key USG stakeholders.
3. Develop discussion guides, instruments, checklists, and tools for data collection.
4. Conduct preliminary meetings with responsible parties within participating organizations.
5. Participate in Peace Corps conferences.
6. Conduct fieldwork, meet with AB partners, Project Hope, and Peace Corps youth leaders and participants from sites selected for review.
7. Develop a first draft of the Peace Corps Case Study.
8. Develop a first draft of the report on Project Hope end of project assessment.
9. Finalize the Case Study and Project Hope reports.
10. Develop a preliminary draft of the final report of the AB portfolio.
11. Submit the final report on the AB portfolio.
12. Undertake DDIU workshop with USG Interagency Working Group and AB partners to interpret findings and identify how findings can be used to strengthen programs

Year 1 Quarter October, November, December

Plans:

* Design assessment materials to be shared and discussed with Technical Working Group in December.

* Visit Mozambique in early December to review with Technical Working Group which USG partners will be included in the assessment (and collect materials for review).

Progress:

During this quarter, MEASURE Evaluation TO accomplished all of its planned activities. In particular, the team designed a document with a description of the proposed strategy for the program assessment. This document was reviewed and approved by the USAID Mission. In December, two members of the MEASURE Evaluation TO team (Speizer and Michaud-Letourneau) visited Mozambique. During the trip, 13 partners were selected to participate in the portfolio review. Documents on program activities from these partners were collected while in country.

During the trip, staff also undertook a site visit with Project Hope. This involved 2-days of meetings with the project management as well as a visit up-country to Mocuba to meet with field staff.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Write and submit a report on the Project Hope program assessment (a deliverable).

* Review literature on abstinence pledges for the case study on the use of abstinence pledges of AB partners in Mozambique.

* Review project materials for partners to be visited in the spring.

* Coordinate site visits for the April to June, 2008 period.

NG-3TO: Technical Assistance to Nigeria: NNRIMS

Lead: David Boone (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to improve the design and implementation of the HIV/AIDS information gathering process through technical guidance and increased capacity (technical, human, and organizational) among NACA and partners to collect, process, and use HIV/AIDS data.

Description:
MEASURE Evaluation has been providing technical assistance to NACA since 2003 to design and implement the Nigeria National Response Information Management System (NNRIMS). To date, MEASURE Evaluation has assisted NACA with system design, development of training materials, initial training in five pilot states, database development and training, GIS training and mapping of service delivery points, evaluation of NNRIMS pilot implementation, design and revision of data collection tools and NNRIMS database, development of a NNRIMS scale-up plan, training of 16 states (TOT) in the revised system, and technical assistance for state-level "step-down" training workshops. The MEASURE Evaluation TO will focus TA to selected states and/or facilities to ensure the collection, reporting and use of high quality data for program improvement and decision-making occurs. In addition to TA to selected focal states and/or facilities, MEASURE Evaluation TO will continue to ensure the general quality of central level TOTs and step-down training workshops through the revision and improvement of the NNRIMS training curriculum. Furthermore, MEASURE Evaluation TO will conduct training for national, state, and facility users of a new web-portal data management system produced by Voxiva, and provide technical assistance to Voxiva for roll-out of the system and to ensure optimum data analysis and use. MEASURE Evaluation TO will provide TA to NASCP to review and improve the nationally adopted patient tracking system and subsequently will provide TA to roll-out the system nationally. This activity also supports the MEASURE Evaluation TO Resident Advisor based in Nigeria who coordinates and provides direct TA in the areas described above.

Tasks:
1. Provide TA to link NNRIMS to the SCMS/Voxiva web portal (under development).
2. Provide TA with SCMS/Voxiva toward core indicator development, training materials, and curricula for data quality and use and training in the system.
3. Continue to support the NNRIMS development toward improved reporting, data quality, and information use.
4. Conduct capacity building at the state and IP levels toward full implementation of the SCMS/Voxiva web portal.
5. Provide oversight to ensure that quality data are generated for use in program management and decision making for policy at all levels.
6. Provide TA and training to NASCP to implement harmonized ART PMM system and scale up the system nationally.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Conduct ToT in Abuja for NNRIMS/Voxiva web-portal for 12-15 master trainers.

* Supervise the step-down training of 40-60 health facility personnel from 20-30 facilities in Lagos/Oyo, Benue, and FCT.

* Continue to support the National Action Committee on AIDS (NACA) and the Ministry of Health (NASCP) for the roll-out of the Patient Monitoring Mechanism (PMM) for ART patient tracking.

* Continue to provide TA to the NACA for performance monitoring of NNRIMS.

Progress:

Due to delays out of the control of MEASURE Evaluation TO, the LHPMIP ToT could not be conducted in the October - December quarter. The new date for the ToT is the end of January, 2008. The training manual for the LHPMIP ToT was completed in November, 2008. Presentations and other workshop materials were also finalized.

MEASURE Evaluation TO staff supported the National Action Committee on AIDS (NACA) and the Ministry of Health (NASCP) for the roll-out of the Patient Monitoring Mechanism (PMM) for ART patient tracking. Arrangements were made for finalizing the training materials for Patient Monitoring in the upcoming quarter. Staff also provided TA to the NACA for performance monitoring of NNRIMS.

Year 1 Quarter January, February, March

Plans:

* Conduct ToT in Kano for the NNRIMS/LHPMIP web-portal for 40-50 master trainers (January 22-24, 2008).

* Supervise the step-down training of 120 health facility personnel from 60-80 facilities in Lagos/Oyo, Benue, Kano, Gombe, Bayelsa and FCT.

*Identify and hire a second Resident Technical Advisor for MEASURE Evaluation TO.

* Continue to support the National Action Committee on AIDS (NACA) and the Ministry of Health (NASCP) for the roll-out of the Patient Monitoring Mechanism (PMM) for ART patient tracking.

* Conduct a training materials revision and adaptation workshop.

* Finalize the training materials for the patient monitoring system.

* Continue to provide TA to the NACA for performance monitoring of NNRIMS and the LHPMIP web portal reporting system.

NG-5TO: Technical Assistance and Capacity Development for Nigeria in M&E

Lead: Nicole Judice (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen the M&E capacity of representatives of the Government of Nigeria (GON), US Government (USG), Nigerian NGOs, FBOs, and USG implementing partners (IPs) in the national response to HIV/AIDS.

Description:
MEASURE Evaluation TO will coordinate and facilitate two general M&E workshops for staff from the GON (including zonal level staff), IPs, USG, NGOs, FBOs, and CBOs to build M&E capacity of HIV/AIDS programs (COP07 funds will partly cover workshop costs, the remaining costs will be recovered by participant tuition). One workshop is tentatively scheduled for early 2008 and the second during the summer of 2008.

Tasks:
1. Prepare for and facilitate one general M&E workshop for various stakeholders in Nigeria's response to HIV/AIDS in the winter/spring of 2008.
2. Prepare for and facilitate one general M&E workshop for various stakeholders in Nigeria's national response to HIV/AIDS in the summer of 2008.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Begin preparations for the first general M&E workshop, tentatively scheduled for January or February 2008. Preparations will include starting to make any necessary revisions to the existing agenda and curriculum; identifying venue and dates for the workshop; sending out notice and beginning the process of registering participants for the workshop.

Progress:
The MEASURE Evaluation TO Nigeria team began the planning and preparation process for the first general M&E workshop, tentatively scheduled for late March - April 2008. The objectives of the workshop were revisited and potential audiences were discussed.

Year 1 Quarter January, February, March

Plans:
* Determine the audience for the M&E workshop.

* Conduct a brief questionnaire to identify training needs.

Task Order October-December Activity Sheets

* Send out a training announcement.

* Design the curriculum.

NG-7TO: Technical Assistance to Nigeria: DDIU

Lead: Nicole Judice (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to help build the capacity within the GON, USG, and USG IPs as well as of groups that conduct national outcome evaluation studies in facilitating demand for quality information as well as the use of information in policymaking, planning and program management.

Description:
MEASURE Evaluation TO will facilitate a Data Demand and Information Use (DDIU) training for representatives of the GON, USG, IPs, NGOs, CBOs and FBOs. The DDIU training will focus on facilitating demand for and use of quality health-related information, data analysis, interpretation, and communication. Participants will develop data use action plans using available HIV/AIDS information such as from the SCMS/Voxiva web portal. MEASURE Evaluation TO will also provide DDIU assistance and other TA as requested to groups conducting national outcome evaluation studies. This will include conducting stakeholder meetings and TA with groups conducting national outcome evaluation studies on DDIU of study findings, building capacity in DDIU among these groups, and providing TA for design and analysis of outcome studies as requested and as funds allow.

Tasks:
1. Develop curriculum for DDIU workshop based on developments in the SCMS/Voxiva web portal.
2. Conduct DDIU workshop to help facilitate and expand the use of available HIV/AIDS information.
3. Conduct stakeholder meetings and TA with groups conducting national outcome evaluation studies on DDIU of study findings.
4. Provide TA on the design and analysis of outcome studies as requested and as funds allow.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Begin to plan stakeholder meetings with groups that conduct national outcome evaluation studies.

Progress:
During this quarter, Oyediran and Judice identified the need to provide DDIU TA to the team conducting the national OVC survey also (see NG-9TO). TA from Judice will

complement ongoing TA and training being provided by Oyediran, Chapman, and Nyangara to the Ministry of Women's Affairs and others responsible for conducting the national OVC survey.

Year 1 Quarter January, February, March

Plans:

* Provide TA to the team conducting the national OVC survey.

* Identify other groups requiring DDIU assistance and/or training in conducting national outcome evaluation surveys.

NG-9TO: Technical Assistance to Nigeria: OVC

Lead: Jenifer Chapman (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen the capacity of the Government of Nigeria and other stakeholders in the implementation of a national OVC situation assessment that provides benchmark information for evidence-based target setting and intervention strategies.

Description:
The main aim of the national OVC situation assessment is to estimate the magnitude and prevalence of OVC in Nigeria, determine where they live, and their characteristics and well-being to enable the government to develop effective programs and policies to support them.

MEASURE Evaluation TO staff will review the results of the pre-test with stakeholders in Nigeria, and define objectives for the assessment study. MEASURE Evaluation TO staff will subsequently work closely with stakeholders in country to refine data collection tools to be used in the assessment, coordinate the writing of a research protocol describing the objectives and design of the assessment, and provide a detailed data analysis plan. MEASURE Evaluation TO staff will travel to Nigeria in late 2007 to observe the process of data collection and entry and provide TA as needed. In December 2007 or January 2008 data analysis will be conducted and information disseminated through a workshop in the spring of 2008.

Tasks:
1. Work with the FMoWASD and other stakeholders to agree on the objectives of the OVC national situational assessment and in a collaborative manner help develop a sound design and protocol for the assessment.
2. Review and collaborate with the FMoWASD and others to refine the existing survey instrument to ensure that it meets the highest standard available for research in this area.
3. Create a written plan of data analysis to guide finalization of survey instrument and data collection protocols, and to plan for data dissemination and use.
4. Provide training and capacity building as needed to support data collection and/or data entry.
5. Provide TA as needed in the areas of data collection, data entry and data cleaning.
6. Conduct a presentation of preliminary findings amongst stakeholders in Abuja and contribute to the production of a final report.
7. Work with the FMoWASD and other stakeholders to interpret findings to guide policy and programming decisions regarding OVC in Nigeria.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* Finalize the survey instruments in collaboration with the Government of Nigeria and other members of the Technical Working Group.

* Finalize the research protocol.

* Obtain approval of US and Nigeria research ethics boards.

* Contribute to the creation of the interviewer manual and provide TA in planning for field work.

* Observe and input into data collection process and procedures.

Progress:

The research protocol and all qualitative and quantitative data collection tools have been finalized. Approval has been received from a local IRB in Nigeria and the US IRB approval process is currently underway. A ToT workshop as well as state-level field worker training workshops have been scheduled for January to February 2008 and a manual to support training has been drafted.

Year 1 Quarter January, February, March

Plans:

*Obtain US IRB approval.

* Develop a SOW for a national consultant with international experience to support data collection, data analysis, and DDIU activities locally, and contract a suitable consultant.

* Facilitate the TOT in Kaduna as well as state-level fieldworker training workshops where logistically feasible.

* Develop a data analysis and dissemination strategy in collaboration with the FMoWASD and the consultant.

RW-1TO: Technical Assistance to Rwanda: PEPFAR

Lead: Andrew (Drew) Koleros (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
To increase the ability of the CNLS to plan and execute a national M&E system for HIV/AIDS.

Description:
This activity includes TA to support the CNLS Planning, Coordination and Monitoring & Evaluation (PCM&E) Unit to make all essential components of the national HIV M&E system functional. The CNLS PCM&E Unit includes a Director, Planning and Coordination Officer, M&E Officer (vacant since June 2007) and two Data Analysts. The MEASURE Evaluation TO will also support the CNLS in capacity development to improve M&E implementation for the CNLS PCM&E Unit staff and development partners, including the umbrella organizations civil society organizations.

Tasks:
1. Hire long term advisor and local staff.
2. Provide TA to carry out the M&E Systems Strengthening Assessment and contribute to the M&E road map development.

Year 1 Quarter October, November, December

Plans:
* This activity closed under Year 4 of MEASURE Evaluation Phase II and re-opened under the Task Order on October 1, 2007.

* Recruit expatriate long term Resident Advisor.

* Hire local staff member to provide coordination of the PEPFAR Steering Committee (PSC).

* Hire local staff person for the integration of the AIDS response into the health and other relevant sectors of the national development strategy.

* Facilitate the application of the GFATM/PEPFAR/USAID MESST tool to assess the status of the TB, malaria, and HIV M&E systems at the national level.

* Participate in PM&E TWG meetings and functions.

* Participate in meetings and discussions required to prepare the National HIV M&E Roadmap.

Task Order October-December Activity Sheets

Progress:
The first activity under the TO, to hire a long term resident advisor and local staff, was accomplished this quarter. The expatriate long term resident advisor was recruited in October and began work in December. In addition, three local staff were recruited for the project: a staff member to provide coordination to the PEPFAR steering committee, a staff member for the integration of the AIDS response into other sectors, and a staff member for the identification, documentation, and dissemination of best practices. By the end of the quarter, all four staff were in place at post.

In October 2007, MEASURE Evaluation TO provided TA to the Global Fund to Fight AIDS, TB, and Malaria and the Government of Rwanda to carry out a national participatory monitoring and evaluation system assessment using the M&E systems strengthening tool (MESST) to assess the HIV M&E system at the national level. The tool assesses three components of a functional M&E system including organizational structures and a national, multi-sectoral M&E plan. The assessment report including strengths, weaknesses, and action items is being finalized by the Global Fund.

In addition to the Global Fund assessment, MEASURE Evaluation TO staff provided TA to the World Bank and the Government of Rwanda in a more in-depth assessment of the national M&E system based on the Monitoring and Evaluation Reference Group (MERG)'s National HIV M&E Road Map draft assessment tool. This activity assesses twelve focus areas identified by the MERG as the essential components of a comprehensive, functional costed M&E plan, including a human capacity development plan and a plan for the dissemination and use of M&E data to guide policy formulation and program planning and improvement. The MERG assessment used the results from the three components of the Global Fund MESST assessment, and assessed the remaining nine components with their own draft tool. The final assessment report is being compiled by the World Bank.

In December, MEASURE Evaluation TO staff provided financial and technical assistance to the World Bank and the Government of Rwanda in the development of their National HIV M&E Plan. The work plan development used the draft results from the National M&E Road Map assessment in October to decide action items for the work plan. The work plan was then drafted and validated in a participatory approach during a three-day workshop. After all activities were delineated, each activity was costed so that a final, costed M&E Road Map could be presented to the Government of Rwanda for implementation. The final costed workplan is currently being finalized by the World Bank.

Year 1 Quarter January, February, March

Plans:
* Finalize the M&E Road Map in collaboration with the Global Fund.

RW-3TO: Technical Assistance to Rwanda: Data Collection Systems

Lead: Andrew (Drew) Koleros (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is for the CNLS to have functioning national and subnational HIV/AIDS data bases that contain up-to-date and valid data that respond to stakeholders' needs.

Description:
This activity will focus on support to the CNLS for the continued refinement and development of the CNLS district level data base as well as implementation of the national M&E Plan. The national M&E plan identifies over 60 indicators that track progress in implementing the national HIV/AIDS strategic plan, but currently has incomplete data and data that are not stored electronically.

Tasks:
1. Provide TA to and capacity building for the CNLS in data quality assurance (DQA).
2. Provide TA to update tools and procedures.
3. Provide TA to the PCM&E Unit to assess the national level planning and reporting database.
4. Provide TA and financial support to carry out an independent assessment to review the CNLS database.
5. Provide IT support for the PCM&E Unit Data Analysts.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity RW-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Provide TA and limited financial and logistical support to the CNLS for joint supervision visits to the districts for data quality control.

* Provide required TA to the CNLS to modify or update data collection tools and forms for the collection of data for the national M&E system.

* Provide on-line remote TA to the CNLS data analysis unit for the refinement of their web-based district level data base as requested.

Task Order October-December Activity Sheets

Progress:
The CNLS did not perform any supervision visits this quarter, as there were several national-level workshops held that brought the district-level representatives to Kigali, including the MESST assessment, the National HIV M&E Roadmap workshop, and a meeting of all representatives of the District AIDS Control Committees to discuss 2007 reporting and the development of 2008 action plans.

Providing TA to the CNLS for joint supervision visits to the districts for data quality control was discussed during the CNLS staff meeting held in December 2007. The CNLS is preparing to develop a new National HIV/AIDS Strategic Plan (NSP) 2008-2012 in April and May 2008. Since the new strategic plan may change data collection needs and priorities, the Planning, Coordination, and Monitoring and Evaluation (PCM&E) Unit will conduct this activity after the new NSP has been developed.

The CNLS data analysts did not conduct any district-level database activities this quarter, thus requested no assistance.

Year 1 Quarter January, February, March

Plans:
* Fund the CNLS/Rwanda M&E Officer to participate in the CESAG Seminar on Monitoring and Evaluation of HIV/AIDS Programs in Senegal from February 4-15,2008.

* Begin planning a regional M&E workshop for national and district-level M&E stakeholders on the generalities of M&E including data quality assurance, in collaboration with the Planning, Coordination, and Monitoring and Evaluation Technical Working Group (PCM&E TWG) chaired by CNLS.

* Provide technical and financial assistance to CNLS's planned supervisory visits in the field.

* Assist CNLS in completing an IT Needs Assessment and prioritizing equipment and training needs.

RW-4TO: Technical Assistance to Rwanda: DDIU

Lead: Andrew (Drew) Koleros (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
To increase the demand for and use of HIV and AIDS related data by stakeholders in Rwanda.

Description:
This activity supports TA and capacity development to the CNLS and CDLS to use district-level data for routine monitoring and decision making. The MEASURE Evaluation TO will use the DDIU Framework, developed under MEASURE Evaluation, and associated tools to improve the demand for and use of HIV/AIDS data by the CNLS and its partners. This framework uses a participatory approach that includes relevant stakeholders. The project will also support the development and dissemination of CNLS information products.

Tasks:
1. Provide TA for the dissemination and use of CNLS M&E information products.
2. Provide TA to complete and disseminate Part B of the national M&E plan.
3. Provide TA and financial support to carry out the Mid-term Review of the National Multi-sectoral Plan for HIV/AIDS Control.
4. Provide technical and financial assistance for the organization of the 4th Annual Rwandan Research Conference on HIV/AIDS.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from activity RW-1 under MEASURE Evaluation Phase II on October 1, 2007.

* Assist with the development and dissemination of information products at the request of the CNLS.

* Provide TA to complete "Part B" of the national HIV/AIDS M&E Plan.

Progress:
No information products were developed nor disseminated this quarter. Some initial discussions began between MEASURE Evaluation TO staff and the CNLS on the dissemination of the results of the PLACE study conducted in Rwanda by MEASURE Evaluation. These discussions will continue next quarter.

The Completion of 'Part B' of the national HIV/AIDS M&E Plan is one of the activities in the Roadmap planned for next quarter.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Provide technical and financial assistance to the CNLS in the development of brochures highlighting 2007 accomplishments and 2008 action plans.

* Assist CNLS in finalizing "Part B" of the National M&E Plan.

* Provide technical and financial assistance to the CNLS in conducting the Mid-term review of the National Multi-sectoral Plan for HIV/AIDS Control and the development of the new National Strategic Plan 2008-2012 based on the EDPRS plan.

* Begin planning the 4th Annual Rwandan Resarch Conference on HIV/AIDS with the CNLS.

SAF-2TO: Master's Degree Training (Pretoria)

Lead: Sohail Agha (Tulane University)

Technical Advisor: Lisa Maniscalco (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to build national M&E capacity in the Africa region by increasing, in a cost-effective way, the number of Master's level individuals trained in M&E.

Description:
This activity includes supporting the School of Health Systems and Public Health (SHSPH) at the University of Pretoria, to offer a M&E concentration in the Master of Public Health degree program and financially support up to three students to attend the 2008-09 program. MEASURE Evaluation TO staff will collaborate with SHSPH to review the content of the M&E course in the masters degree program and will provide instructional support. Staff will also provide teaching materials, books, and other relevant publications on M&E and provide appropriate software related to the instruction of the M&E course, if needed. It is expected that 28-30 master-level students will take the M&E course in 2008. The fellowships will support qualified applicants from USAID assisted countries and will cover the following expenses incurred during the period January 2008 - February 2009: tuition, books, airfare, research practicum, thesis, health insurance, accommodation, and a living allowance. SHSPH, using funds made available under this agreement, will support the above costs for the fellowship recipients. The 2008-09 cohort will begin classes in January 2008 and is expected to graduate in June 2009.

SAF-2TO will run concurrently with the MEASURE Evaluation Phase II activity SAF-2 from October 1, 2007 - September 30, 2008.

Tasks:
1. Review applications and select fellowship recipients for the 2008-09 program.
2. Monitor the progress of the 2008-09 fellows.
3. Provide instructional support to the master-level M&E course.
4. Prepare Activity Report for 2008-09 Program.

Year 1 Quarter October, November, December

Plans:
* This activity will run concurrently with MEASURE Evaluation Phase II activity SAF-2 from October 1, 2007 - September 30 - 2008.

* Respond to information requests from potential applicants to the 2008-09 MPH program.

* Review applications and select 2-3 fellowship recipients for the 2008-09 MPH cohort.

Task Order October-December Activity Sheets

* Provide administrative support as needed.

* Execute the new agreement between SHSPH and MEASURE Evaluation Task Order.

Progress:
Two fellowship recipients were selected for the 2008-09 cohort, and are expected to begin classes in January 2008. These partial fellowships will cover expenses incurred during the period January 2008 - January 2009.

The Task Order sub-agreement, covering the 2008-09 cohort, has been prepared and sent to University of Pretoria for signature.

Year 1 Quarter January, February, March

Plans:
* Execute the sub-agreement covering the 2008-09 cohort.

* Monitor the arrival of the two MEASURE Evaluation TO fellows in Pretoria in January and continue to monitor their progress.

TZ-2TO: Technical Assistance to Tanzania: SAM

Lead: Michael Rodriguez (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The long-term objective of this activity is to enable district and national planners to use Service Availability Mapping (SAM) as a key tool for public health decision-making.

Description:
MEASURE Evaluation TO will collaborate with the Tanzania Ministry of Health (MoH), WHO/Geneva and WHO/Tanzania to facilitate implementation of the Service Availability Mapping (SAM) of select VCT and PMTCT sites in 3-5 districts (depending on size of the district) in Tanzania. This work will build on the SAM that was conducted under MEASURE Evaluation in 2005-2006. The MoH will play a lead role in the implementation of the SAM with technical support from the MEASURE Evaluation TO and WHO/Geneva. The SAM tool aims to provide a visual representation of estimated coverage and health service gaps at the district level.

Tasks:
1. Develop MOU for SAM implementation with the MoH.
2. Update the data collection tools, in collaboration with the MoH, USAID/Tanzania, and WHO.
3. Select 3-5 districts (depending on size of district) where SAM is to be conducted in collaboration with USAID/Tanzania and the MoH.
4. Train data collectors and data entry staff in collaboration with the MoH.
5. Supervise data entry, analysis, and the final report by MoH.
6. Conduct a data dissemination workshop in collaboration with the MoH.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Develop MOU for SAM implementation with the MoH.

* Update the data collection tools in collaboration with the MoH, USAID/Tanzania and WHO.

* Select 3-5 districts (depending on size of district) where SAM is to be conducted in collaboration with USAID/Tanzania and the MoH.

Task Order October-December Activity Sheets

Progress:
This activity was put on hold during the quarter pending discussions and clarifications from the Tanzania Mission on priorities. Following further discussions and planning, MEASURE Evaluation TO was advised by the Tanzania Mission that a radical shift in priorities has resulted in the cancellation of this activity for the Services Availability Mapping (SAM). There will be no additional work under this activity and it is now closed.

TZ-4TO: Technical Assistance to Tanzania: USG SI Support

Lead: Molly Strachan (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to strengthen USG SI systems.

Description:
Strengthened SI systems will improve PEPFAR reporting, improve data quality, promote data for decision making, promote use of Geographic Information Systems (GIS) analytic tools, and build human capacity. TA will be provided by a resident technical advisor to USG SI partners to enhance USG efforts to effectively monitor and evaluate the progress of PEPFAR.

Tasks:
1. Collaborate with SI Interagency technical team (ITT) to ensure high-quality PEPFAR data is reported to OGAC.
2. Collaborate with SI ITT to have a functioning PEPFAR reporting database (TaPRS).
3. Support SI ITT data quality assessment efforts.
4. Participate as an active member of the SI ITT.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Plan, prepare, and complete the Annual Program Results (APR07) Report.

* Use TaPRS to process and de-duplicate APR data, and become a program management tool for PEPFAR managers.

* Complete the Strategic Information Manual for PEPFAR partners and review and finalize reporting guidance for USG agencies.

* Provide support to prevention partners in collaboration with the SI focal person on data collection and reporting issues.

Progress:
MEASURE Evaluation TO participated in the planning, preparation, and completion of the Annual Program Results report for USG/Tanzania. Support included updating the excel template provided to partners to include indicator changes from OGAC, review of draft partner submissions and technical assistance prior to submission to USAID for several partners, and participation in interagency technical review team meetings to review, clean

and de-duplicate PEPFAR data at the site level.

Data entry was initiated for TaPRS, however, time constraints and concerns over the robustness of TaPRS resulted in not using TaPRS to roll-up data for the APR. Data was manually collated for USG to submit to OGAC. MEASURE Evaluation TO is preparing a spreadsheet of APR07 data for USAID program managers to ensure easy access to the data. MEASURE Evaluation TO hired a consultant to conduct the remaining data entry into TaPRS.

Drafts of the Strategic Information Manual and the reporting guidance for USG agencies was prepared and the latter reviewed by some members of the SI ITT. Competing priorities at the USG-level has pulled attention away from these two documents during this quarter.

MEASURE Evaluation TO and the SI Liaison conducted site visits to multiple prevention prime partners and sub-partners in Arusha and Moshi to review data collection and collation strategies and to discuss additional monitoring and evaluation needs in the field. Strachan and Gasioriwicz created draft guidance on prevention indicators to share with the Prevention ITT in order to improve the specificity and quality of data collected in the field.

Year 1 Quarter January, February, March

Plans:

* Participate as an active member of the SI Interagency technical team.

* Finalize the entry of PEPFAR data from 2005 through 2008 into the current PEPFAR reporting database.

* Conduct one M&E Steering Committee of USG PEPRAR partners.

* Conduct one Implementing Partner's M&E Working Group meeting.

* Facilitate preparation of GIS maps for the USG VIP visit in February.

TZ-6TO: Technical Assistance to Tanzania: Database Support

Lead: Michael Edwards (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to improve the capacity of USG agencies and their partners to monitor the national HIV/AIDS program in Tanzania and strengthen the M&E capacity within selected Tanzania HIV/AIDS program implementing institutions.

Description:
MEASURE Evaluation TO supports USG agencies and partners in developing a system for coordinating collection and collation for purposes of tracking PEPFAR activities, updating the USG indicators, generating reports as required for USG oversight of its programs and reporting to OGAC. In support of this activity, the Tanzania HIV/AIDS Program Monitoring System (TaPRS), a Microsoft Access based indicator monitoring database for use in the management and monitoring and evaluation of HIV/AIDS treatment and prevention programs supported by PEPFAR has been developed and is currently in use by the Tanzania USG SI team.

Tasks:
1. Test the new version of TaPRS to ensure its full functionality for the April 2007 Report.
2. Assist the Tanzania USG/SI team with the data input and collation for all reporting periods.
3. Refine TaPRS to meet the specifications requested by Tanzania USG/SI Team.
4. Train Partners in the use of TaPRS.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Refine TaPRS to meet the specifications requested by the Tanzania USG/SI Team.

* Assist Tanzania USG/SI team with the data input and collation for all reporting periods.

Progress:
TaPRS database was refined to meet the specifications requested by the Tanzania USG/SI team. Assistance was provided to the Tanzania USG/SI team with the data entry and collation for the APR07 report. Funding for assistance was put on hold in November, awaiting further guidance from USG and MEASURE Evaluation TO management.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Conduct limited assistance for data entry for the 2008 semi-annual and annual reports.

* Prepare TaPRS data exports in XML format.

TZ-7TO: Technical Assistance to Tanzania: DDIU

Lead: Charles Pill (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to facilitate DDIU of HIV/AIDS information by the GoT ensuring that it capitalizes on opportunities that complement Tanzania's M&E system and operational plan primarily focusing on activities at the district and sub-district levels.

Description:
MEASURE Evaluation TO plans to continue efforts started under Phase II of MEASURE Evaluation to insert DDIU curricula and materials into on-going and planned trainings in support of Tanzania's road map of M&E support activities. This training program will serve as a model for district level DDIU in consort with TACAIDS M&E activities. MEASURE Evaluation TO will integrate various data sources where possible into DDIU training materials and tools to adapt these materials and tools to the Tanzanian context.

MEASURE Evaluation TO will provide TA to TACAIDS M&E Unit and other relevant GoT partners to develop an agenda for DDIU and focus on developing support activities to all 121 districts to be managed between TACAIDS and the Prime Minister's Office for Regional Administration and Local Government/PMORALG.

Because there was a hiatus in DDIU activities in Tanzania due to funding issues, there is a need to revisit these planned activities with TACAIDS, USG, and other partners. The specific details of the workplan and activities are subject to adaptation after further discussion with TACAIDS, other GoT partners, and USG.

Tasks:
1. Conduct two DDIU district level case studies to adapt tools to the Tanzanian experience with TACAIDS staff - cofunded with core funds.
2. Develop a three day DDIU curriculum to train 121 district HIV/AIDS coordinators to use data at the district and subdistrict levels.
3. Develop a plan for the next steps with TACAIDS and other stakeholders and ensure that the next steps will build on the DDIU work to date and focus on more district and sub-district data use activities.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Hold discussions with TACAIDS, USG, and other relevant partners to determine the details of this scope of work.

Task Order October-December Activity Sheets

* Adapt and revise the details of this workplan to any changes in the local environment and situation.

* Travel to Tanzania to begin the process of collecting information for the district level case studies, which will be used to inform development of training materials and curricula in future quarters.

Progress:
There were no activities conducted pending the revision of the workplan as per USAID mission guidance.

Year 1 Quarter January, February, March

Plans:
* This activity has been suspended pending approval of a new SOW for the entire Tanzania portfolio.

TZ-8TO: Technical Assistance to Tanzania: GIS

Lead: Andrew Inglis (Macro International Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to improve the analysis and presentation of data for use in decision-making by USG and its partners in Tanzania.

Description:
Building on the GIS activities conducted under Phase II of MEASURE Evaluation, the MEASURE Evaluation TO proposes to continue the semi-annual mapping and expand the analysis (to include more indicators) of PEPFAR program data. Using the existing GIS database of HIV/AIDS information (DHS, PEPFAR reporting, Census, Sentinel Surveillance etc.), this activity will continue to map PEPFAR programs following the semi-annual and annual reporting cycles for both mainland Tanzania and Zanzibar. MEASURE Evaluation TO will work closely with TACAIDS, ZAC and NACP to update the non-PEPFAR HIV/AIDS activities in Tanzania (mainland and Zanzibar) for the benefit of USG planning. MEASURE Evaluation TO will produce semi-annual GIS data viewers on CDs and carry out a training of trainers so that the CDs can be used by GoT at the district level, as well as by USG and their partners. Additionally, MEASURE Evaluation TO will continue to integrate new sources of HIV/AIDS related information into the GIS database, such as the Service Provision Assessment (SAM) and poverty estimates.

Tasks:
1. Expand the mapping, analysis, and integration of new sources of HIV/AIDS related information with the semi-annual PEPFAR reporting data.
2. Continue to produce semi-annual GIS data viewers of PEPFAR reporting data for USG agencies.
3. Provide a training of trainers on the use of the GIS data viewers CDs as requested by USG partners.
4. Integrate new sources of HIV/AIDS related information into the GIS database.
5. Provide TA to TACAIDS, ZAC and NACP for mapping various HIV/AIDS based activities.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

*Continue to refine a stand alone CD GIS data viewer and linkage to the TAPRS that can be updated on a semi-annual basis with new district map.

Task Order October-December Activity Sheets

* Continue to support and enhance USG reporting on HIV/AIDS interventions using available data and GIS; obtain updated non-USG program data and provide requested shapefiles and data.

* Run a workshop for the PEPFAR maps and GIS data viewer.

Progress:
Inglis visited Tanzania and meet with the USG team. Inglis worked with the USG to resolve issues that have been affecting the production of conclusive maps and a stand alone CD GIS data viewer. He also met with members of the PMTCT, VCT, and ART Technical Working groups and was able to get cooperation to resolve issues that have been preventing the generation of conclusive maps of each technical areas. During the trip, Inglis was provided with the de-duplicated data for the APR 07 outside the the TaPRS, Inglis has relinked that to the GIS database and has set that to be able to map this data for a VIP visit to the US Mission in the February 2008.

Year 1 Quarter January, February, March

Plans:
* Prepare maps requested by the USAID/Tanzania Mission for their VIP visit, including ART maps showing who, what, and where over time for adults and children.

* Prepare a map showing total adults currently on ART.

* Prepare 3 PMTCT maps showing an animation of who, what, and where over time, and the total number of pregnant woman receiving CTR and ART.

* Prepare a map showing the animation of who, what, and where over time of clinics and PITC.

* Prepare a map showing the total number of people CTR, showing male/female split in a circle and using hollow circles around a site to designate the mobile VCT coverage.

* Prepare GIS data to be able to be linked to a new database structure.

TZ-9TO: Technical Assistance to Tanzania: Partner Capacity Building

Lead: Dawne Walker (Macro International Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to build the M&E capacity of the USG HIV/AIDS implementing partners and to provide technical support to their SI activities.

Description:
Under the MEASURE Evaluation TO, TA will be provided to support the SI activities of USG partners to effectively monitor and evaluate the progress of PEPFAR in support of the national response to HIV/AIDS. MEASURE Evaluation TO staff will work towards strengthening the M&E systems and capacity of USG partners and subgrantees through TA on data collection, data quality, analysis, and use to meet PEPFAR reporting requirements. Capacity Building activities will include periodic partner meetings, targeted mini-trainings, and one-on-one mentoring.

Tasks:
1. Support the M&E system strengthening efforts for USAID partners.
2. Conduct four IP M&E Working Group meetings.
3. Provide one-on-one mentoring and TA to partners.
4. Provide targeted mini-trainings to partners in various topics including data use, data quality, and data analysis.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Develop a Capacity Building Plan for FY08.

* Hold one IP M&E Working Group meeting.

* Provide M&E TA and mentoring to IPs.

Progress:
Activities were put on hold as the USAID/Tanzania Mission was restructuring the activities under MEASURE Evaluation TO.

Year 1 Quarter January, February, March

Plans:
* Provide support to planning the DQAs that will take place during the April-June quarter.

* Conduct initial planning for the 3 data quality workshops to take place during the April-June quarter.

TZ-12TO: Technical Assistance to Tanzania: OVC

Lead: Florence Nyangara (Constella Futures)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to evaluate the effectiveness of the PACT program intervention model (largest OVC program in Tanzania) on benefiting the lives of orphaned and other children made vulnerable by HIV in Tanzania.

Description:
The PACT program evaluation is one of the three programs being studied in Tanzania to find out their effectiveness in terms of program models, components, costs, and outcomes, in improving the well-being of OVC. Specifically, this activity will focus on supporting a local research organization to make necessary preparations and collect data from a group of OVCs receiving services and comparing the different levels of program intensity (low and high doses) of interventions by the PACT program. To achieve this, the PACT evaluation, a PEPFAR-funded program model, will be examined in-depth through two activities: mini-case study and outcomes study.

Tasks:
1. Support a sub-contract with a local research organization in Tanzania to collect the data necessary to evaluate the PACT program.
2. Provide overall technical support and coordination to the targeted evaluation study of the PACT program model and its impact on the lives of OVC.
3. Provide guidance on data collection preparation (mini-case study, sampling frame, logistics, etc).
4. Conduct data collection.
5. Conduct data entry and cleaning.
6. Conduct data analysis and dissemination of the findings.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Coordinate a pre-data collection site visit to develop an OVC sampling frame.

* Conduct data collection preparations including, developing and pre-testing survey tools and finalizing questionnaires and other necessary documents for field work.

* Supervise the data collection including the management of fieldwork coordinators, data collectors, and supervisors.

* Provide guidelines on data entry and data cleaning.

Task Order October-December Activity Sheets

Progress:
The sub-contracting process to the local Tanzania research organization (AXIOS) has not yet been completed. As a result, no activity occurred during the quarter except managing the process.

Year 1 Quarter January, February, March

Plans:
* Coordinate a pre-data collection site visit to develop an OVC sampling frame.

* Conduct data collection preparations, including developing and pre-testing survey tools and finalizing questionnaires and other necessary documents for field work.

* Supervise the data collection including the management of fieldwork coordinators, data collectors, and supervisors.

* Provide guidelines on data entry and data cleaning.

VN-4TO: Technical Assistance to Vietnam: Avian Influenza

Lead: Denise Johnson (Macro International Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Avian Influenza (AI))

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
This activity will focus on providing TA to the Government of Vietnam (GoV) through the Partnership for Avian and Human Influenza (PAHI), formed by GoV, UN agencies, international donors and NGOs to coordinate and monitor the national response and international assistance on avian and human influenza (AHI), to develop a country-level M&E strategy for its AI program.

Description:
The MEASURE Evaluation TO will provide a consultant who will present the regional AI guidance to members of PAHI, key officials in the GoV, and their implementing partners. Following the initial presentation, and after having read reference materials provided by PAHI and RDM/A, the consultant will work closely with PAHI Secretariat and GoV focal points (representing both the animal and human health sectors) to develop a M&E framework and strategy tailored to the Vietnamese AI program. This strategy will include a conceptual framework, indicators, data collection methods, and suggested reporting schedules for the overall AI program in Vietnam. Briefly, MEASURE Evaluation TO will facilitate and document inputs from participatory discussions and consultations with the GoV, PAHI and related stakeholders, including through sectoral workshops and follow-up discussions and other related meetings, prepare a draft M&E framework based on the inputs, present the draft for feedback and revise it for the final submission. If funds are still available, the MEASURE Evaluation TO staff will train GoV staff on the implementation of the strategy.

Tasks:
1. Present the AI M&E Guide to PAHI and Government of Vietnam.
2. Participate in the development of the M&E strategy for Vietnam.
3. Train GOV staff and local partners on M&E for AI.

Year 1 Quarter October, November, December

Plans:
* Travel to Vietnam to make presentation on the AI M&E Guide.

Progress:
The presentation on the AI M&E guide was postponed due to scheduling conflicts on the part of PAHI staff.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Travel to Vietnam for the presentation on the AI M&E Guide.

* Coordinate with PAHI to identify roles and responsibilities in the development of a country M&E strategy for Avian Influenza and Pandemic Preparedness.

WAF-4TO: Workshop on M&E of HIV/AIDS (Francophone) 2008

Lead: Renee Fiorentino (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to increase individual and institutional capacity for M&E of HIV/AIDS programs.

Description:
This activity includes working with CESAG, a regional training institution in Dakar, Senegal, to adapt and implement a two-week training workshop in French on M&E of HIV/AIDS programs for mid-level professionals in the Francophone Africa region. The workshop will be preceded by a training of trainers. The workshop will combine theory, state-of-the-art, and practical exercises in monitoring and evaluation. The key workshop objectives are: to enhance knowledge and skills in the development and implementation of M&E plans for HIV/AIDS programs at the national and sub-national level; to increase knowledge and skills in the analysis and interpretation of data related to the HIV/AIDS epidemic; and to improve reporting and dissemination skills. The course includes a wide range of topics such as general M&E skills (frameworks, indicators, performance monitoring plans), monitoring specific components of HIV/AIDS programs, evaluation of programs, and dissemination of M&E findings.

Tasks:
1. Plan content, location, instructors, budget, logistics, and timeline.
2. Negotiate agreement with collaborating institution.
3. Adapt and translate existing M&E HIV/AIDS curricula as necessary.
4. Conduct workshop with partner institution.
5. Prepare workshop activity report.

Year 1 Quarter October, November, December

Plans:
* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Work with CESAG to plan the content, location, instructors, budget, logistics, and timeline for the training tentatively scheduled for February 4-15, 2008 (Training of Trainers to take place directly before, on January 31-February 1, 2008).

* Negotiate an agreement with CESAG formalizing the collaboration.

* Update the existing M&E HIV/AIDS curricula and translated as necessary.

Task Order October-December Activity Sheets

Progress:
During the past quarter, MEASURE Evaluation TO worked with CESAG to plan the content, location, instructors, budget, logistics, and timeline for the February 4-15, 2008 training (Training of Trainers to take place directly before, on January 31-February 1, 2008).

The project also worked with CESAG to select scholarship recipients and began updating the existing M&E HIV/AIDS curricula as necessary.

Year 1 Quarter January, February, March

Plans:
*Co-facilitate workshop with CESAG.

* Draft workshop activity report.

WAF-8TO: West Africa CB Working Group

Lead: Renee Fiorentino (John Snow, Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The primary purpose of the activity is the continued capacity development of CESAG as a center of excellence in monitoring and evaluation for Francophone Africa. A secondary purpose is the coordination of capacity building activities across actors in the region.

Description:
MEASURE Evaluation TO will continue to support CESAG in its role as an emerging center of excellence for monitoring and evaluation in Francophone Africa as members of the editorial board and facilitators at the November 2007 IMEA training for non-M&E specialists, at the UNAIDS/TSF/WCA refresher training of M&E expert consultants, and as co-chairing members of the interagency WCA CB TWG.

Tasks:
1. Participate in IMEA's editorial board for the M&E component of their November 2007 HIV course for non-M&E experts.
2. Attend (as guest observers, with CESAG) the four days of the IMEA HIV course during which the M&E component will be covered.
3. Co-facilitate the UNAIDS/TSF/WCA refresher training of M&E expert consultants.
4. Co-chair the interagency WCA CB TWG.

Year 1 Quarter October, November, December

Plans:
* Participate as a member of IMEA's editorial board for the M&E component of their November 2007 HIV course for non-M&E experts. This will include attendance (by both MEASURE Evaluation TO and CESAG) in the 4 days of the HIV course during which the M&E component will be covered, to serve as guest observers.

* Co-facilitate the UNAIDS/TSF/WCA refresher training of M&E expert consultants, to take place in Dakar directly before the IMEA training (Nov 2007).

* Continue to participate in (and co-chair with UNAIDS) the interagency WCA CB TWG, which will be especially involved in planning for these two trainings this quarter.

Progress:
During the past quarter, MEASURE Evaluation TO participated as a member of IMEA's editorial board for the M&E component curriculum of their November, 2007 HIV course for non-M&E experts. The project also co-facilitated (along with CESAG and UNAIDS) the M&E component of the HIV course and the UNAIDS/TSF/WCA refresher training of

M&E expert consultants and UNAIDS reps, which took place in Dakar directly before the IMEA training (November, 2007), including a supplemental day for TSF consultants.

Fiorentino participated in an evening session of UNAIDS' annual MERG meeting in Geneva, Switzerland in December, 2007, during which the work of the WCA TWG's work was presented and discussed.

Year 1 Quarter January, February, March

Plans:

* Continue to co-chair the WCA TWG CB, including assisting in the development of a ToT training course concept paper to extend the use of the non M&E module.

* Coordinate participation from WCA TWG CB members at the CESAG M&E of HIV/AIDS programs course in February 2008.

WAF-9TO: Workshop on RHIS (Francophone)

Lead: Mounkaila Abdou Billo (John Snow, Inc.)

Technical Advisor: Lisa Maniscalco (Elements: Bureau Wide Priority)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objective of this activity is to build the institutional capacity of CESAG to carry out the Routine Health Information System (RHIS) workshop, developed under Phase II of the MEASURE Evaluation Project, in French.

Description:
The proposed RHIS short course stemmed from a shared interest of both MEASURE Evaluation and CESAG. The level of effort for this activity will be limited to translating course material from English to French, a training of trainers, and transport and personnel time for two MEASURE Evaluation TO Staff. RHIS is the backbone of the health systems and essential for M&E of health programs. In addition, the RHIS workshop is in great demand in Francophone Africa, and was identified by CESAG one of the priority workshops in their capacity building plan developed in 2006. Capacity in RHIS training represents a good asset for CESAG, as it's moving towards becoming a reference center for M&E and creating more opportunities for TA and evaluation research.

Tasks:
1. Organize an announcement or communication campaign.
2. Translate the course material in French.
3. Conduct planning for the workshop including content, instructors, budget, logistics, and timeline.
4. Organize and carry out a training of trainers workshop.
5. Conduct the workshop and provide administrative and training support as needed.
6. Prepare the workshop Activity Report.
7. Design and implement a follow-up system of the participants.

Year 1 Quarter October, November, December

Plans:
* Organize the announcement/communication campaign.

* Conduct planning for the workshop including content, instructors, budget, logistics, and timeline.

Progress:
The announcement/communication campaign was deferred to the next quarter. Two meetings were held with CESAG, on November 3 and December 13, 2007, to discuss the activities pertaining to the Francophone RHIS course. As result, Mr Jerome Bassene was nominated focal person of the workshop, and a workplan was agreed upon.

Task Order October-December Activity Sheets

Year 1 Quarter January, February, March

Plans:

* Finalize the workshop announcement pamphlets by the end of January, 2007.

* Organize a course content review workshop from March 3 - 7, 2008 in Washington.

* Conduct planning for the workshop including content, instructors, budget, logistics, and timeline.

ZM-1TO: Technical Assistance to Zambia: SBS

Lead: Bates Buckner (University of North Carolina at Chapel Hill)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
The objectives of this activity are: (1) Provide TA to the Central Statistics Office (CSO), Government of Zambia, in preparation for the next round of the Zambia Sexual Behaviour Survey/AIDS Indicator Survey (ZSBS/AIS), including preparation of questionnaires, tabulation plan, sampling plan, and field implementation and data use plan; (2) Build capacity among stakeholders in Zambia (e.g., NAC, MOH, CAs, CSO) to use data from the existing (1998-2005) and future ZSBS/AIS surveys for monitoring and evaluation, and for HIV/AIDS policy analysis, advocacy and public education; (3) Strengthen capacity of staff at the CSO through activities that will enable CSO staff to assume a larger role in analysis and report-writing for the bi-annual ZSBS/AIS surveys, continuing a steady and systematic progress towards CSO assuming full responsibility for future ZSBS/AIS surveys, and resolve planning, supervision, and field implementation issues that constitute lessons learned from past surveys with the aim of achieving an improved response rate and more effective management of data quality in the field and during data entry.

Description:
This work builds on a long-standing (10 year) collaboration between the CSO, Government of Zambia, and Phase II of the MEASURE Evaluation Project, centering on the Zambia Sexual Behavior / AIDS Indicator Surveys. The two institutions worked together on the first ZSBS/AIS in 1998, and on all subsequent rounds of the ZSBS/AIS surveys. Activities under the MEASURE Evaluation TO will continue and expand institutional capacity building at CSO, in conjunction with collaboration and technical assistance on survey design, as well as preparation and implementation of fieldwork. In addition, new capacity building activities will address CSO and a broader group of stakeholders, e.g., NAC, MOH, NGOs, and USAID CAs. These activities focus on increasing the local accessibility of ZSBS/AIS data, and promoting the use of this rich data source for purposes of policy analysis, program M&E, advocacy, and education of the public.

Tasks:
1. Organize and conduct a policy analysis and data use workshop for multiple stakeholders.
2. Provide TA to the CSO in preparation for the 2009 ZSBS.
3. Organize and conduct a survey planning workshop with CSO.

Task Order October-December Activity Sheets

Year 1 Quarter October, November, December

Plans:

* This activity transitioned from MEASURE Evaluation Phase II on October 1, 2007.

* Prepare for a policy analysis and data use workshop involving multiple stakeholder groups, tentatively scheduled for late January-early February 2008.

* Prepare the data set for use at the workshop.

* Collaborate with USAID/Zambia and CSO to develop a stakeholder participant list and potential venues.

* Collaborate with USAID/Zambia and CSO to develop an agenda and teaching materials for the workshop.

Progress:

Work on a standard recode data set for the ZSBS survey years 2000, 2003, and 2006 is underway.

Delays in Zambia with completion of the 2007 ZDHS report made it impossible to adhere to plans for a policy analysis workshop in late January - early February, 2008. A new schedule is being negotiated with host country collaborators.

Year 1 Quarter January, February, March

Plans:

* Travel to Zambia in January to initiate plans for two workshops.

* Revise the original schedule in consultation with host country collaborators, primarily CSO, due to delays in Zambia in completing the ZDHS report.

* Conduct at least one, and possibly both, of the two workshops originally planned for this quarter.

* Schedule the Policy Analysis workshop for March, 2008 prior to the January Zambia visit.

* Schedule the survey planning workshop, taking into account likely dates for ZSBS 2008 fieldwork once the ZDHS is completed.

ZM-4TO: Technical Assistance to Zambia: DHS

Lead: Adrienne Cox (Macro International Inc.)

Technical Advisor: John Novak (Elements: HIV/AIDS)

Year 1 Workplan Scope of Work (08/03/2007 - 02/02/2009)

Objective:
This activity has two objectives. The first is to provide TA to the 2007 DHS for data collection, laboratory processing of DBS specimens, data processing and tabulation, report preparation, and dissemination. The second objective is to assist in capacity building by conducting a workshop with local researchers to enhance their skills in data manipulation and analysis, using the ZDHS data set. The workshop will focus on helping local researchers manipulate the recoded dataset, using STATA or SPSS, merge files, produce new tables, and perform bivariate analyses.

Description:
In addition to the 2007 Zambia Demographic Health Survey (ZDHS), Zambia has conducted three DHS survey in the past: 1992, 1996 and the 2001/2002. The CSO is the implementing agency and is collaborating with the MOH, the University of Zambia (UNZA), and the Tropical Disease Research Centre (TDRC) on the 2007 ZDHS activities. The 2007 ZDHS is in the final stages of data collection. The 2007 ZDHS survey will provide a wealth of demographic and health information that is linked to HIV prevalence data. The 2007 ZDHS data, in conjunction with the 2005 Zambia Service Provision Assessment (ZSPA) findings, and other country-specific data, can be used to guide national and provincial level evidence-based planning, monitoring and evaluation, and advocacy efforts. To increase access to and use of these data, MEASURE Evaluation TO in collaboration with CSO will carry out a range of activities designed to ensure the quality of the ZDHS results and their widespread dissemination. Major activities will include: (1) completion of survey data collection; (2) laboratory processing of HIV specimens including the purchase of test kits; (3) completion of data processing, tabulation, and preparation of recode file; (4) preparation and publication of the Preliminary and Final Reports on the ZDHS survey; (5) a national seminar on the Final Report in Lusaka; (6) a data user's workshop; and (7) further dissemination activities including the production of two factsheets and conducting a workshop focusing on a host country priority (e.g., provincial results or GIS).

Tasks:
1. Provide technical assistance to CSO for ZDHS.
2. Disseminate 2007 ZDHS Results.
3. Conduct data users workshop.

Year 1 Quarter October, November, December

Plans:
* Provide TA to CSO for ZDHS for data collection, laboratory processing of the DBS specimens, data processing and tabulation, and report preparation.

Task Order October-December Activity Sheets

* Disseminate the 2007 ZDHS Results through a national seminar and a provincial-focused or GIS seminar at a central location.

* Conduct a data users workshop.

Progress:
TA was provided to the Zambia Central Statistical Office (CSO) and the Tropical Disease and Research Centre (TDRC) for the 2007 Zambia DHS. Fieldwork ended in late October 2007. The Macro Data Processing team provided TA in December to the CSO for questionnaire data file cleaning and preparations of tables for the preliminary and final reports. The TDRC laboratory scientists were trained on the HIV test-tracking software.

Year 1 Quarter January, February, March

Plans:
* Continue to provide TA for drafting the preliminary and final reports.

* Publish the 2007 ZDHS preliminary report in March.

* Conduct a report-writing workshop in March in Lusaka to draft the chapters of the final report (tentative).

* Continue TA to TDRC throughout the HIV testing process.

Europe and Eurasia Regional Family Planning Activity

USAID FROM THE AMERICAN PEOPLE

JSI John Snow, Inc.

Six-Month Progress Report

July 2007 – December 2007

The Europe and Eurasia Regional Family Planning Activity

ACRONYMS

CAR	**Central Asian Republics**
CS	**Contraceptive Security**
DFID	**Department for International Development (UK Government)**
EU	**European Union**
FP	**Family Planning**
GAVI	**Global Alliance for Vaccines and Immunizations**
HWG	**Healthy Women in Georgia Project**
IPH	**Institute for Public Health**
JHPIEGO	**Johns Hopkins University International Health Organization Arm**
M&E	**Monitoring and Evaluation**
MOH	**Ministry of Health**
MoLHSA	**Ministry of Labor, Health and Social Affairs**
PAC	**Post-Abortion Care**
PHC	**Primary Health Care**
PP	**Post-Partum**
RA	**Regional Activity**
RFHI	**Romanian Family Health Initiative**
RH	**Reproductive Health**
SS	**Supportive Supervision**
TA	**Technical Assistance**
TOT	**Training of Trainers**
UNICEF	**United Nations Children's Fund**
USAID	**United States Agency for International Development**
WHO	**World Health Organization**

SUMMARY

This report details the USAID-funded Europe and Eurasia Regional Family Planning Activity's (Regional Activity) work and achievements in the last six months of the Project's First Year. The Regional Activity is a regional effort to strengthen the family planning (FP) environment in Eastern Europe and Eurasia. The goal is to replicate, accelerate, and expand FP throughout the region based on the successes, innovative approaches and lessons learned from current and past regional projects and recent state-of-the-art advancements in family planning programming.

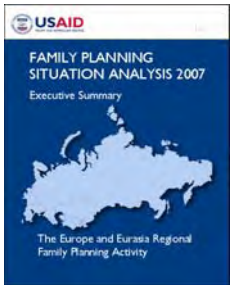
With support and assistance from the USAID/Washington E&E Regional Bureau Health Team, the Regional Activity undertook a number of successful activities, and this year the Activity has truly become a "learning partnership." With the addition of new funding and the expansion of family planning activities in the countries, the Activity has grown in size and scope and has produced an exciting array of new initiatives and activities.

The Regional Activity remains grateful to USAID/Washington E&E Regional Bureau Health Team for its flexibility and support. In sum, notwithstanding challenges, the Regional Activity has continued its activities and made good progress this year.

Activities and Events: Key Highlights

- "Best Practices in Family Planning in the Europe and Eurasia region" regional workshop in Bucharest, Romania conducted
- Desk Reviews finalized and disseminated
- Regional Training Curriculum, job aides and tools on Supportive Supervision developed for training in Georgia
- Contraceptive Security Activities in Albania developed and initiated
- "Do you know your family planning choices?" wall chart translated (into Russian), printed and distributed

One of the Project's key foci over this period was the production and finalization of desk reviews for five countries in the region: Albania, Azerbaijan, Georgia, Kyrgyzstan and Tajikistan. The main impetus for these reports was to have an overview of the state of family planning practices in these countries, based on past and present factors that have shaped its presence and to provide recommendation for addressing the gaps. The desk reviews will be instrumental in helping to have a better working library of knowledge on family planning as well as to help guide future planning and programming for FP/RH activities in the region.



II. **REGIONAL INITIATIVES**

"Best Practices in Family Planning in the Europe and Eurasia Region" Regional Workshop

In September, the Regional Activity conducted a four-day regional family planning workshop, entitled "Best Practices in Family Planning in the Europe and Eurasia Region," which took place in Bucharest, Romania. The purpose of the meeting was to bring together key FP/RH stakeholders from the EE region interested in strengthening and promoting their family planning programs and activities and to discuss best practices, successful strategies, approaches and challenges.

The workshop had been held in conjunction with the end of the very successful Romanian Family Health Initiative (RFHI) Project that assisted the Ministry of Public Health in Romania to develop and implement a national FP program. Participants attended the RFHI End-of-Project conference where Romanian policy-makers, family doctors, district public health authorities, health practitioners and other key stakeholders shared the results and challenges of their programs.

This regional workshop also served as a kick-off for orienting participants to the goals and objectives of the Regional Activity and its potential contributions to country and regional programs.

Forty participants, from the Ministries of Health, National RH Councils, NGOs, USAID Health Officers, and other family planning/reproductive health policy makers from nine countries in the region participated in the regional workshop. County teams gave brief presentations on the current FP situation in their countries sharing the best practices, challenges and future perspectives of FP in their countries with workshop participants.

Dr. Gunta Lazdane, Regional Adviser from the WHO/EURO gave a presentation on the latest developments and trends in family planning in the EE region. Special plenary sessions with participation of PSP-One were held on Contraceptive Security (CS) that addressed both the public and private sectors, including a broader total market approach, innovative mechanisms and approaches for encouraging private sector involvement/commitment in reaching national contraceptive security goals.

Participants had an opportunity to visit fields which they chose based on their interests and country needs. The field visits included:

- Observation of a comprehensive local FP program and the safety net implementation at the district level, with all the elements of a well-functioning FP system – the District Public Health Authority, the FP center in an urban area , the hospital, including PAC and PP immediate FP service provision, and the family doctor clinic in the rural areas.

- Hands-on workshop for the National LMIS and GIS at the agency's headquarters for collecting FP service data.

Regional Workshop Attendees

- Roundtable policy meeting with the Ministry of Public Health and other key stakeholders and professionals involved in the introduction of key legislation and regulatory framework for the National Romanian FP Program.

On the last day of the workshop, participants worked within their country teams to identify those best practices which they thought were of high priority for implementing or strengthening in their respective countries. They also identified challenges and barriers that needed to be addressed, and determined which next steps and resources would be needed in order to implement high-priority best practices. Interestingly, the most common best practice identified by the country teams was the need for "up-to date policies, regulations, guidelines and standards". As the Armenia country team expressed : "… this is like the Bible for any activity. When you have standards in place, you have [the] framework for how you should proceed and what to look for…"

The meeting was very successful. The consensus was that these types of meetings are extremely helpful in sharing innovative approaches and lessons learned. This is what makes the difference and helps to scale-up and adapt best practices. As one workshop participant said, "Knowledge and experience from the region is what will be the key in making changes in our countries."

Integrating and Strengthening FP into Pre-Service Medical Education

The JSI *Family Planning Situation* analyses (desk reviews) in several E&E countries (Georgia, Azerbaijan, Kyrgyzstan, Tajikistan and Albania) highlighted common trends in undergraduate and postgraduate medical education: inadequate pre- and in-service training with continuing medical education in evidence-based, WHO-approved practices in FP service provision.

During the last couple of months, USAID/W and the Regional Activity have had extensive discussions with the Missions in the region about enhancing pre-service education in FP, including: WHO FP standards and guidelines, counseling and communication techniques in pre-service training for health care professionals. Although the process of revising pre-service training requires patient consensus-building at various levels, it is one of the single most important means of ensuring the sustainability of health practice reforms, to the extent in which it can be accomplished.

We have developed a concept paper detailing the importance of the pre-service education in sustaining gains in family planning service delivery, human resource capacity and describing initial steps in integrating evidence-based FP and counseling into pre-service training curricula for doctors and nurses. The concept paper was sent to the Missions in the region to get an idea as to how much interest is out in the region among the Missions, implementing partners and other key local stakeholders. The response from the Missions has been extremely positive. The initiative has been met with great enthusiasm and several Missions support the development and piloting of the strengthening FP pre-service education in medical and nursing schools in their countries.

The Regional Activity has developed a preliminary set of criteria for selecting the participating countries and, during the next quarter, will continue its discussions with USAID Missions, key country stakeholders and other partners in the region to finalize the plans for this work and in-country preparatory activities.

III. **COUNTRY ACTIVITIES**

The second half of the Year One activities focused heavily on research and strategizing for work within the region. The Regional Activity focused, specifically, on work in Albania, Georgia and in the Central Asian Republics (CAR) – Kyrgyzstan and Tajikistan. The focus going into Year Two is to take the knowledge gained from these efforts in Year One and apply it to functional, in-country work, as outlined in Section V. The activities taking place in each of the focus countries are detailed below.

ALBANIA

As part of the goal of strengthening CS in Albania, USAID/Albania committed funds to the Regional Activity. The challenge facing the Ministry of Health and health authorities in Albania is to ensure that contraceptive procurements are done in a timely manner and based on accurate forecasts to avoid a repeat of the stock outs of recent years. Because contraceptive forecasts require regular updating, the MOH needs its own internal forecasting capacity; according to a recent contraceptive security needs assessment conducted by the Regional Activity, this is an area they lack. Therefore, one of the main objectives of the Regional Activity is to develop the capacity of the MOH to conduct forecasting and, in general, mobilization of the MOH for contraceptive security.

In December 2007, the Regional Activity team - Dr. Nino Berdzuli and Dr. Laurie Cappa - carried out a preliminary assessment and needs quantification for contraceptive security work in Albania. The needs assessment visit coincided with the JHPIEGO Access-FP team visit in planning their work for upgrading and expanding standardized postpartum/post-abortion FP counseling and services**.** The findings from the visit and the related needs were discussed with USAID/Albania and a plan on strategic next steps to improve contraceptive security in Albania was developed in consultation with USAID/Albania and the MOH.

The Regional Activity's technical work plan includes direct assistance to the Ministry of Health of Albania in the following technical areas:

- *resource mobilization for contraceptive security* to develop long-term strategies for effective forecasting, procurement, distribution, and the financing of contraceptives
- *human capacity improvement* to foster the knowledge, skills, attitudes, and practices necessary to operate logistics systems and conduct effective forecasting
- *logistics system improvement* aiming to upgrade the procedural components necessary to ensure the availability of contraceptives at service delivery points.

GEORGIA

The RA provided several recommendations for improving the family planning policy environment and the supportive supervision (SS) system at the primary health care (PHC) level in Georgia. Based on these recommendations, USAID/Georgia provided the Regional Activity with funding to provide TA to the USAID-funded HWG program to establish effective SS system for FP service providers at the PHC level. The RA will provide TA and support to the HWG in all steps of development, implementation, monitoring and fine-tuning of the SS system in Georgia. Within the framework of ongoing health reforms, the SS initiative will target priority regions as well as collaborate with the senior staff at the Ministry of Labor,

Health and Social Affairs (MoLHSA) and other major donors' (EU, GAVI/UNICEF, DFID) sponsored projects to lead into an evolving national SS system for a primary health care program.

The framework and tools of the SS system developed for Georgia will also serve as a model for replication in other countries in the region as appropriate.

Within this scope, the Regional Activity, in collaboration with the HWG project, conducted a consultation meeting with key stakeholders from the MoLHSA, donors, NGOs, leading health professionals and regional health leaders, discussed SS work and prepared strategic plans for testing and monitoring the system.

One of the main key activities within this scope has been the development of an evidence-based curriculum for the training of trainers, job aides and tools for supportive supervision. The testing of a newly developed SS training curricula and the first TOT training will be conducted by the Regional Activity from February 11-16, 2008.

CENTRAL ASIA

The Regional Activity was awarded designated funds for Year Two for specific regional work in the following countries: Kyrgyzstan and Tajikistan. The activities are proceeding well and we are looking forward to the upcoming Contraceptive Technology Update conference in Bishkek, Kyrgyzstan and Dushanbe, Tajikistan in May of this year. Health care professionals and key health stakeholders will be invited to attend a three-day workshop designed to update the regional medical community on the latest advances in contraceptive technology. In terms of Tajikistan, there was a delay in getting the process started due to a change of personnel at the local USAID Mission. This is, however, no longer an issue and we are now discussing plans for the upcoming months.

IV. MONITORING AND EVALUATION (M&E)

Monitoring and Evaluation (M&E) are key components to the continued success of the Regional Activity. M&E are fully integrated into all aspects of the Activity and not seen as stand-alone activities. The purpose of the M&E activities is to keep track of the progress of the project in achieving its goals and to assist with the overall project management.

The Regional Activity has developed a Monitoring and Evaluation (M&E) Plan that follows the U.S. Agency for International Development (USAID) guidance on Performance Monitoring Plans[1] and JSI's own Basic Management Package which was developed to assure quality to JSI's clients. The Plan details the Activity's approach to M&E, data sources, data collection methods, and indicators of performance and effectiveness. Through performance M&E, the Regional Activity measures, analyzes, interprets and reports on activities and outcomes to ensure effective program implementation and achievement of results.

Activity *performance indicators* measure the direct outputs of one or more activities, and are designed primarily to inform management decisions and ensure that activities are on track. We use specific indicators for each Activity component. *Effectiveness indicators* measure the direct effects that should stem from

[1] Pricewaterhouse Coopers (2001). *The Performance Monitoring Toolkit for USAID*, under the Integrated Managing for Results Contract.

completion of program tasks, and are indicators of the desired results for the Activity. "Number of best practices identified, analyzed, documented" is an example of one *effectiveness indicator*. These indicators are available from program records as the activities whose progress they measure are completed.

An internal monitoring system has been put in place that enables stakeholders to track inputs, processes, and outputs for each activity. This system is centered on the detailed work plan (for both the region and the individual countries) and can be modified as necessary over the course of the Activity. It is based on a user-friendly monitoring database for the generation of reports on a quarterly basis, as well as corresponding forms and administrative procedures. For each country in which the Activity is working, a separate set of indicators has been developed in concert with the individual country work plans. Since the activities in the individual countries have only recently gotten underway, we do not have anything to report on these indicators at present. Progress on these indicators will be included in subsequent bi-annual reports.

V. ANTICIPATED ACTIVITIES

The Regional Activity anticipates that the next six months of the Project's Year Two will be very full of activity. It will closely follow its current and approved country work plans, formulate and begin activities (in consultation with USAID/W and Missions) on FP pre-service education with current regional and expected supplemental funding. The Regional Activity will develop a calendar system that will help staff, partners and USAID track multiple simultaneous activities. Some of the major events planned by the Regional Activity both in the region and in individual countries are provided below.

- Finalization of a joint JSI and PSP-One paper on public/private best practices in family planning in the region
- Testing of Supportive Supervision Training Curriculum, job aides and tools and TOT training in Batumi, Georgia (February 11-16, 2008)
- Technical Assistance in rolling out of SS system in Georgia
- Roundtable policy meeting with the Albanian MOH, the Institute of Public Health, key stakeholders in the public and private sectors on CS, in particular with regard to trends affecting contraceptive needs in 2008 (February 12, 2008)
- Training of Albanian MOH, IPH and National Contraceptive Security Working Group members in contraceptive forecasting and trend analyses (March 2008)
- Regional contraceptive technology update workshop in Bishkek, Kyrgyzstan and Dushanbe, Tajikistan (May 2008)
- Selection of pilot countries for strengthening FP pre-service medical education and preparation for the pre-service regional consultation workshop
- Developing communications materials for the Regional Project – an undertaking that will work towards the advocacy for family planning best practices

VI. FINANCIAL SNAPSHOT

This report summarizes the project's financial situation for the end of Year One. The situation is that add-ons to the RA's contract have complicated financial reporting by making the pipeline look bigger than it actually is.[2]

In its first year of operation, spending in the Regional Activity was low due to a late program start. The funding for Year One was lower than originally projected as a lot of time was needed in Year One to get activities going and to develop materials. Consequently, much time was spent in Washington researching and developing the materials for the project's long-term goals. However, spending increased significantly in the second half of Year One; activities were also able to "catch up". By the end of Year One, the Regional Activity had spent approximately $370,000, or around 90%, of its projected budget for Year One. This gives the project about 9 months to go with the current monthly burn rate of approximately $57,250.

VII. PROBLEMS ENCOUNTERED

Over Year One, the project was faced with several obstacles. One of the challenges was the resignation of our regional FP/RH advisor. Our resident senior advisor was also beset with an illness which has kept her off of the project for the past several months. To counteract these challenges, we are currently in the process – through active discussions with USAID/W – of hiring a new FP/RH Advisor to help assist the Project Director in her technical work. This is a primary goal over the short-tem for the first calendar months of 2008 and is pending USAID/W approval.

Another challenge that the Regional Project was faced with over Year One had to do with the restrictions with our ceiling limitation. We have addressed this issue in the past, as it as been a hurdle in getting various regional and country-specific projects going. Consequently, we were forced to turn down a sizable buy-in from the USAID/Albania Mission due to a ceiling issue. Our hope is that as this project progresses that we will be able to have this ceiling lifted substantially so that we are able to broaden our scope of work and accept projects solicited to us.

[2] Our first modification gives the impression that we have been obligated beyond our ceiling limit. We have spoken to USAID/W about this, though, and they are working hard on resolving this.

Russia

Maternal and Child Health Initiative

TASC Russia
Maternal and Child Health Initiative
(MCHI)

FINAL TECHNICAL REPORT

March 2007

Laurel A. Cappa MD MPH
Natalia Vartapetova MD PhD

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Many hands and many voices contributed to this document. Certainly, special thanks is due to every speaker, panelist, trainer and participant at the Final Dissemination Conference "Improving Quality of Medical Care of Women and Infants: The MCHI Experience" held in Moscow in May 2006. The presentations, the discussions, and the obvious enthusiasm of all made the achievements enabled by the WIN/MCHI interventions really come alive.

Most definitely, special thanks are also due USAID/Russia for its consistent vision, commitment and support for the MCHI interventions, and especially to Betsy Brown, Larissa Petrosian, and Elena Gurvich for their many extra efforts.

In addition to sincere thanks, a round of applause is also due the MCHI staff for the determination, skill, and dedication with which they implemented this project and to encourage them and wish them all the best as they move forward as the Institute for Family Health.

Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
ARO	Assistance to Russian Orphans
CA	Cooperating Agency
CDC	Centers for Disease Control and Prevention
COP	Chief of Party
CTO	Cognizant Technical Officer
EE/EA	Eastern Europe and Eurasia
EII	Early Intervention Institute
FCMC	family-centered maternity care
FCT	Facility Coordinating Team
FORF	Future of Russia Foundation
GDA	Global Development Alliance
GORF	Government of the Russian Federation
G-R	Gideon-Richter
HIV	human immunodeficiency virus
HR 2020	Healthy Russia 2020
IDU	injection drug user
IEC	information, education and communication
IFH	Institute for Family Health
IR	Intermediate Result
IUD	intrauterine device
IWR	Interregional Working Group
JSI	John Snow, Incorporated
M&E	monitoring and evaluation
MCH	maternal and child health
MCHI	Maternal and Child Health Initiative
MOH	Ministry of Health
MOHSD	Ministry of Health and Social Development
MOU	Memorandum of Understanding
MTCT	mother-to-child transmission
NGO	non-governmental organization
ob-gyn	obstetrician-gynecologist
PHC	primary health care
PMTCT	prevention of mother-to-child transmission of HIV
QAP	Quality Assurance Project
RC	Regional Coordinator
RCT	Regional Coordinating Team
RFE	Russian Far East
RSOG	Russian Society of Obstetricians/ Gynecologists
SO	Strategic Objective
SOW	Scope of Work
STI	sexually transmitted infection
TASC	Maternal and Child Health Technical Assistance and Support Contract
TO	Task Order

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC	University Research Corporation
US	United States
USAID	United States Agency for International Development
USG	United States Government
VCT	voluntary counseling and testing
VRF	Vishnevskaya-Rostropovich Foundation
WEI	World Education, Incorporated
WGY	Inter-regional Working Group on Youth Reproductive Health
WHO	World Health Organization
WIN	Women and Infants' Health Project

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I. Executive Summary

In September 2003, the Russian Mission of the United States Agency for International Development (USAID/Russia) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract (TASC I) to implement its three-year Maternal and Child Health Initiative (MCHI). MCHI's stated objective was to ensure the adoption of internationally recognized maternal and child health (MCH) standards and practices by targeted health facilities in Russia.

As is common in most large, complex, multi-component projects, the MCHI Project's statement of work and expected results and tasks evolved over time to reflect an expanded scope of work responsive to changes in external realities and corresponding changes in USAID and MOHSD priorities and emphases. *Appendix A: Evolution of Expected Results and Tasks* outlines these changes in detail as the Project moved from seven **Results** to be implemented via nine **Tasks** to 17 **Results** to be implemented via 30 **Tasks.** For the purposes of this Final Technical Report, the statement of work as defined in modification #7 will be used.

As outlined in modification #7 of the original Contract, the following **Results** were to be achieved by the end of the Project:

- 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 means 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 the Vishnevskaya-Rostropovich Foundation in the Far East.
- Early intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI models.
- 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 healthcare 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 updated 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 perinatal health care program at the Moscow Region Perinatal Center (MRPC) through a subcontract with the Future of Russia Foundation.

These expected results were to be achieved via the implementation of 30 explicit **Tasks** which are listed with their relevant **Results** in Section IV: Status of Expected Results and Tasks**.** *Appendix B: Result Indicators* lists the 55 indicators that were originally specified in MCHI's December 2003 Three-Year Workplan and whose results are given in the main text of this report.

MCHI ultimately worked in 16 regions of the Russian Federation; its innovative design helped regional and municipal government-supported health facilities adopt internationally-recognized, client-centered, evidence-based maternal and child health standards and practices in multiple areas: antenatal care, family-centered maternity care, essential newborn care, exclusive breastfeeding, and family planning counseling and services, especially for postpartum and post-abortion clients. Attention was also given to family planning for HIV+ women and the prevention of mother-to-child transmission of HIV.

MCHI Programmatic Components
- **Antenatal Care**
- **Family Planning/Reproductive Health**
- **Family-Centered Maternity Care**
- **Exclusive Breastfeeding**
- **Newborn Care**
- **Infection Control in Maternities**
- **Neonatal Resuscitation**
- **Youth-Friendly Services**
- **HIV/AIDS Prevention/PMTCT**

USAID's long-range purpose in funding the Maternal and Child Health Initiative has been realized: a strong, credible, indigenous **Russian "legacy" organization** with proven broad-range expertise – the Institute for Family Health – now exists as a registered entity well-positioned to continue the promotion and provision of MCH innovations in Russia by partnering with and implementing programs for both international and Russian donors. IFH has already attracted considerable funding from multiple sources for the next three years, with one implementing partner pledging additional millions of its own in matching funds.

While IFH was being registered, the Russian Federation's Federal Service for Surveillance in Consumer Rights Protection and Human Welfare organized an open national competition to implement their National Health Project in HIV/ AIDS including PMTCT, and MCHI was invited to bid. MCHI partnered with Russia's oldest and largest national medical education

institution, the Sechenov Moscow Medical Academy, to prepare a proposal. In March 2006, the pair was awarded the 20 million rubles (~USD $800,000) grant to improve PMTCT and family planning practices among HIV+ women in 15 regions (a group which did not include any Far East regions) and disseminate the national PMTCT Guidelines developed by MCHI.

Once registered, the Institute for Family Health then submitted two concept proposals to USAID/ Russia requesting GDA funding and an additional proposal for continuing the work of MCHI. All three were awarded to IFH as part of a three-year USD $7.5 million (~187.5 million rubles) cooperative agreement called Maternal and Child Health Initiative II, with the University Research Corporation (URC) as a subcontractor for implementation of the "quality" component. In addition to expanding the work carried out under the original MCHI contract, MCHI II will also extend the work done for the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's National Health Project in HIV/AIDS to two key Far East regions – Irkutsk Oblast and Primorsky Krai. The second of the two GDA-funded components of MCHI II is particularly interesting, as it involves significant matching funds from the local government partner. Omsk Oblast will provide 150 million rubles (~USD $6 million) working with IFH to essentially roll out the MCHI interventions throughout the entire Oblast.

Certainly this is an impressive beginning!

√ *Lesson Learned:* The transformation of MCHI from an external donor-funded project to the Institute for Family Health, a self-sustaining indigenous Russian NGO, is a success story that will hopefully encourage and inspire the legions of committed, hard-working public health professionals in Russia and elsewhere who have dedicated themselves to improving the health and well-being of their fellow citizens.

As implementation strategies, MCHI focused on **process as well as content** and chose strategies that not only stressed evidence-based medicine but that also offered a **total paradigm shift** from focus on the provider to focus on the client, a shift that literally transformed the way in which maternal and infant services were delivered.

The 16 MCHI Regions

1. Perm Oblast (1999 – WIN Region)
2. Novgorod Oblast (1999 – WIN Region)
3. Altai Krai (2003)
4. Irkutsk Oblast (2003)
5. Kaluga Oblast (2003)
6. Komi Republic (2003)
7. Krasnoyarsk Krai (2003)
8. Murmansk Oblast (2003)
9. Omsk Oblast (2003)
10. Orenburg Oblast (2003)
11. Tyumen Oblast (2003)
12. Vologda Oblast (2003)
13. Khabarovsk Krai (2004)
14. Primorsky Krai (2004)
15. Sakhalin Oblast (2005)
16. Sakha Republic (2005)

As a result, the adoption and integration of **internationally-recognized, evidence-based standards** has occurred at a very impressive pace across an impressive range of political and health institutions while actively involving an impressive number of people over an impressive geographic area. As MCHI's scope of work broadened over time geographically and programmatically, the number and type of facilities directly involved in project activities increased significantly. The Project included 101 facilities at its beginning, growing to 198 facilities by its conclusion.

The active involvement of a variety of stakeholders—health officials, policymakers responsible for decision making and resource allocation, and experts and providers from all levels of the health system—was cultivated from the very beginning. This helped establish full ownership for the innovative

changes being introduced and helped motivate many to work towards the expansion and sustainability of the program.

- √ *Lesson Learned:* MCHI basically created a **community of change agents** by defining its stakeholders broadly and keeping them actively involved.

- √ *Lesson Learned:* By identifying and supporting **"catalyst" institutions and individuals**, MCHI helped multi-level leadership implement **bold, rapid, substantive changes**. The amount of change that has occurred and the potential for continued achievement and further expansion within the target regions is great.

Inter-linking components and multi-level focus gave the Project's implementation strategies **strength, breadth, adaptability and flexibility.** By building on the successes of WIN and adapting additional materials from CDC, WHO, UNFPA, UNICEF and other CAs; MCHI was able to promote evidence-based interventions with efficiency. The **capacity building** at the regional level is substantial and has laid the foundation for further replication. The improvements in the Project's Results Indicators seen over a relatively short time interval are both impressive and heartening.

- √ *Lesson Learned:* The MCHI **process—participatory, interactive, kind, respectful**—was as important as the content. Throughout, explicit efforts were made to carry out implementation in a participatory, transparent, low hierarchical manner. In effect, an effort was made to model with the regions the client-centered, mother-friendly, baby-friendly, youth-friendly, family-friendly approach that WIN/MCHI was striving to introduce into Russia's reproductive health services. The training component especially modeled this approach. The participatory and interactive training techniques were widely appreciated, as was the interdisciplinary approach modeled by the composition of the trainers as well as by the mix of participants in the courses. Course participants described the trainers as being kind, respectful, interactive, energetic, highly professional and accessible—welcome compliments given the effort that both WIN and MCHI devoted to developing a strong cadre of all Russian trainers.

- √ *Lesson Learned:* The **evidence-based approach** literally became a credo and supported the health care professionals in their roles as change agents as they introduced and implemented evidence-based practices. At the regional level, this **dual focus** on both process and content was very **empowering** and contributed substantially to the high degree of capacity building that occurred.

> **"Now when someone asks why do you do this, it's no longer because we've always done that. It's because it's evidence-based."**
>
> ***Chief Physician, Municipal Perinatal Center, Orenburg, at MCHI's Final Dissemination Conference***

- √ *Lesson Learned:* The **selection process** (incorporating an element of self-selection that promoted commitment and built in readiness) and criteria worked extremely well and were key contributors to the Project's robustness. The competitive element was **innovative and positive.** The co-financing requirement was also motivating. Requiring letters of support from municipal

and regional authorities and from the regional RSOG branch helped instill a broad sense of ownership from the beginning. The requirement that the **facilities chosen be an inter-related set** of maternities, women's consultation clinics, children's polyclinics, family planning centers, and HIV/AIDS centers helped to **horizontalize** previously vertical institutions and to standardize the content and continuity of care.

- *Needed Next Step:* The regions see a significant need for a **federal *prikaz*** that supports MCHI interventions in order to facilitate and enable the further rolling out and adoption of MCHI practices throughout the regions. Many non-Project sites were eager to adopt Project approaches but were concerned about being in violation of federal mandates without the "protection" of being a designated MCHI facility. For example, authorities are cautious about allowing partnership deliveries because they are in violation of the federal regulations.

The Inter-regional Working Group on Youth Reproductive Health was functional and appeared effective. Although many more than two regions demonstrated a specific interest in youth programming, their functioning programs differed widely, and although MCHI did develop useful Youth Programming Guidelines, it is too early to assess the extent to which they were put into practice.

- *Lesson Learned/Needed Next Step:* Clearly there is great interest in youth and a deep recognition of the importance of addressing youth's special needs. The task is not an easy one but it would be a wise choice for any donor investing in Russia to consider a focus on youth.

Considerable attention has been given to increasing **active male participation** and support at multiple junctures. Adult males and youth have visibly benefited from **improved physical and emotional access** to reproductive health care in MCHI facilities.

√ *Lesson Learned:* Regardless of how well-intentioned both parties were, having an independent entity (HR 2020) essentially responsible for MCHI's IEC/BCC component did not work well. At critical junctures, MCHI did not have the right or responsibility to implement or carry out IEC/BCC activities that would most likely have strengthened the Project. Collaboration is certainly valuable but, for maximum impact and efficiency, a project needs to be in control of its key components.

The introduction of internationally-recognized, evidence-based standards for selected maternal child health interventions into the **pre-service and post-graduate curricula** of training institutions for physicians, nurses and midwives has been initiated in all MCHI regions having such institutions, as well as in a major state medical academy in Moscow. Faculty members from regional medical schools have been an integral part of all MCHI components at multiple levels as committee members, trainers, and participants.

- *Needed Next Step:* To move beyond these important first steps will require a much more focused and explicit program, to which Russian institutions would likely be highly receptive.

Although updated in the Project's final year, the **new family planning curriculum** has been well-received and should still be very useful to many, given its user-friendly structure and approach. The small pilot component to extend family planning activities into rural rayons in two oblasts is still in its early implementation phase. Additionally, the pilot oblasts had to formulate their initial implementation plans with almost no data relevant specifically to rural couples. The household survey carried out in Vologda has now provided some helpful information that may suggest needed strategic modifications.

- *Needed Next Step:* A thorough evaluation and reassessment after at least a few more months of implementation would do much to inform future rural-focused activities.

Although not included in the original MCHI Contract, MCHI has become a **major leader in Russia for PMTCT** policy development and service standards of care, as well as for the overall reproductive health needs of HIV+ women.

√ *Lesson Learned:* MCHI's strong technical and managerial capabilities provided the flexibility needed to allow MCHI to smoothly incorporate these major new components into its program and thus be responsive to evolving external realities and the needs of USAID/Russia. The MCHI project design provided an excellent mechanism for **humanizing, "horizontalizing" and integrating the care** of HIV+ women and their infants into the health care system, a need that will grow **e**xponentially as Russia's HIV/AIDS epidemic progresses.

√ *Lesson Learned:* The recently completed PMTCT+FP Study provides valuable **data for decision making** to inform the development of strong future policy and service standards, laying the groundwork for the development of needed Reproductive Health Guidelines for HIV+ Women.

Coordination with donors and USAID-funded CAs was **close and synergistic** rather than pro forma and perfunctory. Collaboration with Russian regional and municipal government partners and with the MOHSD has been strategic and successful.

√ *Lesson Learned:* Again, MCHI created a **community of change agents** by defining its stakeholders broadly and keeping them actively involved.

MCHI has been exceptionally attentive to documentation and dissemination both nationally and internationally, and has created a set of accessible and adaptable tools including IEC materials, a film and detailed replication packages. The MCHI website includes many of these tools in Russian and in English. MCHI has become well-known and well-respected for the quality and inclusiveness of its work and has become a model for both implementing evidence-based practices and for scaling-up.

In 2005, USAID published a calendar entitled "12 Months of Telling Our Story" to help document the "uncounted thousands of lives" that USAID touches and that are "the true faces of America's foreign assistance programs."

For February, the story was "Russia Adopts New Methods of Prenatal and Infant Care" and described the interventions begun under WIN and scaled up by MCHI.

√ *Lesson Learned:* Planning for replication and dissemination from the beginning pays off. The positive momentum that MCHI was able to create resulted in regions seeking to be part of the change process.

√ *Lesson Learned:* Both sustainability and replicability are key WIN/MCHI success stories.

The management guru Peter Drucker once said, "Management is doing things right; leadership is doing the right things." MCHI exhibited strong leadership skills as well as strong management skills by **continually revisiting both the content and the process** of their interventions. In terms of doing the right things, for example, MCHI smoothly incorporated PMTCT as a major new component and thus was able to be responsive to evolving external needs. MCHI also quickly recognized the dearth of available information and designed a PMTCT+FP Study to provide needed data for decision making to inform the development of relevant policy and service standards. Again, when beginning the rural family planning pilot component, the need for additional Russia-specific data-based information was recognized; in response, MCHI helped arrange for a locally conducted population-based household survey (including a male component) in Vologda Oblast similar to those conducted during the WIN Project.

In terms of doing things right, MCHI conducted an internal mid-term evaluation which, among other actions, led to the decision to revise and update the family planning curriculum with counseling skills as its organizational backbone. Using the *WHO Medical Eligibility Criteria for Contraceptive Use* as its evidence-based content foundation, the new curriculum also stressed informed choice, the health and human rights aspects of family planning, emergency contraception, STIs, HIV/AIDS, and PMTCT.

Final Conclusion: The design, content and implementation process of the MCHI Project is an **excellent model** for similar work in other countries, especially those in the former Communist-bloc. MCHI's innovative ideas and practical approaches can be adapted by program managers and policymakers and, in fact, have already been adapted successfully in Ukraine and Georgia. Additionally, the MCHI Project is an excellent model for the incorporation of additional evidence-based, internationally-recognized standards of care into the Russian health care system (e.g. additional reproductive health, family planning, and HIV/AIDS interventions; tobacco; tuberculosis). Because of its client-centered, client-friendly approach, the MCHI model is also an effective model for reaching traditionally hard-to-reach and/or stigmatized populations (prisons, drug rehab centers, institutionalized youth) in need of these same services.

"The Government of the Vologda Oblast …assumes that the current Project can become 'a bridge of friendship' between Russian and American people."

I.A.Pozdniakov, First Deputy Governor of the Vologda Oblast in a letter to the Mission Director of USAID/Russia

II. Introduction

In September 2003, the Russian Mission of the United States Agency for International Development (USAID/Russia) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract (TASC I) to implement its three-year Maternal and Child Health Initiative (MCHI). MCHI's stated objective was to ensure the adoption of internationally recognized maternal child health (MCH) standards and practices by targeted health facilities in Russia.

The Maternal and Child Health Initiative was designed to support and contribute to USAID/Russia's Strategic Objective, SO 3.2: *Use of Improved Health and Child Welfare Practices Increased*; Indicator 3.2.3: *Abortion rates*; Intermediate Result 3.2, IR 1: *Access to More Effective Primary Health Care (PHC) Services Increased*; and its indicator: *Number of health facilities implementing evidence-based maternal and child health care practices;* and to build upon USAID/Russia's very successful previous pilot, the 1999-2003 Women and Infants' Health (WIN) Project.

The Women and Infants' Health Project, also implemented by JSI, had promoted a range of interventions in model sites in Perm Oblast and Novgorod Oblast and had provided a new service model for the Russian health care system. WIN supported the creation of a training and resource center; assembled and designed training curricula and information, education and communication (IEC) materials; developed a group of Russian master trainers; and established a core group of local best trainers. WIN also developed a number of data-based presentations for introducing evidence-based practices to new participants derived from WIN monitoring and evaluation data, and prepared a guide for replication of WIN interventions in other regions. The WIN Project's advocacy for policy change led to the development of three protocols for health care practice based on internationally-recognized standards: breastfeeding, post-abortion care, and infection control in maternity hospitals. The Post-abortion Care Guidelines were issued as a federal guideline ("*prikaz*") by the then Ministry of Health (MOH), now Ministry of Health and Social Development (MOHSD), of the Government of the Russian Federation (GORF).

As is common in most large, complex, multi-component projects, the MCHI Project's statement of work and expected results and tasks evolved over time to reflect an expanded scope of work responsive to changes in external realities and corresponding changes in USAID and MOHSD priorities and emphases.

In May 2004, modification #1 to the MCHI contract increased the funding ceiling, changed the designated Cognizant Technical Officer (CTO) and added a new reporting requirement. In July 2004, modification #2 increased the funding ceiling and amended the statement of work to emphasize strengthening and expanding reproductive health and family planning services and to include the Vishnevskaya-Rostropovich Foundation as a subcontractor charged with implementing Hepatitis B vaccination programs for adolescents in the Far East. Also in July 2004, modification #3 added incremental funding. In September 2004, modification #4 again increased the funding ceiling and amended the statement of work to include the Future of Russia

Foundation (FORF) as a subcontractor charged with helping to establish a model perinatal health care program at the Moscow Region Perinatal Center (MRPC) in Balashaikha using Global Development Alliance (GDA) funding.

The original Contract stipulated that at the Project's mid-term, JSI should prepare a report that "*highlights accomplishments against workplans, gives the statues of the expected results, addresses lessons learned during implementation, and suggests solutions for resolving constraints identified. The report should demonstrate how Russian partners will continue activities beyond the completion of the project to ensure project sustainability*." This mid-term evaluation was completed in April 2005.

In June 2005, modification #5 increased the level of effort and ceiling price, added incremental funding, revised the budget, and modified the statement of work to further expand the family planning (including a rural component and work with HIV-positive women) and prevention of mother-to-child transmission of HIV (PMTCT) components, and to address Project dissemination expectations. In August 2005, modification #6 added incremental funding.

In May 2006, modification #7 extended the task order for four months, added incremental funding, revised the level of effort and ceiling price and modified the statement of work to clarify several previous modifications. In November 2006, modification #8 provided an administrative extension for three months, giving the Project a final completion date of 7 April 2007.

Ultimately, MCHI's client-centered, evidence-based interventions were implemented in 16 of Russia's 89 regions and included antenatal care, family-centered maternity care, PMTCT, essential care of the newborn, exclusive breastfeeding, and family planning, especially for postpartum and post-abortion women.

Appendix A: Evolution of Expected Results and Tasks outlines these changes in detail as the Project moved from seven **Results** to be implemented via nine **Tasks** to 17 **Results** to be implemented via 30 **Tasks.** For the purposes of this Final Technical Report, the statement of work as defined in modification #7 will be used.

As outlined in modification #7 of the original Contract, the following **Results** were to be achieved by the end of the Project:

- 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 means 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 the Vishnevskaya-Rostropovich Foundation (VRF) in the Far East.
- Early intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI models.
- 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 healthcare 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 updated 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 perinatal health care program at the Moscow Region Perinatal Center (MRPC) through a subcontract with the Future of Russia Foundation.

These expected results were to be achieved via the implementation of 30 explicit **Tasks** that are listed with their relevant **Results** in **Section IV: Status of Expected Results and Tasks.** *Appendix B: Result Indicators* lists the 55 indicators that were originally specified in MCHI's December 2003 Three-Year Workplan and whose results are given in the main text of this report.

To quantitatively assess the majority of the 55 specific Result Indicators, MCHI conducted a Baseline Facility-based Survey in 2004 and an Endline Facility-based Survey in 2006. Table 1 below shows the number and distribution of facilities surveyed by region, city, and service type.

Table 1: Number and distribution of facilities surveyed by region, city, and service type in the Facility-based Baseline and Endline Surveys

Region/Sites	Maternity	Gynecological Unit	Women's Consultation	Family Planning Center	Total
MCHI Regions—Original 10					
Altai Krai - Barnaul	2	2	2	-	**6**
Irkutsk Oblast					
Irkutsk	2	1	1	-	**4**
Bratsk	1	1	1	-	**3**
Kaluga Oblast - Kaluga	2	2	2	1	**7**
Komi Republic					
Syktyvkar	2	1	2	1	**6**
Vorkuta	1	1	1	-	**3**
Krasnoyarsk Krai - Krasnoyarsk	2	1	9	-	**12**
Murmansk Oblast – Murmansk	3	4	3	1	**11**
Omsk Oblast					
Omsk	2	1	2	1	**6**
Tara	1	1	1	-	**3**
Orenburg Oblast - Orenburg	1	2*	2	-	**5**
Tyumen Oblast - Tyumen	2	2	2	-	**6**
Vologda Oblast					
Vologda	1	1	1	-	**3**
Cherepovets	1	1	1	-	**3**
MCHI Regions—First Additional 2*					
Primorsky Krai**					
Vladivostok	2	1	2	-	**5**
Nakhodka	1	-	1	-	**2**
WIN Regions—Original 2					
Perm Oblast					
Perm	2	2	2	1*	**7**
Berezniki	1	1	1	1	**4**
Novgorod Oblast - V. Novgorod	2	2	3	-	**7**
Total	**31**	**27**	**39**	**6**	**103***

*In the Baseline Facility-based Survey, Orenburg surveyed one less Gynecological Unit and Perm surveyed no Family Planning Center so the Total in the Baseline was 101.

**As an "expansion" region, Primorsky Krai's Baseline Facility-based Survey was conducted in January 2005; all other Baseline Surveys were conducted in May 2004. The Endline Facility-based Surveys were conducted in February 2006. The second of the first additional regions, Khabarovsky Krai, conducted a Baseline survey but was unable to carry out an Endline Survey. The second group of additional regions – Sakhalin Oblast and Sakha Republic – did not conduct either Baseline or Endline surveys for reasons of time.

Project activities ultimately also involved Children's Polyclinics and HIV/AIDS Centers, but these facilities were not part of the Baseline surveys and thus were also not part of the Endline Surveys. In addition to the facilities in the three regions not covered by the Endline and Baseline Surveys, other regions over time expanded Project coverage to involve additional facilities so that ultimately – as will be seen in Table 2 in Section IV.B: Internationally-Recognized,

Evidence-Based Standards Adopted, a total of 198 facilities were included directly in MCHI activities.

As with the midterm assessment, the original Contract stipulated that, at the Project's end, JSI should again prepare a report that "*highlights accomplishments against workplans, gives the status of the expected results, addresses lessons learned during implementation, and suggests solutions for resolving constraints identified. The report should demonstrate how Russian partners will continue activities beyond the completion of the project to ensure project sustainability*." This report is intended to fulfill that requirement.

Appendix C: Reviewed Documents lists the materials used in the preparation of this report. Quantitative data presented are from the Endline and Baseline Surveys unless otherwise indicated.

III. Background

In terms of area, the Russian Federation is the largest country in the world, stretching 11 time zones from west to east and including containing the world's deepest lake and Europe's highest mountain and longest river. With a population of 143 million (July 2006 estimate), it is also the world's eighth most populous country. Russians are universally literate (~100 %) and are predominately urban residents (73%). Administratively, Russia is divided into 89 regions (48 oblasts, 21 republics, 9 autonomous okrugs, 7 krais, 2 federal cities, and 1 autonomous oblast) that have more recently been grouped into seven Federal Districts. The population, while predominantly ethnically Russian, is quite diverse: Russian (80%), Tatar (4 %), Ukrainian (2%), Bashkir (1%), Chuvash (1%), other unspecified (12%).

Health care in the Russian Federation is primarily a state responsibility and the Ministry of Health (now the Ministry of Health and Social Development - MOHSD) is the largest health care provider. The MOH historically has been responsible for maintaining the overall infrastructure and setting national priorities for health care, as well as for establishing norms and standards that dictate policies and practices across the entire nation. There has been a gradual shifting of responsibility for health care administration and financing to the regional and municipal levels, but the federal level remains the most important health policymaker.

Russia has made significant progress during the past two decades toward improving the health status of women and children. Compared to Western Europe, the United States, and recommended international standards, however, a gap still remains. Although encouraging declines have been recorded, Russia's maternal mortality rate, infant mortality rate, and abortion rate continue to be of concern, as do a reportedly increasing infertility rate and a steadily increasing HIV prevalence rate.

In addition to poor maternal and child health status, Russia faces another predicament, a low birth rate. Although some recent reports indicate that the birth rate in Russia may be increasing, the overall trend is still low. Understandably, the resulting decline in the population has become one of the Russian government's major concerns.

The use of modern contraception does not have a long history or well-developed service delivery infrastructure in Russia. Abortion has historically been the primary means of birth control. Triggered by political and church worries about Russia's falling population size, concerns surrounding the morality of induced abortion, and misunderstandings about family planning and its role in maternal and infant health; direct public sector support for family planning was discontinued by the State Duma in 1998 and funding was merged into the Safe Motherhood Program.

USAID's maternal and child health initiatives to date, in particular the Women's Reproductive Health Project and the Women and Infants' Health Project, along with other USAID and international donors' interventions, have set up effective models to address some of these challenges and improve services provided to women and infants. Nevertheless, the need for continued health system development was recognized as most Russian health care facilities continued to perform outdated and non-evidence-based practices. It was in this context that the Maternal and Child Health Initiative was designed and awarded.

Increasingly, as WIN was ending and MCHI was beginning, Russia's attention and the attention of USAID/Russia turned to Russia's worsening HIV/AIDS situation. Although initially confined to the high-risk subpopulation of injection drug users (IDUs), Russia's HIV epidemic is increasingly moving into the general population via heterosexual transmission. In some Russian regions, heterosexual transmission now accounts for 50% of new cases. The 2003 Russia Longitudinal Monitoring Survey revealed that, among unmarried participants 14-20 years of age, 21-30 years of age, and 31-40 years of age, respectively 41.8%, 64.5%, and 78.0% did not use a condom during their last sexual encounter.

IV. Status of Expected Results and Tasks

A. "Legacy" Russian Partner Organization Identified

MANDATE

The Result, **"***A Russian organization with a strong MCH mandate empowered and strengthened, to partner with MCHI in implementing the replication model,"* was to be achieved via two main **Tasks:**

1. *"The Contractor shall identify and partner with a key Russian health organization with a strong MCH mandate in order to promote the replication component of the activity. The selection criteria used to identify this partner organization should include, but not be limited to, the ability of the Russian partner to cost-share (for example contribution of overhead, staff time, office space/ equipment, etc.). In addition, the organization should have a favorable reputation and be well-respected by the Russian government health authorities, academicians, and the international donor community in Russia."*

2. *"The Contractor shall conduct a limited number of organizational development activities to contribute to developing the Russian Society of Obstetricians/ Gynecologists (RSOG) capacity as an implementation partner. Specific activities would be jointly determined by both MCHI and RSOG. Continue working relationship with individual members of the RSOG at both regional and central levels, furthering the goals of both the MCHI Project and the Society as a whole."*

IMPLEMENTATION

The intent of the original Contract was that a "legacy" Russian organization would be identified who would partner with MCHI to implement the current Project and who would *"be able to continue the promotion and provision of MCH innovations in Russia beyond the period of USAID's assistance."* and that *"One of the tasks of the Contractor shall be to develop and build the capacity of the selected Russian organization throughout the course of the contract, to enable it to follow-on and continue similar replication efforts after USAID programming ends in Russia."*

Russian Society of Obstetricians/ Gynecologists (RSOG)

After due consideration, JSI chose the Russian Society of Obstetricians/Gynecologists, a non-commercial professional membership organization and a registered non-governmental organization (NGO), as its prime Russian partner for implementing the Maternal and Child Health Initiative. On 9 October 2003, at the very start of the MCHI Project, RSOG and JSI signed a Memorandum of Understanding (MOU). RSOG then appointed a MCHI/RSOG Coordinator, a respected physician who had already been involved in WIN as an expert in family planning and thus was already cognizant of the Project's goals and objectives. As part of the RSOG/MCHI collaboration strategy, it was agreed that regional RSOG members should be part of the Regional Coordinating Teams (RCTs) responsible for overseeing Project implementation at the regional level. RSOG would also be part of the MCHI Interregional Working Group

(IWG) and thus would participate in initial and follow-up site visits. It was also planned that some RSOG members would become trainers, thus providing RSOG with training capability and providing MCHI with needed additions to their cadre of consulting trainers. MCHI was to submit articles for publication in the RSOG journal. Quite early in the Project, the idea developed to have JSI hold its planned Eastern Europe and Eurasia (EE/EA) Regional Conference in Moscow in October 2004 at the time of the RSOG annual "Mother and Child" Congress and to have JSI sponsor a major session on RSOG's opening day. This took place as planned: JSI presented a very well-received three-hour session on "Implementing Modern Maternal Child Health and Reproductive Health Practices in Eastern Europe and the Newly Independent States" which highlighted JSI work underway in Russia, Central Asia, Romania, and Ukraine. JSI and MCHI also had a booth in the exhibit hall throughout the RSOG convention.

In June 2004, a senior staff member from JSI's partner organization, World Education, Incorporated (WEI), conducted an assessment to help determine the extent to which RSOG could be engaged in a capacity building process to enable them to continue the MCHI work beyond the period of USAID's assistance. This assessment involved studying RSOG's goals and objectives, its structure, its major activities, how RSOG's Board is constituted and functions, and the relationship between RSOG centrally and RSOG regionally.

The findings were that, in essence, RSOG is in many ways an informal organization without permanent staff or infrastructure. Not all of Russia's 33,000 ob-gyns belong to RSOG, but RSOG is not able to document who is and who is not a member. RSOG's structure parallels the official state structure; one's role in RSOG is determined more by position than by personal characteristics. No one defines him/herself first and foremost as an RSOG official. A change in state position would bring a change in RSOG position. The head obstetrician-gynecologist (ob-gyn) at the Ministry of Health has traditionally been the president of RSOG. A self-organized, self-selected and self-perpetuating 50-member Presidium governs RSOG and selects the nine-member executive committee. Reportedly there are committees that deal with issues such as quality assessment, education and certification, and medical ethics, etc., but they meet informally and sporadically. There are 54 "official" branches in the 89 Russian regions. Smaller regions may have "unofficial" branches and/or may join up with neighboring regions. The RSOG regional branches are traditionally headed by their head ob-gyns. The relationships between regional RSOG groups and central RSOG are reportedly personal rather than organizational.

The mid-term evaluation team also reviewed RSOG's potential for being the desired "legacy" organization and concluded that whereas RSOG was a very appropriate and worthy partner for implementing the MCHI Project, RSOG would not be able to continue or expand the scale-up unaided. Additionally, providing the level and extent of the capacity building that RSOG would need to allow them to continue MCHI-type interventions was beyond the resources (time, human, financial) of MCHI. Also, it was unlikely that RSOG would be able to absorb such intense capacity building efforts, even if available.

Based on these two assessments, a frank and open discussion between MCHI and USAID/Russia concluded that RSOG would not likely be the appropriate "legacy" organization but that relevant and feasible organizational development work with RSOG should be continued as appropriate.

In May 2005, the same senior staff member from World Education who had earlier conducted the RSOG assessment co-facilitated an Organizational Development Workshop for RSOG

representatives from all MCHI regions as well as from the central level. The Workshop focused on strategic and financial planning to help strengthen RSOG and was very well-received by the regional participants but generated little to no interest at the central level. Subsequently, as before, RSOG members continued to be heavily involved in MCHI activities by virtue of their official positions but no further substantive work took place with RSOG as an institution.

During the MCHI Project, RSOG was very much an organization in transition, in part due to major external changes: the ongoing restructuring of the MOHSD and the advent of federally-mandated obligatory free medical services. RSOG would like to be in more of a position to advocate for policy change at the federal level and is interested in helping to determine standards of care. It would also like to take on some of the MOH's licensing and continuing education roles but recognized it did not have the structure, funding, or capacity to do this.

In the final year of the Project, RSOG members were heavily involved in the development of needed clinical protocols and guidelines as well as in the updating of the family planning curriculum and the consequent training of trainers (TOT) and family planning courses that followed. See Section IV.F: Family Planning Capacity and Services Strengthened and Section V.B:National Policy: Clinical Protocol Development for details.

Institute for Family Health (IFH)

In the spring of 2006, USAID conducted an assessment of its two major reproductive health projects – MCHI and Healthy Russia 2020. A key objective of this assessment was to evaluate the likelihood that current activities would be successfully continued by appropriate Russian "legacy organizations" and – in MCHI's case - to consider an appropriate transition process from a project implemented by JSI to a new program mechanism. A main conclusion of the assessment was that MCHI staff made unique and vital contributions to MCHI's obvious success and that the tools and methodologies developed under WIN and MCHI were also key to that success and merited further support.

Concurrently and rather spontaneously, as the MCHI Project entered its final months, the MCHI staff began discussing with JSI the possibility of they themselves becoming the "legacy organization". Staff turnover had been minimal; most had been together since the WIN Project. As a team and individually, they were well-recognized and well-respected throughout Russia as change agents for client-centered, evidence-based MCH. JSI enthusiastically and proudly supported the MCHI staff as they thoroughly and conscientiously explored the ramifications of undertaking such a challenge.

With full support from JSI, the MCHI staff registered as an **indigenous Russian non-governmental organization to be called the Institute for Family Health.** The original intention was to form a nonprofit Russian organization but, as IFH began the registration process, it was discovered that the process to register as a nonprofit would take many months to complete, if not several years, or possibly would never happen due to recent regulatory changes within the federal government regarding nonprofit NGOs operating within Russia. As a result, while IFH initially began (and continues) its application process for registration as a nonprofit NGO, it followed local legal advice to register as a for-profit organization. One clear advantage of registering as a for-profit was that the registration process was completed in a matter of weeks rather than months or years.

While IFH was being registered, the Russian Federation's Federal Service for Surveillance in Consumer Rights Protection and Human Welfare organized an open national competition to implement their National Health Project in HIV/ AIDS including PMTCT, and MCHI was invited to bid. MCHI partnered with Russia's oldest and largest national medical education institution, the Sechenov Moscow Medical Academy, to prepare a proposal. In March 2006, the pair was awarded the 20 million rubles (~USD $800,000) grant to improve PMTCT and family planning practices among HIV+ women in 15 regions (a group which did not include any Far East regions) and disseminate the national PMTCT Guidelines developed by MCHI.

Once registered, the Institute for Family Health then submitted two concept proposals to USAID/ Russia requesting GDA funding and an additional proposal for continuing the work of MCHI. All three were awarded to IFH as part of a three-year USD $7.5 million (~187.5 million rubles) co-operative agreement called Maternal and Child Health Initiative II with the University Research Corporation (URC) as a subcontractor for implementation of the "quality" component. In addition to expanding the work carried out under the original MCHI contract, MCHI II will also extend the work done for the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's National Health Project in HIV/ AIDS to two key Far East regions – Irkutsk Oblast and Primorsky Krai. The second of the two GDA-funded components of MCHI II is particularly interesting as it involves significant matching funds from the local government partner. Omsk Oblast will provide 150 million rubles (~USD $6 million) working with IFH to essentially roll out the MCHI interventions throughout the entire Oblast.

IFH has also submitted other proposals to other donors that are pending. IFH anticipates that there will be further tenders offered for bid by the Government of the Russian Federation. IFH intends to bid on these tenders as well as seek opportunities for funding for additional reproductive health projects from a variety of donor sources (e.g. the European Union, WHO, UNICEF, UNAIDS). IFH expects to submit four to six proposals per year and configure its staffing accordingly for effective program implementation and management of funding sources. IFH is currently developing a marketing strategy to disseminate its capabilities to a wide range of potential donors.

RELEVANT INDICATORS

Supportive Policy Environment

- Memorandum of Understanding between RSOG and JSI signed: **Yes**
- MOH agrees on partnership with RSOG to implement MCHI: **Yes**
- Monthly collaborative meetings with RSOG leadership: **Initially attempted but not continued**

Organizational Capacity

- Persons responsible for MCHI-RSOG coordination of joint activity identified: **Yes**
- RSOG participation in MCHI Interregional Working Group activities: **Yes**
- RSOG participation in Regional Coordinating Teams activities: **Yes**
- RSOG participation in joint MCHI workplan development at national and regional levels: **Initially at national level; throughout at regional level**

- RSOG participation in MCHI staff meetings, monitoring and evaluation (M&E) team meetings, and follow-up visits: **Continuously in follow-up meetings but not in MCHI staff meetings or M&E team meetings**
- Number of RSOG members trained in capacity building: **25**
- RSOG and JSI jointly organize MCHI conference in the frame of the National Congress "Mother and Child": **Yes**
- RSOG regularly publishes MCH/MTCT/RH evidence-based updates in RSOG journal: **Once at beginning of Project**
- RSOG has a follow-on strategy to continue MCHI activities by the end of the project: **No; See Implementation section above**

Technical Capacity

- Number of RSOG trainers trained at MCHI TOTs: **All ob-gyns attending TOTs would consider themselves RSOG members if asked but do not normally identify themselves in that way.**
- RSOG participation in training activities in regions: **Continuously**

CONCLUSIONS

A strong, credible, registered indigenous Russian "legacy" organization with proven broad-range expertise now exists. The Institute for Family Health is well-positioned to continue the promotion and provision of MCH innovations in Russia by partnering with and implementing programs for both international and Russian donors. IFH has already attracted considerable funding from multiple sources for the next three years, with one implementing partner pledging additional millions of its own in matching funds. Certainly this is an impressive beginning!

Despite its limitations, the well-recognized and well-respected RSOG has been a very appropriate and worthy partner for implementing the MCHI Project. Realistically, there is no other known organization that would have been a stronger choice. Working with RSOG has led to greater dissemination of MCHI innovations through professional channels than working through the MOHSD alone would have afforded. The President of RSOG signs all certificates issued by the MCHI training courses, lending prestige, and credibility to the training provided. RSOG "approval" is also on Project materials which underscores the quality and importance of the contents. Regionally, for Project implementers to say they have the support of RSOG makes the MCHI activities more Russian, a very important attribute at the regional level.

B. Internationally-Recognized, Evidence-Based Standards Adopted

MANDATE

The Result, *"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"* was to be achieved via three main **Tasks**:

1. *"The Contractor shall compile a comprehensive Replication Package, including evidence-based guidelines, protocols, and practices defining new approaches to MCH services, perinatal care and PMTCT. This package should include the WIN Project's*

"how-to-guide," materials developed under the Women's Reproductive Health Project, and other USAID-funded MCH initiatives to date. Selected materials should be updated and/or adapted as appropriate (e.g. the Family Centered Maternity Care and Family Planning curricula). This package should also include any other newly developed and appropriate MCH practices by other donor organizations."

2. "*Fourteen new regions shall be selected on a competitive base for the implementation of the replication component of this activity. The Contractor shall propose a design for the selection process, including selection criteria to be used to identify the participating oblasts and the corresponding health facilities. Cost sharing, a supportive regional health administration, and in-kind staff time shall be included among the selection criteria. Priority should be given to US government and USAID priority regions, as well as those sites where other AID or USG projects are being implemented. Four of the new regions shall be in the Russian Far East."*

3. *"A comprehensive replication strategy shall be developed by the Contractor specifying the process and timelines for newly selected health facilities. The Contractor, along with the Russian partner organization, shall carry out and facilitate this process. The range of interventions to support the replication process may include health provider training, restructuring of services, technical assistance, cross-regional visits, etc. Resources developed under the WIN Project, i.e., a pool of master trainers and the training center in Perm, as well as other resources developed under USAID programs (including models supporting the institutionalization process developed under Phase III of USAID's Quality Assurance Project) should be utilized. In addition, the replication plan should be adapted to be appropriate for each targeted region or facility to address their unique needs and circumstances."*

IMPLEMENTATION

To introduce new evidence-based clinical practices into an historically inflexible health care system locked into largely outmoded practices and to meet their strategic objectives and achieve demonstrable results, MCHI used approaches that respected existing Russian systems, structures and professionals, while at the same time providing training and education to ensure policymakers' and providers' ability to improve Russia's maternal and child health care.

The mandatory rules and guidelines for healthcare throughout Russia are communicated by the federal MOH through a system of orders (*prikazes*). Because they are standardized throughout federal, regional and local facilities, the health system does not readily allow for innovation. Many *prikazes* have been in place for years. A health care facility can be punished officially for not following a *prikaz.* For many years under the Soviet system, Russian medical science developed in isolation from the mainstream of international scientific information so that some Russian medical practices remained informed by a unique Russian approach or reflected Western standards of the 1950s and 1960s. In general, professional cultural norms in the Russian health care system have been governed by the absence of open discussion, a closed system of decision-making and a management culture that does not embrace a team approach or generally use data for decision-making.

Traditionally, provider-client communications were poor, with client satisfaction often ignored. Assumptions were made in regard to the client's needs; decisions were made for the client; the client's input was not sought. As might be expected, given the prevailing impersonal style of provider/ client relations, there was also a historical lack of research into client satisfaction.

Not surprisingly, "foreign" interventions that presented alternatives to accepted Russian practices often met resistance from Russian professionals. In this context, WIN initially and then MCHI was charged with providing a new evidence-based model for reproductive health care services; with increasing access to, demand for, and the quality of these services; and with increasing the practice of preventive health behaviors among women in the community.

To do this, **MCHI chose strategies that not only stressed comprehensive training in evidence-based medicine but also offered a total paradigm shift from focus on the provider to focus on the client** as they worked with existing health care facilities and involved health care providers, administrators and authorities in the planning, policymaking, hands-on-training and public education needed to achieve change.

From the beginning, there was no question that Russian physicians, nurses, midwives and others wanted to provide the very best care they could; however, in addition to the natural human resistance to change, other factors also came into play:

- Providers needed to feel supported by institutional readiness for the new services;
- Providers needed to know there was client readiness for the new services;
- Providers needed to see irrefutable evidence that the new practices were better than the ones they have used for years; and
- The new services needed to be appropriate for implementation within the Russian system of health care, the particular facility, and the community.

MCHI's replication strategy was implemented via a set of working groups that introduced and incorporated the new concepts. To bring together professionals with different levels of authority, experience and perspective and to create an environment for exploring, implementing and maintaining needed changes; technical working groups were established at various levels of policymaking, administration, and service provision. **Teamwork** and **coalition building** were the principles guiding these working groups. For many Russian healthcare professionals at all levels, these were novel concepts. The working groups provided a forum where participants learned about international health standards and could explore together the coming interventions and their own roles in implementation. Technical Working Groups (TWGs) in each health care facility were responsible for maintaining program implementation through continued in-service trainings and by ensuring the continuous collection, analysis, and utilization of data by staff. In addition, each region had a Regional Coordinator and Regional Coordinating Teams (RCTs) were established to facilitate, support, and supervise program activities at the regional and/or municipal levels. Importantly, a culture of open communication was promoted to spark dialogue among the working groups and all stakeholders. An Interregional Working Group

(IWG) supported the regional innovations (many of which ran counter to existing MOH regulations), promoted and disseminated project results, conducted multiple site visits to monitor and support implementation, and continually reviewed progress to see if program modifications were needed to better achieve desired outcomes.

These collaborative networks and this teamwork approach proved essential to program success by:

- Encouraging communication and sharing among providers from different levels and facilities;
- Promoting collaboration between providers and health administrators;
- Ensuring shared ownership for innovations; and
- Unifying services and information provided to clients.

In October 2003, at the end of the Project's first month, the MCHI Project convened a working meeting of MCH experts and consultants from Moscow and Perm to develop the criteria and methodology for selecting the new MCHI regions and to outline the replication strategy for implementing the Project in the new regions.

Already, after the WIN Dissemination Conference in May 2003 and the advocacy and dissemination efforts of Healthy Russia 2020 and the Quality Assurance Project, close to 20 regions had indicated interest in replicating the WIN model. At the start of MCHI, the nature of the Project and the selection criteria were widely publicized via the RSOG Annual Meeting, MOH announcements, professional journals, e-mail, pharmaceutical company distributors, and word-of-mouth. See *Appendix D: MCHI Selection Criteria* for a detailed list of the criteria used. Ultimately, 39 of Russia's 89 regions submitted applications.

A selection committee formed at this time then reviewed the 39 applications received and conducted oral interviews with both administrative heads and facility heads to be certain they understood MCHI's key concepts. The following 10 regions (three of which were municipal-level only) were selected: Barnaul in Altai Krai, Irkutsk Oblast, Kaluga Oblast, Komi Republic, Krasnoyarsk city in Krasnoyarsk Krai, Murmansk Oblast, Omsk Oblast, Orenburg city in Orenburg Oblast, Tyumen Oblast, and Vologda Oblast.

The 10 sites ultimately selected were officially announced 12 January 2004, and MCHI signed agreements with the Regional Health Care Administrations shortly thereafter. Mutually agreed upon Regional Coordinators were selected, who then formed Regional Coordinating Teams.

In January 2004, as an integral part of the Project's replication strategy, MCHI convened a two-day Interregional Working Group meeting composed of representatives from RSOG, MOHSD and USAID; the Project experts in family planning, family-centered maternity care (FCMC), breastfeeding, antenatal care, neonatal care, newborn resuscitation, and infection control; and Project staff to address multiple components of Project implementation. Together, the working group reviewed the upcoming MCHI Launch Conference, the annual workplan, and the monitoring and evaluation plan, including key indicators, and also discussed how to strengthen the MCHI training courses. In addition, the IWG reviewed a standardized set of presentations on the WIN experience and the planned MCHI interventions designed to assist in policy

development and the creation of a supportive environment. The group also developed a schedule for initial site visits to the new regions.

In mid-February 2004, a three-day MCHI Launch Conference was conducted in Perm. The more than 100 participants included multiple representatives from the Regional Coordinating Teams from the 10 new regions, as well as representatives from RSOG, the medical press, Healthy Russia 2020, USAID/Russia and JSI/Boston. During this Conference, participants heard in detail about the WIN results and the core integrated MCHI internationally-recognized, evidence-based practices: FCMC, exclusive breastfeeding, essential newborn care, family planning, infection control, and PMTCT. Overviews of the Project training courses were presented and two half-days were devoted to site visits to pilot facilities to see implementation results firsthand. Each regional delegation then drafted its own region-specific workplan.

In early March 2004, several weeks after the Launch Conference, the RCT members responsible for conducting the Baseline Facility Surveys in their respective regions attended a two-day Monitoring and Evaluation Workshop in Moscow. During the WIN project, both household surveys and facility surveys that interviewed both providers and clients had been conducted. The conclusion during WIN was that the most useful data came from the client portion of the facility survey. Therefore, MCHI planned from the beginning to only interview clients, a first step in what became a total **paradigm shift from focus on the provider to focus on the client**.

The Workshop further introduced the Project's monitoring and evaluation system and trained participants in facility-based survey techniques and data entry using SSPS software. Prior to the Workshop, the survey questionnaires had been finalized and field-tested by Project experts and staff. Shortly thereafter, baseline data collection for the facility-based surveys started in all 10 new regions and was completed in May. The collection of official medical statistical data at the facility, municipal and oblast levels was also begun. A special monitoring form was also developed for follow-up supervision visits to be done twice yearly to monitor progress, provide technical assistance, address implementation issues, and adjust Project activities if necessary.

Also beginning in March, representatives of the Interregional Working Group together with Project staff visited all 10 new regions to help in policy development and needs assessment and to discuss and finalize the region-specific MCHI implementation plans. The IWG met again after the first four visits to review results to date and then completed the remaining six visits by mid-May.

Although PMTCT was not included in the original Contract, from the very start of the MCHI Project, MCHI and USAID/Russia agreed that HIV/AIDS and PMTCT should be integrated into MCHI activities. This focus necessitated incorporating the regional HIV/AIDS Centers into Project activities, an intervention also beyond the original scope of the Project.

Comprehensive Replication Packages

- Family Planning/Reproductive Health/ HIV/AIDS Prevention
- Family Centered Maternity Care/ PMTCT
- Breastfeeding/ Baby-Friendly Initiative/ HIV/AIDS Prevention
- Newborn Care and Breastfeeding/ PMTCT
- Neonatal Resuscitation
- Infection/HIV Control in Maternities
- Antenatal/PMTCT
- Youth Friendly Services/ HIV Prevention

In June 2004, in response to needs identified by the regions and also by the JSI/Ukraine Maternal and Infant Health Project, project experts and staff held a two-day workshop with support from

World Education to review the antenatal component and update the antenatal curriculum. Representatives from the Novgorod branch of the Early Intervention Institute (EII) supported by Assistance to Russian Orphans also participated, and some of the EII approaches and materials were incorporated. The completed, reformatted course was then pre-tested and minor changes made before being put into general use. During this same time period, materials used in the breastfeeding course were also updated to include more materials on family planning and PMTCT.

For each content area, MCHI compiled a detailed Replication Package comprised of relevant curricula and supporting materials; these Replication Packages have been continuously updated and refined throughout the life of the Project. For example, in response to an identified need, MCHI developed new evidence-based guidelines for perinatal care. Also, the antenatal and family planning curricula were extensively revised and an FCMC refresher training course developed. *Appendix E: Final MCHI Replication Packages* shows the contents of each Replication Package in detail.

By mid-2004, Project training had started in earnest, with multiple courses being given in multiple locations. Family planning and breastfeeding were not new concepts, of course, but many aspects of FCMC and PMTCT were truly revolutionary. *Appendix F: Workshops and Training by Topic and Region* outlines the multiple interventions offered by MCHI to its regional partners.

To meet MCHI's expanded training needs, MCHI worked continuously to expand its cadre of master trainers, searching out and mentoring regional trainers who showed exceptional interest and promise. In all, 17 such trainers were identified, two of whom became master trainers in two areas: four for antenatal care, seven for FCMC, three for neonatal care, and five for family planning.

> **"You taught trainers to listen to the opinions of others. We never felt forced to do anything. We had many discussions, some quite heated!"**
>
> ***RCT member, Vologda Oblast, during the Mid-term Evaluation***

Additionally, there was the expectation that those selected by the RCTs to attend MCHI courses would be ready and willing to train others upon their return. In many other health projects, this "cascade" training approach has been problematic, but it appeared to function well for MCHI. First of all, attendees were chosen in part based on their interest and willingness to share their experiences with others; this readiness and willingness to train others was an explicit criterion for selection. Secondly, most, if not all, MCHI courses included counseling and communication components.

In July 2004, per Contract modification #2, two additional regions were added to the MCHI portfolio – Khabarovsky Krai and Primorsky Krai, both in the Russian Far East. By September, agreements with the new regions had been signed, initial site visits had been conducted, region-specific workplans had been developed, and both new regions had been incorporated into the training plans. In October, the two new regions received monitoring and evaluation training, including the methodology for conducting their facility-based surveys. The baseline surveys for the two new regions were then conducted in January 2005 and the survey report completed by March.

In June 2005, per contract modification #5, two more additional regions in the Far East - Sakhalin Oblast and the Sakha Republic (formerly Yakutia) – were added to the MCHI portfolio, bringing the total to 16 (14 MCHI regions plus 2 WIN regions). By September, agreements with the new regions had been signed, initial site visits had been conducted, region-specific workplans had been developed, and both new regions had been incorporated into the training plans. Given the limited implementation time available, baseline facility-based surveys were not part of the workplans or training plans.

In September, 2005, Vladivostok in Primorsky Krai hosted an MCHI Conference, "Improving Medical Care to Women and Infants Based on Evidence-based Medicine." This Conference was held within the framework of the Second Far East Congress, "A Man and Medicine." The goal of the Conference was to present evidence-based practices in perinatology, family planning and PMTCT; to discuss strategies for the implementation of modern technologies into medical practice; and to present MCHI's experience implementing maternal child health practices based on evidence-based medicine. Representatives from all 16 MCHI regions were among the 216 participants. MCHI also displayed its IEC materials.

As MCHI's scope of work broadened over time geographically and programmatically, the number and type of facilities directly involved in project activities increased significantly. As Table 1 displayed, the Project included 101 facilities at the beginning. Table 2 below displays the 198 facilities participating in the Project at its conclusion.

Table 2: Number and distribution of facilities by region, city and service type participating in the MCHI Project at its completion

Region/Sites	Maternity	Gynecological Unit	Women's Consultation	Family Planning Center	Children's Polyclinic	HIV/AIDS Center	Total
MCHI Regions—Original 10							
Altai Krai - Barnaul	2	2	2	1	2	1	**10**
Irkutsk Oblast							
Irkutsk	2	1	1	-	2	1	**7**
Bratsk	1	1	1	-	1		**4**
Kaluga Oblast - Kaluga	2	2	2	1	2	1	**10**
Komi Republic							
Syktyvkar	2	1	3	1	2	1	**10**
Vorkuta	1	1	1	-	1		**4**
Krasnoyarsk Krai -Krasnoyarsk	2	8	9	-	3	1	**23**
Murmansk Oblast -Murmansk	3	4	3	1	2	1	**14**
Omsk Oblast							
Omsk	2	1	3	1	1	1	**9**
Tara	1	1	1	-	1		**4**
Orenburg Oblast - Orenburg	2	2	2	-	2	1	**9**
Tyumen Oblast							
Tyumen	2	2	2	-	2	1	**9**
Tobolsk	1	-	1	-	1		**3**
Vologda Oblast							
Vologda	2	1	1	1	1	1	**7**
Cherepovets	1	1	1	1	1		**5**
MCHI Regions—First Additional 2							
Primorsky Krai							
Vladivostok	2	1	2	-	1	1	**7**
Nakhodka	2	-	1	-	2		**5**
Khabarovsky Krai							
Khabarovsk	3	1	2	1	3	1	**11**
Komsomolsk-on-Amur	1	1	1	-	1		**4**
MCHI Regions—Second Additional 2							
Sakhalin Oblast – Yuzhno-Sakhalinsk	2	4	1	1	1	1	**10**
Sakha Republic (Yakutia) - Yakutsk	1	1	4	-	1	1	**8**
WIN Regions—Original 2							
Perm Oblast							
Perm	2	2	2	1	2	1	**10**
Berezniki	1	1	1	1	1		**5**
Novgorod Oblast - V. Novgorod	2	2	3	-	2	1	**10**
Total	**42**	**41**	**50**	**11**	**38**	**16**	**198**

In June 2005, contract modification #5 had mandated MCHI to **"***Conduct a broad MCHI Dissemination Conference with involvement of non-MCHI regions, especially those that have already participated in MCHI activities at their own cost and/or sent official letters of interest"* and to *"Conduct a workshop to orient selected non-intervention regions interested in implementing MCHI practices, using an updated Replication Package and sharing the experience of successful intervention regions."* These additions in part reflected the fact that there was no identified "legacy" organization at that point to carry on the Project interventions

after the MCHI Project concluded. In response, MCHI decided to hold its Final Dissemination Conference earlier than planned and also decided to expand its format. The Conference date was set for May 2006. This decision also meant that the Endline Facility-based Surveys would need to be conducted and the data analyzed in time to be presented at the Conference. Consequently, refresher training on facility-based surveys was conducted for the regions in January 2006. Data collection and data entry started in February and were completed by the end of April.

Although not explicitly part of the MCHI scope of work, MCHI staff and consultants provided support and guidance integrated into their other activities to help the regions maintain and/ or achieve Baby-Friendly Hospital status for their maternities if they so desired. By the end of the Project, Murmansk had maintained its two Baby-Friendly Hospitals and the Komi Republic had added two more. Kaluga Oblast, Krasnoyarsk city in Krasnoyarsk Krai, Omsk Oblast. Orenburg city in Orenburg Oblast, Primorsky Krai and Vologda Oblast had or were about to have a certified facility and Irkutsk Oblast was working diligently on qualifying its first facility. See Section V.C: Baby Friendly Hospitals.

RELEVANT INDICATORS

Supportive Policy Environment

- Number of regions institutionalized MCHI approaches in their official policies: **16**
- Number of RSOG regional groups involved to facilitate MCHI implementation: **As discussed above, RSOG members were heavily involved in all regions but did not necessarily identify themselves as "RSOG."**

Evidence-based MCH Practices Implemented in Facilities

- Number of facilities implementing evidence-based MCH practices: **198**

Antenatal Care

- Percent of antenatal clients who report that provider discussed breastfeeding:

2004	2006
59.1 %	**74.5 %**

- Percent of antenatal clients who report that provider discussed partner/family participation and support during childbirth:

2004	2006
34.2 %	**57.3 %**

- Percent of antenatal clients who report that provider discussed healthy lifestyle:

2004	2006
69.1 %	**77.7 %**

- Percent of antenatal clients who report that provider discussed healthy nutrition:

2004	2006
83.6 %	**90.4 %**

Labor and Delivery Services: Beneficial Practices are Increased

- Percent of postpartum women who report that they had their baby in their room day and night, for the entire hospital stay:

2004	2006
69.0%	**86.4%**

- Percent of postpartum women who had a partner/close person support during labor and delivery:

2004	2006
12.5 %	**29.2 %**

- Percent of deliveries with completed WHO partograph*:

2004	2006
60.0%	**83.0%**

*Data source: follow-up visits in 14 regions.

- Percent of women who were allowed to walk and/or sit during labor:

	2004	2006
Walk	**81.5 %**	**91.9 %**
Sit	**42.6 %**	**84.8 %**

- Percent of women who receive oxytocin during 3rd stage of labor:

2004	2006
57.0%	**90.0%**

Labor and Delivery Services: Harmful Practices Decreased

- Percent of postpartum women who report a perineal shave:

2004	2006
41.6 %	**12.4 %**

- Percent of postpartum women who report an enema:

2004	2006
71.9 %	**28.1 %**

- Percent of postpartum women who report a routine IV:

2004	2006
68.5 %	**46.0 %**

- Percent of postpartum women who report labor induced:

2004	2006
37.5%	**29.3%**

- Percent of postpartum women who report an episiotomy:

2004	2006
32.5 %	**21.0 %**

Labor and Delivery Services: Breastfeeding Implemented

- Percent of postpartum women who report that their infant received only breast milk during entire hospital stay:

2004	2006
38.0 %	**64.4 %**

- Percent of children exclusively breastfed up to 6 months*:

2004	2006
33.0%	**43.0%**

*Data source: follow-up visits in 14 regions.

Satisfaction with Services Increased

- Percent of antenatal women who would recommend a friend come for care at this facility:

2004	2006
65.7 %	**78.4 %**

- Percent of postpartum women who would recommend a friend come for care at this facility:

2004	2006
71.4 %	**86.8 %**

- Percent of post-abortion women who would recommend a friend come for care at this facility:

2004	2006
71.7 %	**82.3 %**

- Percent of family planning clients who would recommend a friend come for care at this facility:

2004	2006
68.8 %	**80.8 %**

CONCLUSIONS

The adoption and integration of internationally-recognized, evidence-based standards has occurred at a very impressive pace across an impressive range of political and health institutions actively involving an impressive number of people over an impressive geographic area. Inter-linking components and multi-level focus has given the Project implementation process strength, breadth, adaptability and flexibility. The capacity building that has occurred at the regional level is substantial and has laid the foundation for further replication.

The selection process and criteria (incorporating an element of self-selection that promoted commitment and built in readiness) worked extremely well and were key contributors to the Project's robustness. The competitive element was innovative and positive. The co-financing requirement was also motivating. Requiring letters of support from municipal and regional authorities and from the regional RSOG branch helped instill a broad sense of ownership from the beginning. The requirement that the facilities chosen be an inter-related set of maternities, women's consultation clinics, children's polyclinics, family planning centers, and HIV/AIDS centers helped to horizontalize previously vertical institutions and to standardize the content and continuity of care.

By identifying and supporting "catalyst" institutions and individuals, MCHI helped multi-level leadership implement bold, rapid, substantive changes. Investing in human capital and providing access to (international) evidence-based interventions lead to rapid and major changes in clinical practices over a relatively short period of time.

> **"The Project has changed the very principles by which we provide care to women."**
>
> ***Regional Coordinator, Vologda Oblast, at MCHI's Final Dissemination Conference***

Outside observers during the mid-term evaluation and during the Final Dissemination Conference heard similar messages from Project participants. Continuity of care had reportedly become more consistent across facilities. Providers in the maternities reported that the women arriving for delivery had been well prepared by the women's consultation clinics' antenatal care and childbirth preparation classes. The decreases in harmful practices and the increases in beneficial practices were inspiring.

Many sites had converted delivery halls into spacious, single delivery rooms to facilitate partner/family support during labor and delivery. Rooming-in was the norm. Almost everyone mentioned how quiet and calm the maternity wards had become, that the women were much more relaxed and the newborns rarely cried. Many staff reported decreases in medications used, decreases in episiotomies (but slight increases in perineal tears), as well as decreases in the use of IV anesthesia and more reliance on local anesthesia when needed. A wide range of printed materials, posted on the walls or provided as handouts, reinforced the MCHI messages.

More than the physical changes in their facilities and more than their deepened knowledge of evidence-based practices, however, many in the regions stressed the changes in their ways of thinking—in their "mentality"—as the most powerful outcome of being involved with the MCHI Project. The process and content of MCHI seemed to have been exceptionally timely for Russia. Many saw the Project as fostering a renewed support and respect for the Russian family, values that they felt had suffered in recent times but that were core to the Russian spirit. They spoke of a "transformation." Many also spoke of the Project as having changed totally the way they related to their patients and clients, as well as the way health professionals related to each other. They spoke of being less "authoritative" and more "humane." They spoke of a strong sense of partnership. Midwives, especially, described feeling empowered and finding new purpose in their work. Many reported seeing a shift of responsibility from doctors to midwives and several commented on how especially relevant this new role could be in a rural context.

The RCs and RCT members also spoke of a camaraderie that had started at the Perm Launch Conference and that only grew stronger with each opportunity to interact with other regions and learn of their experiences. They clearly relished opportunities to participate in meetings and

courses together and to visit others' sites. They also relished hosting courses in their region so they could reciprocate and show off their own work. They were very open and candid when describing and sharing challenges and implementation issues.

Many voiced a strong need to bring federal regulations into line with the new practices. Many non-Project sites were eager to adopt Project approaches but were concerned about being in violation of federal mandates without the "protection" of being a designated MCHI facility. For example, authorities are cautious about allowing partnership deliveries because they are in violation of the federal regulations.

The amount of change that has occurred and the potential for continued achievement and further expansion within the target regions is great.

C. Reproductive Health Programming for Youth Strengthened

MANDATE

The **Result "***A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions*" was to be achieved via the following **Task:**

1. "*To develop a comprehensive reproductive program for youth, an MCHI interregional working group on youth reproductive health shall be established. This group will consist of representatives from the regions, MCHI consultants and staff. The working group shall review existing programs, regional, national and international experience on reproductive health programs on youth and develop a comprehensive reproductive health program for youth including policy document, training curriculum for health providers, information for youth, follow-up and monitoring and evaluation plans. The Program shall be implemented in at least 2 of the MCHI regions.*"

IMPLEMENTATION

By design, MCHI would have been expected to reach thousands of youth, especially those between the ages of 15 and 24, because of its MCH and RH mandate. Youth receive reproductive health services and related counseling through maternity houses, pediatric polyclinics, women's consultation centers, and specialized family planning and HIV/AIDS centers in all sites. All types of sites are frequented by youth, in varying degrees in different regions. In fact, MCHI's 2004 Baseline Facility Survey showed that, in about half of the MCHI regions, youth aged 15-24 made up the majority of both antenatal and family planning clients but less than the majority of abortion clients.

This group usually has specific characteristics not addressed by programs designed primarily for adults and thus merits its own special focus. In Russia, as in most industrialized countries, youth are at increased risk of unwanted pregnancy, abortion, STIs and HIV infection (including an increased biological vulnerability to STIs/HIV/AIDS), and other negative health outcomes.

Early on, MCHI conducted a technical and programmatic review of existing attempts to reach youth in the Project regions. An initial working group was formed in January 2005 and met in March to hear representatives from Barnaul in Altai Krai and Velikiy Novgorod in Novgorod

Oblast present their experiences and challenges working with youth. In August 2005, 14 representatives from four Project regions – Barnaul in Altai Krai, Novgorod Oblast, Orenburg in Orenburg Oblast, and Tyumen Oblast – participated in a five-day "summer school" in Barnaul for volunteers working in the field of youth health care.

In time, additional regions expressed interest in youth programming so that in November 2005, representatives from eight Project regions – Barnaul in Altai Krai, Khabarovsky Krai, Komi Republic, Novgorod Oblast, Orenburg in Orenburg Oblast, Primorsky Krai, Tyumen Oblast, and Vologda Oblast – joined MCHI staff and consultants in Moscow to form the Inter-regional Working Group on Youth Reproductive Health (WGY). The WGY reviewed Russian and international experience regarding youth, agreed to develop MCHI Youth Programming Guidelines, made preliminary plans for a workshop on youth-friendly services to be held in March 2006, and agreed to participate in a training workshop on initiatives to recruit and support youth reproductive health volunteers to be given in Altai Krai by the Barnaul-based NGO "Siberian Initiative" in early 2006.

The WGY members did participate in the "Siberian Initiative" workshop and, in March 2006, MCHI conducted a training course on youth-friendly services for these eight Project regions plus Irkutsk Oblast, using an adapted version of the EngenderHealth Youth-Friendly Services manual.

In April 2006, Barnaul and Altai Krai hosted a Conference on Multisectoral Collaboration for Youth Programming with the active participation of Altai Krai and Barnaul City government officials. Representatives from the health, education, social support, and youth sectors of eight MCHI regions participated and learned about intersectoral collaboration in the field of youth reproductive health, the regional experience in conducting youth programs and the Barnaul City program for adolescents. The Conference included site visits to the Barnaul City youth facilities. Participants developed plans for their regions, using lessons learned from Barnaul and Altai Krai.

Participants also reviewed the draft MCHI Youth Programming Guidelines that had been developed by MCHI and the WGY. The finalized Guidelines were then presented at the MCHI End of Project Conference in May 2006 and posted on the MCHI website.

Youth Reproductive Health Programs in MCHI Regions

Three MCHI regions (Altai Krai, Novgorod Oblast, and Orenburg Oblast) produced their own local youth strategies and in some cases used a replication package that included WIN training materials. These programs tended to have started before MCHI; in Velikiy Novgorod, the WIN advocacy network was utilized to include educational as well as health structures. Each one was unique. While effectiveness data is generally not available, Barnaul in Altai Krai noted that its UNICEF-sponsored program had led to "improved effectiveness, including lower abortion rates among youth." In another three MCHI regions (Tyumen Oblast, Primorsky Krai and Khabarovsky Krai), there were programs for youth that reflected one or more pieces of a comprehensive youth package. For example, in Primorsky Krai, the health authorities created a youth-friendly reproductive health curriculum for medical students. Also, USAID's "US-RFE Partnership Activity Health Partnerships" supported the creation of a Health Fair Center to sustainably increase regional capacity to conduct health fairs promoting healthy lifestyles, with youth as a targeted group. In Tyumen Oblast, programming included a new "parallel" site at the University to reach young adults. Other MCHI regions have programs that target youth in high-risk groups.

RELEVANT INDICATORS

Supportive Policy Environment

- Number of regions including reproductive health youth-friendly services in their official policies: **6 (Barnaul city in Altai Krai, Velikiy Novgorod city in Novgorod Oblast, Orenburg city in Orenburg Oblast, Komi Republic, Primorsky Krai, Khabarovsky Krai)**

Organizational Capacity

- MCHI working group on reproductive health youth-friendly services organized as a part of MCHI Interregional Working Group: **Yes, functional**

Reproductive Health Youth-friendly Curriculum Introduced in Facilities

- Number of providers in MCHI facilities trained on youth-friendly services: **23**

Reproductive Health Youth-friendly Services Implemented in Selected Facilities

- Number of MCHI facilities implementing youth-friendly services: **14**

CONCLUSIONS

The Inter-regional Working Group on Youth Reproductive Health was functional and appeared effective. Many more than two regions demonstrated a specific interest in youth programming and had functioning programs of varying types. Although MCHI did develop useful Youth Programming Guidelines, it is too early to assess the extent to which they were put into practice. Clearly there is great interest in youth and a deep recognition of the importance of addressing youth's special needs. The task is not an easy one, but it would be a wise choice for any donor investing in Russia to consider a focus on youth.

The mid-term evaluation noted that international standards require that when the target group is youth, youth should have a voice in reviewing planned interventions. Various options were suggested: add one or more youth to the WGY directly or create a Youth Advisory Committee to work with MCHI and the WGY. Subsequently, representatives from youth organizations were included in the WGY, the Guidelines review process, and the Altai Krai/ Barnaul conference.

D. Male Involvement Emphasized

MANDATE

The **Result** "*Access to reproductive health services and information for men increased in the targeted regions*" was to be achieved via the **Task**:

1. "*The Contractor, together with its Russian partner, shall develop appropriate strategies and interventions to increase male participation in family planning counseling and other reproductive health services. The Contractor shall propose a coordination strategy outlining linkages with Healthy Russia 2020 in regards to planned communication interventions on reproductive health issues.*"

Additionally, under **"Gender Involvement,"** the Contract notes, *"Although the primary focus of this activity is improving health care services for women and infants, gender integration is an important component of the proposed activity. The new activity must include information and communication interventions targeted at both women and men beneficiaries. Men play a crucial role in the decision-making process around family planning issues. Men and families in general should be encouraged to benefit from the comprehensive family-centered maternal care approach as active family member participants. The activity should reach male audiences through communication interventions as well as services offered by the targeted health facilities. This activity should also focus on creative models of increasing male participation in reproductive health issues."*

IMPLEMENTATION

In the Russian context, the social and psychological barriers to men seeking care are well-documented and pervasive, making increased access to reproductive health information and services an important priority for MCHI. MCHI supported information and communication interventions targeted at both female and male beneficiaries and supported service delivery interventions that created a positive environment for increased male access to participation in reproductive health care for themselves and their families.

MCHI developed appropriate strategies and interventions to increase male participation in family planning counseling and other reproductive health services. These included interventions in training, communications, monitoring, and follow-up visits that supported male involvement. MCHI also emphasized male involvement in several training programs for providers, especially in family planning counseling, and used each additional training component as a way to reinforce methods for increasing male involvement in reproductive health care. The site-based monitoring tool for follow-up visits also reflected this concern for male involvement.

An anticipated critical partnership for MCHI in the area of male involvement and communications was its alliance with Healthy Russia 2020 (HR 2020). A Coordination Strategy for joint actions was developed and approved by USAID/Russia in February 2004 that included a "Couples Campaign." Research results and experts were used to design the campaign, whose overall goal was "to promote creating habits of responsible behavior for improvement of reproductive health of men and women in regions of Russia." There were specific objectives related to increasing awareness, changing attitudes, and changing behaviors of both men and women aged 18-35. The intent was to provide measurable support to increasing reproductive health awareness, changing male attitudes, and changing male behaviors related to family planning, mutual care for partners including risk for STIs and HIV, the importance of communication about reproductive health issues between couples, and abortion. A reportedly well-defined monitoring and evaluation component was to advise MCHI RCTs on progress as the Campaign progressed and to alert them to any recommended mid-course adjustments.

Initially, HR 2020 was to conduct the Couples Campaign in the then 14 MCHI regions using the following components: radio and TV spots and talk shows; print materials for men and women;

booklets for service providers; magazine and newspaper articles; and advocacy events. In support of the Couples Campaign, Healthy Russia 2020 developed a workshop curriculum to train representatives from all MCHI regions in "Effective Communication Programs in the Area of Reproductive Health." This workshop, after considerable delay, was finally conducted in April 2005 in preparation for the launch of the Couples Campaign. The training was to assist MCHI regions in best utilizing and supporting the Couples Campaign events and materials and in effectively planning to use their own resources to support the Campaign's aims.

After training the MCHI regions, the launch was then postponed again to October 2005, by which time Healthy Russia had decided to launch the full Campaign in only four Russian regions, of which only two – Irkutsk Oblast and Orenburg Oblast – were MCHI regions. However, HR 2020 did indicate that their "Couples Campaign" materials – posters, cue card, fact sheets, stickers for public transportation, brochures, TV spots, and radio spots – would be made available to all regions. Ultimately, HR 2020 agreed to also carry out a full-scale Campaign in the two regions – Vologda Oblast and Tyumen Oblast – that would pilot MCHI's new rural family planning component.

The Campaign was launched in October 2005 in Irkutsk Oblast and Orenburg Oblast and in March/April 2006 in Tyumen Oblast and Vologda Oblast. Ten regions received sets of printed materials and, by the end of 2006, three additional regions – Altai Krai, Krasnoyarsk Krai and Primorsky Krai – were to not only receive printed materials, but also the whole package of technical assistance for a full Campaign.

RELEVANT INDICATORS

Practices Supporting Partner/Family Involvement Introduced in Antenatal Care

- Percent of antenatal women who had a partner with her during antenatal visits:

2004	2006
14.4 %	**22.4 %**

Practices Supporting Partner/Family Involvement Introduced in Labor and Delivery Care

- Percent of postpartum women who had partner/family support during labor and delivery:

2004	2006
12.5 %	**29.2 %**

Practices Supporting Partner/Family Involvement Introduced into Family Planning

- Percent of antenatal clients who report discussing contraception with their partners:

2004	2006
Not asked	**Not asked**

- Percent of postpartum clients who report discussing contraception with their partners:

2004	2006
72.7 %	**71.6 %**

- Percent of post-abortion clients who report discussing contraception with their partners:

2004	2006
78.4 %	**79.6 %**

CONCLUSIONS

Considerable attention has been given to increasing active male participation and support at multiple junctures. Adult males and youth have visibly benefited from improved physical and emotional access to reproductive health care in MCHI facilities. FCMC, especially, with its emphasis on partnership deliveries and the active involvement of partners during labor, has completely changed the atmosphere in the maternity houses. Men are not only allowed into spaces formerly reserved for women and health care providers alone, but they are also invited in and supported in their new roles by nurses, midwives, doctors and others. Literally everyone who made a site visit commented on the visibility of male partners: holding their newborns, massaging their partners while they labored, holding hands, and talking to the women they cared about. Male participation, including that of youth, increased not only in labor and delivery, however, but also with regard to breastfeeding support, family planning, post-abortion care, and counseling. Gender integration is considerable.

The substantial delays and incomplete coverage of the multi-media campaign addressing male involvement were beyond the reasonable control of MCHI, as the technical design of the actions was the primary responsibility of a partner organization. This may well have had an impact on MCHI's final results regarding men's increased access to both reproductive health services and information. The two indicators measuring couple communication were basically unchanged (postpartum couples showing a slight decrease and post-abortion couples showing a slight increase). The Campaign's expanded reach to more of the MCHI regions is a welcome action.

E. Medical School Involvement Encouraged

MANDATE

The **Result,** "*Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated*" was to be achieved via two **Tasks**:

1. "*A respected national Russian entity shall be identified by the Contractor to facilitate the introduction of the protocols developed based on internationally recognized standards into basic medical school educational materials. This organization can either be the same Russian partner selected to assist with the replication component, or another. The Contractor shall identify one or more potential candidates suitable for this partnership and a list of proposed selection criteria.*"

2. "*Medical school curricula shall be revised to include the latest internationally recognized MCH standards and procedures for inclusion in the local and national medical school educational materials. A team representing the Contractor, the Russian counterpart, and faculty members from selected medical institutions shall be created to*

oversee the achievement of this task. This activity will be the start of a long-term effort toward introducing change into the medical education curricula in Russia, working closely with the selected counterpart."

IMPLEMENTATION

From the beginning, MCHI thought it desirable that the "*Russian organization with a strong maternal child mandate"* with which it would choose to partner overall should also be the *"respected national Russian entity to facilitate the introduction of the protocols developed based on internationally recognized standards into basic medical school educational materials."* And, indeed, had MCHI been looking only for a partner to work with on medical education, RSOG would likely have been its first choice.

One of the MCHI selection criteria for inclusion in the Project was the existence of a medical school in the region. All selected regions except Sakhalin Oblast have a medical academy, university, school, or college that trains doctors, nurses, or midwives. Ten of the 16 regions have medical schools that train physicians. The regional working groups almost universally include representatives from the pediatric and ob-gyn departments of these institutions, and these representatives have also been included in multiple MCHI training courses. Regional medical institution representatives were also purposefully included in the Interregional Working Group. After the October 2004 JSI presentation at the RSOG Annual Meeting, the dean of the Sechenov Moscow Medical Academy, generally regarded as one of Russia's most prestigious medical universities, joined the IWG. The following year, the chairman of the Department of Obstetrics and Gynecology at the Peoples' Friendship University of Russia (and also head of the Quality of Care Section in RSOG) also joined the IWG.

In March 2005, MCHI conducted a six-day orientation workshop in Perm designed explicitly for medical university and academy representatives. All but three (Kaluga Oblast, Khabarovsky Krai, Novgorod Oblast**)** of the then 14 MCHI regions were represented. The workshop combined both didactic presentations on modern perinatal and family-centered maternity care and clinical visits to the Perm pilot sites. As part of the workshop, each representative developed a strategy and plan for further integrating the Project's approaches and materials into pre-service and post-graduate curricula at their home institutions.

RELEVANT INDICATORS

Changes in Medical School Curricula

- Number of regional medical schools curriculum revised to include new MCH practices: **Anecdotally, there appears to have been real impact but given the number of individuals and institutions touched by the Project (see below), a meaningful and accurate assessment of curricular change was beyond MCHI's current scope.**

Technical Capacity of Medical Schools

- Number of representatives of regional medical schools trained in Project courses and workshops: **In all, 117 faculty members from 23 separate institutions were trained in MCHI courses and workshops.**

CONCLUSIONS

The introduction of internationally-recognized, evidence-based standards for selected maternal child health interventions into the pre-service and post-graduate curricula of training institutions for physicians, nurses and midwives has been initiated in all of the MCHI regions having such institutions, as well as in a major state medical academy in Moscow.

Faculty members from regional medical schools have been an integral part of all MCHI components at multiple levels as committee members, trainers, and participants. However, to move beyond these important first steps will require a much more focused and explicit program to which Russian institutions would likely be highly receptive.

F. Family Planning Capacity and Services Strengthened

MANDATE

Two related **Results**, "*Family planning services, with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions*" and "*Family planning capacity strengthened in the regions and at the national level*" were to be achieved via eight main **Tasks**:

1. "*To strengthen family planning activities the Contractor shall provide more training in sites, with a special focus on pos-partum and post-abortion clients as counseling of these women is one of the main issues in provision of family planning services. To improve continuity of care, linkages between women's consultations, maternity hospitals and children polyclinics should be increased. Pediatricians and pediatric nurses should be trained to provide family planning education and counseling to post-partum women during both home and policlinic visits"*
2. *"To reinforce training and assist in implementation, regular follow-up visits will be established. Experienced family planning consultants should help to consolidate and ensure skills in newly introduced practices; identify problems preventing application of new skills in clinic routine; assist medical providers in seeking adequate solution to problems; and support collaboration and knowledge transfer between providers and clients."*
3. *"To increase a core group of family planning experts, training of trainers on counseling skills and in-depth technical family planning issues for regional representatives, Russian Society of Obstetricians-Gynecologists (RSOG) and medical schools should be provided. MCHI master trainers (trained under WIN) will begin to train a core group of family planning/ reproductive health trainers from participating regions (usually members of RSOG). This core group of trainers will consist of staff from regional and city Family Planning Centers, Ob/Gyn Department of Refresher Training Institute, Medical College for Nurses and Midwives and Medical Institute/ University/ Academy. These local trainers will learn to use MCHI Family Planning/ Reproductive Health and HIV/AIDS Prevention Training Package. The Package will include the male involvement module to help establish a male-friendly environment at Women's Consultation Centers, Maternity Hospitals and Family Planning Centers. Family planning local trainers will conduct FP/RH training activities for all obstetrician-gynecologists, nurses, and midwives from participating facilities in the region. Mid-level personnel in gynecology, women's*

consultation centers and Family Planning Centers will be trained to provide group family planning education sessions in in-patient settings.“

4. *“The project should collaborate with pharmaceutical companies to increase access and availability of family planning methods and information at pilot sites.”*
5. **“***Organize MCHI Family Planning Task Force.”*
6. “*Develop family planning curriculum for post-graduate education at medical schools.”*
7. “*Conduct a second round training of trainers (TOT) on family planning for selected MCHI regions.”*
8. “*Enhance regional work with mass media on family planning.*”

IMPLEMENTATION

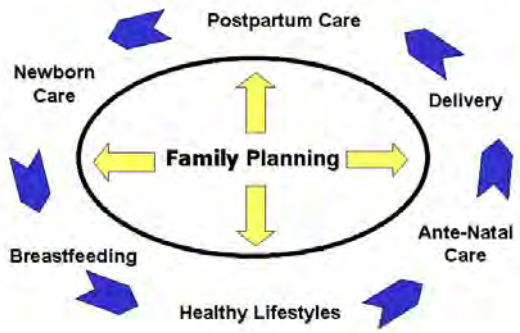
Russian families face a number of constraints with regard to receiving quality family planning services. The external environment has changed markedly since the federal family planning program was discontinued in 1999. Less sex education, including family planning information, is reportedly available in schools due to lack of legislative support and religious opposition. The federally-mandated free package of obligatory services includes maternity care and abortions but not family planning services. Fortunately, some regions do cover family planning services out of their own funds, including the provision of free contraceptives to high-risk groups. Free contraceptives, however, appear to be very limited and only include oral contraceptives, intrauterine devices (IUDs), and sometimes condoms. Definitions of high-risk groups vary and generally include a combination of low-income women, students and adolescents, and “vulnerable” populations.

The range of available modern methods is unnecessarily narrow. Oral contraceptives, IUDs, condoms, and emergency contraception seem widely available, although access for rural populations is more restricted. At one point, the registration for Depo Provera lapsed so the availability of injectables has been intermittent. Norplant was introduced in Russia in the mid-90s but was not re-registered once its initial registration expired; consequently, it is not currently available. Age and parity restrictions limit access to female sterilization nationwide. Vasectomy counseling and services are not available.

Provider barriers are extreme. The quality of counseling reflects many of these problems. The pharmacies in Russia have all now been privatized. Pharmacists can give information about contraceptives but cannot “counsel.” Only ob-gyns can provide contraceptive methods; other physicians and other health care providers can only “counsel.” Russia is attempting to introduce the concept of family medicine. Currently, a family medicine doctor could provide counseling but could not, for example, insert an IUD.

Given this context, the very first training courses offered by MCHI to the initial 10 new regions focused on family planning. In May 2004, a six-day Family Planning Training of Trainers course was held in Moscow in which two to three people from each of twelve regions participated (the ten new regions plus the two prior WIN regions). Some of those trained had the almost immediate opportunity to participate as co-trainers in four-day family planning courses offered in multiple sites (see *Appendix F: Training by Region and Topic*). Only one original WIN region, Novgorod Oblast, did not receive additional family planning training at the very start of the Project. In addition to the courses mentioned, the expectation was that the new regional family

planning trainers would develop regional training plans and train a broad range of health professionals at their regional MCHI sites.



Routine MCHI follow-up visits and the comprehensive mid-term evaluation conducted by JSI in March/April 2005 found that MCHI had indeed placed needed emphasis on family planning, doing much to "horizontalize" and integrate family planning services broadly into MCH care. Multiple examples of expanded "horizontalized" family planning services incorporated into women's consultation clinics, into postpartum and post-abortion services, and into polyclinics serving adolescents were reported. Several sites reported adding staff specifically to improve the provision of family planning information.

The conclusion was that, given these efforts, the regions had a core of family planning trainers and a basic family planning training capability, and that it would be worth the time and resources to further reinforce these gains and to focus on missed opportunities at the facility level. It was also noted that more attention needed to be given to developing providers' basic fund of knowledge regarding contraceptive methods. Since family planning was the "oldest" component of the MCHI Project, its existing curriculum was consequently the oldest.

In August 2005, a Family Planning Curriculum and Materials Working Group was formed to review and update curricular content to reflect the latest evidence-based standards. Particular attention was given to the rationale for adopting evidence-based best practices and to the use of the WHO Medical Eligibility Criteria for Contraceptive Use. Attention was also given to the importance of informed choice, the health and human rights aspects of family planning, and family planning's key role within the "healthy lifestyle" concept. Additional information and materials on STIs, HIV/AIDS, and PMTCT were added as well as more emphasis on emergency contraception. Provider bias and common misinterpretations and/ or misunderstandings (e.g. nulliparous women can't use the IUD, specific legal requirements for tubal ligation, abortion preferable to the use of emergency contraception, HIV+ women should not give birth, vasectomy is castration, etc.) were also addressed. Attention was also given to how providers can use mass media messages and the available client materials to reinforce their counseling. The curricular format was also updated to be similar to the other MCHI curricula, with a comprehensive Trainers' Manual and a comprehensive Participants' Manual with copies of all slides used in presentations. The intent was that the family planning training course be user-friendly and accessible to new trainers who might not be as experienced as the Project's master trainers.

A workshop for four family planning master trainers was held in January 2006 to review the completed curriculum, after which these master trainers facilitated a family planning TOT for prospective trainers from seven regions. The majority of the prospective trainers came from the two rural pilot regions – Vologda Oblast and Tyumen Oblast – while four additional regions – Irkutsk Oblast, Komi Republic, Orenburg city in Orenburg Oblast and Primorsky Krai – sent smaller teams. Soon after the TOT, trainers from Primorsky Krai and Vologda Oblast co-facilitated the family planning course for the Sakha Republic (Yakutia) using the new

curriculum, while other trainers from Orenburg and Vologda Oblast facilitated the family planning course for Sakhalin Oblast.

By June 2006, a complete set of the new family planning training materials had been posted on the MCHI website.

When MCHI launched its activities, it approached three pharmaceutical companies looking for partnerships with regard to family planning. Six months later, Gideon-Richter (G-R) responded enthusiastically; no other company responded. Present in all 16 MCHI regions, G-R sells some of the least expensive contraceptives in Russia and, in some regions, its contraceptives are included in the essential drug lists and are disseminated free of charge. Gideon-Richter participated in regional training and helped to disseminate informational materials in maternity hospitals.

In addition, Gideon-Richter supported the reprinting of MCHI family planning materials and helped to create new educational materials for regional health workers. G-R also disseminated MCHI materials in non-Project regions, thus furthering the reach of the Project.

RELEVANT INDICATORS

See Section IV.J: Abortion Rates Decreased and Use of Modern Contraception Increased below.

CONCLUSIONS

Although updated in the Project's final year, the new family planning curriculum should still be very useful to many, given its user-friendly structure and approach.

The family planning master trainers with the longest involvement with MCHI were justifiably skeptical at first about a family planning curriculum that highlighted counseling so boldly, even though the curriculum was clearly evidence-based and used the WHO *Medical Eligibility Criteria for Contraceptive Use* as its foundation. They were concerned that doctors especially would want a curriculum that highlighted the medical aspects of the various methods (i.e., the contraceptive technology), although when asked what provider skills most needed strengthening, all the trainers identified counseling as the weak link in service provision. Since its introduction, the new curriculum has been reportedly well-received when used in the field and should be an extremely useful tool for IFH and the MCHI II Project, as will all the curricula developed by MCHI over the years.

Gideon-Richter has been an excellent and very helpful partner for MCHI. MCHI estimates that the partnership has enabled the project to save over $20,000 in materials and supplies, savings that the Project put toward further regional training.

G. Family Planning Extension into Rural Areas Piloted

MANDATE

Contract modification #5 added the **Result**, "*Integration of family planning into primary healthcare services piloted in selected rural areas in at least two regions with high abortion rates,*" which was to be achieved via the **Task**:

1. *"Develop a model of family planning services in rural areas in selected MCIII regions through family planning practitioners and rural primary medical units. After piloting, the model should be included in MCHI Replication Package."*

IMPLEMENTATION

For multiple reasons, Vologda Oblast and Tyumen Oblast were chosen to be the two regions piloting the implementation of a new rural model. Both Oblasts had progressed quickly in adopting and integrating the various components offered by MCHI into their initial target sites. Both showed good teamwork and had indicated an interest in and openness to increased involvement in the MCHI Project. Both had higher than average abortion rates and reflected Russia's low overall population density. Both Oblasts also offered the potential of additional strong local partners and possibly some co-financing from their Oblast budgets.

The expectation from the beginning was that each of the two regions would implement its rural model in the way that most made sense for that region. However, MCHI's strategy for the rural pilot involved some elements that would be common to both:

- Expanding the involvement of Oblast-level facilities to provide the opportunity for linkages to be forged between the rural District facilities and their urban counterparts;
- Offering the new Family Planning Training Course in the two pilot Oblasts first;
- Providing equivalent training to both urban and rural providers;
- Potentially extending rural integration beyond the current Project "borders" (i.e. the confines of health facilities) to partner with additional cadres of health care providers, pharmacists, educators, private enterprises, and other community resources;
- Involving the press and media from the beginning; and
- Using relevant, successful rural models in other post-Soviet countries as motivation and inspiration.

Thus, initially, in September and October 2005, MCHI held three-day assessment and planning visits in each Oblast, including field visits to rural Districts. A three-person delegation from Tyumen Oblast participated in the initial planning visit to Vologda Oblast in advance of the similar assessment and planning visit scheduled later for their Oblast.

In late November, representatives from Vologda and Tyumen Oblasts participated in a study tour to Romania to visit the USAID-supported Romanian Family Health Initiative (RFHI) implemented by JSI Research & Training Institute, Inc. throughout Romania to discuss firsthand the challenges and opportunities encountered during the planning and implementation of a nationwide project designed to bring family planning services to Romania's rural areas.

As planned, when the new family planning curriculum was launched via a TOT in January 2006, teams from Vologda Oblast and Tyumen Oblast made up the majority of the prospective trainers. Tyumen Oblast and Vologda Oblast each identified four Rayons (similar to U.S. counties) to include in their rural pilot programs. By September 2006, Vologda had

hosted an Oblast-wide conference and conducted six training courses in which 156 were trained (78 midwives and feldschers, 41 non-ob/gyn physicians, 14 ob/gyns, 21 psychologists and 2 students). The long-term plan is for the trainers who were trained on the new family planning curriculum in January 2006 to travel to the pilot Rayons once a month to conduct training courses in the Rayons. Tyumen Oblast also chose four Rayons as pilot sites. By September 2006, Tyumen had conducted a mix of training courses reaching 291 midwives and feldschers, 287 nurses, 24 ob-gyns, and an array of other specialists. Additionally, the pilot Rayons had offered family planning talks to more than 1,200 women, adolescents, and students; and had offered "schools in contraception" to more than 2,200 citizens.

Among MCHI's long-term **Results** to be achieved at its conclusion are two that address family planning efforts directly: "*The abortion rate reduced in the targeted regions*" and "*Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.*" Unfortunately, the short time period between the addition of the rural pilot component and the end of the entire MCHI Project made it unreasonable to expect that Project impact could be measured for the new rural component even if a baseline were established.

Indeed, the lack of relevant rural data on which to base an implementation strategy was striking. In response, MCHI explored the possibility of locally conducting a population-based household survey (including a male component) in Vologda Oblast similar to those conducted during the WIN Project. The questionnaire used in those surveys draws heavily from the questionnaire used for the 1999 Russia Women's Reproductive Health Survey conducted by the Russian Center for Public Opinion and Market Research in collaboration with the United States Centers for Disease Control and Prevention. In October 2005, MCHI discussed and developed a draft of a questionnaire with the Vologda Research and Coordination Center of the Russian Academy of Science and in November developed indicators and a second draft of the questionnaire. Piloting of the questionnaire was completed in March 2006 and the actual survey was conducted in April. The survey report and database were received and checked by June 2006. It was very interesting to see that the rural contraceptive use findings were similar to those in the WIN surveys which covered predominately urban areas. The Vologda Health Department presented the results at the October 2006 HR 2020 Conference for Vologda Oblast and plans to use the data as a baseline to evaluate their future family planning interventions.

RELEVANT INDICATORS

None beyond the above Result and Task.

CONCLUSIONS

The small pilot component to extend family planning activities into rural rayons in two oblasts is still in its early implementation phase. Additionally, the pilot oblasts had to initially formulate their initial implementation plans with almost no data relevant specifically to rural couples. The household survey carried out in Vologda has provided some helpful information that may suggest needed strategic modifications. A thorough evaluation and reassessment after at least a few more months of implementation would do much to inform future rural-focused activities.

H. ARO Early Intervention Model Integrated

MANDATE

Contract modification #2 added the **Result**, *"Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI models"* to be achieved via the following **Task**:

1. **"***The Contractor shall work with the Early Intervention Institute, its branch in Novgorod and other relevant programs to introduce early intervention activities as feasible in MCHI pilot regions and facilities."*

IMPLEMENTATION

The Assistance to Russian Orphans' Early Intervention model is designed to foster a positive emotional/psychological environment during pregnancy and childbirth and to further promote mother-child bonding. Although designed specifically to counter abandonment, it is applicable to all pregnancies and births and is very congruent with the MCHI model. Its holistic, humanistic approach highlights respect for the newborn and emphasizes the need to be "newborn-friendly" as well as "woman-friendly." Its approach is viewed as being very supportive to families with babies with disabilities.

In May 2004, MCHI and the Early Intervention Institute began exploring ways to collaborate. As a result, the head of EII's Velikiy Novgorod branch participated in the June antenatal curriculum workshop where the ARO-supported Early Intervention model and EII materials were incorporated into a reformatted antenatal curriculum. Contract modification #2 in effect "legitimized" this ongoing collaboration. Beginning with the September FCMC training in Irkutsk, the Early Intervention model was also incorporated into the FCMC training schedule, including lectures by expert trainers and the distribution of ARO/ EII materials to all participants as support for additional policy and service delivery practice changes at MCHI sites.

RELEVANT INDICATORS

None beyond the above Result and Task.

CONCLUSIONS

Integrating ARO's Early Intervention model into multiple MCHI training materials was a substantive, positive addition that has especially strengthened the counseling component of these courses.

I. PMTCT and Family Planning for HIV+ Women Addressed

MANDATE

Contract modification #5 added two related **Results,** "*Family planning and prevention of mother-to-child transmission of HIV (PMTCT) capacity strengthened at HIV Centers*" and

"*Family planning integrated into counseling services for HIV-positive women*" which were to be achieved via four main **Tasks**:

1. *"Build capacity of the Federal Research Center for Health Care of HIV-Positive Women and Children, Federal AIDS Prevention Center, and Regional HIV Centers on family planning and PMTCT."*
2. *"Carry out needs assessment on family planning among HIV-positive women."*
3. "*Develop guidelines on family planning counseling of HIV-positive women."*
4. "*Organize and conduct a conference on family planning and PMTCT in coordination with MOHSD, UNICEF and other international organizations."*

IMPLEMENTATION

Increasingly, as WIN was ending and MCHI was beginning, Russia's attention and the attention of USAID/Russia turned to Russia's worsening HIV/AIDS situation. Although PMTCT was not included in the original Contract, MCHI and USAID/Russia agreed from the very start of the MCHI Project that HIV/AIDS and PMTCT would receive major attention within the MCHI project. MCHI also recognized early on the importance of helping to create the needed linkages between the regional HIV/AIDS Centers and the maternity houses/women's consultation clinics/pediatric polyclinics that would enable them to work together more efficiently to provide care to HIV+ pregnant women and their infants.

Training Materials/ Evidence-Based Practices

The first step was to begin integrating HIV/AIDS and PMTCT information into the MCHI training materials. MCHI immediately began collecting relevant materials dealing with current Russian statistics, risk assessment approaches, counseling and treatment issues, infection control standards, and PMTCT guidelines for review, adaptation, and incorporation. Handouts for MCHI consultants and trainers were developed and PMTCT materials were added to the replication packages.

Consequently, the December 2003 MCHI Three-Year Workplan gave considerable attention to HIV/AIDS prevention generally and PMTCT specifically. At the February 2004 MCHI Launch Conference, PMTCT was included as one of the core integrated MCHI internationally-recognized, evidence-based practices. At the same time, PMTCT was added to the existing breastfeeding curriculum. In March 2004, MCHI staff participated in USAID/Russia's two-day workshop on the Mission's new HIV/AIDS strategy. As agreed to with Healthy Russia 2020, new PMTCT materials – cue cards, brochures for clients, leaflets for providers – were collaboratively developed.

MCHI also sought from the beginning to involve itself with the major Russian individuals and institutions dealing with PMTCT such as the Federal Scientific Center for the Prevention of HIV/AIDS; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's Department for HIV/AIDS Control; the Federal Research Center for Health Care of HIV+ Women and Children; and the Federal Pediatric AIDS Clinic, as well as with the regional HIV/AIDS Centers in the MCHI regions.

Russia currently does not have a confidential voluntary counseling and testing (VCT) system. Widespread involuntary testing occurs, including the testing of pregnant women. Reportedly, a federal *prikaz* mandates HIV testing of all pregnant women at various stages of pregnancy. Children born to HIV+ mothers are registered and tested at regular intervals until the age of 18 months, at which time they are removed from the registry if all tests are negative. Unfortunately, if abandoned, these children are generally institutionalized during most, if not all, of this time period. Another donor is reportedly supporting efforts to reduce the length of time these children are surveyed before being removed from the registry if they continue to test negative.

PMTCT Guidelines

In September 2004, a two-day "PMTCT in MCHI Regions" workshop was held in Irkutsk for all MCHI Regional Coordinators and representatives from their HIV/AIDS Centers. Other participants included the head of the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's Department for HIV/AIDS Control and representatives from USAID/Russia, AIHA's Ukraine PMTCT Project, and the Elizabeth Glazier Foundation. Reportedly, the MCHI regional teams at that meeting indicated a very strong need for clinical/organizational guidelines to improve the quality of PMTCT services.

A MCHI working group on PMTCT guidelines was formed and began collaboration with the MOHSD's Institute for Management and Communication for Health in November 2004. By February 2005, draft guidelines were ready for wider review.

This first draft of the PMTCT Guidelines was distributed to the MCHI regions by early March and, in mid-March, MCHI hosted a PMTCT Guidelines Workshop in St. Petersburg. Participants again included all MCHI Regional Coordinators and the heads of their HIV/AIDS Centers; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare; USAID/Russia; and, in addition, MOHSD's Institute for Management and Communication for Health, the head of MOHSD's Center for Assisting Pregnant Women and Children with HIV and the deputy head of MOHSD's Mother and Child Health Department.

In September 2005, a draft of MCHI's PMTCT Guidelines was distributed to MCHI's Regional Coordinators. In October, the Guidelines were presented at the National HIV/AIDS Conference in Suzdal. After final review and revision, in December, the PMTCT Guidelines received official approval from both the MOHSD and the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare. In May 2006, MCHI sent the regions a set of presentations on the PMTCT Guidelines. Within the framework of the National Health Project in HIV/AIDS, 5,000 copies were printed and distributed.

PMTCT Coordination

As HIV/AIDS generally and PMTCT specifically developed as areas of major concern and increasing activity, the need to collaborative and coordinate also grew. To meet this need, the

MOHSD created a Coordinating Council on PMTCT whose membership includes representatives from institutions like the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNFPA, WHO, and USAID, as well as representatives from some of the USAID-funded health projects, including MCHI.

In late 2004, MCHI did a small survey of the maternity care received by HIV+ women in Perm City Hospital #21. When the results were analyzed and presented to the MOHSD Coordinating Council, the consensus was that there was a great need for more information regarding PMTCT practices and the family planning services and options available to HIV+ women.

At the same time, USAID/Russia also recognized the need for greater coordination among the USAID-funded health projects that often worked with the same counterparts in the same sites. In addition to a closer coordination of activities so as to avoid duplication and achieve synergy, there was also the need to ensure the consistency of key messages in materials and training courses. Equally important was the desire that all the USAID-funded groups be able to contribute to policy discussions in a timely way and that activities and achievements be presented to the MOHSD in a coordinated manner. In early 2004, USAID/Russia asked MCHI to take the lead in coordinating the various USAID-funded projects with regard to PMTCT. A formal agreement between MCHI and USAID was developed, and, as of February 2005, MCHI assumed responsibility for coordinating the PMTCT component among the USAID-funded health projects. This role included serving as the key communication channel on PMTCT with the MOHSD.

This arrangement did not work entirely as planned as some CAs were not happy with MCHI's role. In practice, MCHI continued bilateral collaboration. AIHA participated in the development of the PMTCT guidelines and MCHI shared its materials with them. URC used our MCHI's family planning materials and trainers and MCHI presented the findings from the PMTCT+FP study at the URC meeting in Saratov.

PMTCT+FP Study

MCHI staff increasingly recognized the need to know more about 1) family planning method use among HIV+ women, and 2) existing PMTCT practices in order to better understand the challenges related to family planning and PMTCT among HIV+ women. In order to develop evidence-based strategies for improving the quality of family planning and PMTCT services for HIV+ women, additional Russia-specific data-based information was needed. A study to collect such data was proposed.

MCHI staff collaborated with Russian experts to develop the study design. The objectives were to collect quantitative information on: 1) the awareness of family planning options among HIV+ women who have recently delivered or had an abortion; 2) the use of modern contraceptive methods by HIV+ women; 3) the involvement of HIV+ women's partners in decision making about family planning issues; 4) healthcare workers' counseling of HIV+ women on family planning; 5) HIV testing practices; 6) PMTCT practices in the antepartum, peripartum and postpartum periods; and 7) the risk of MTCT. The study also was designed to look at social and demographic factors and the prevalence of STIs and other risk factors. Additionally, the prevalence of stigma and discrimination by healthcare workers of HIV+ women was to be

determined, as well as the HIV+ women's level of satisfaction with the healthcare provided to them.

Strong safeguards to assure informed consent, privacy and confidentiality were built into the study design. Eight regions with various HIV prevalence rates and previous experience with quality data collection were selected as study sites: Altai Krai, Irkutsk Oblast, Khabarovsky Krai, Krasnoyarsk Krai, Murmansk Oblast, Orenburg Oblast, Perm Oblast, Primorsky Krai and Tyumen Oblast.

As a follow-on to the mid-March PMTCT Guidelines Workshop in St. Petersburg, the resulting study protocol was reviewed and discussed by a wide range of individuals and institutions: MOHSD and MOHSD's Center for Assisting Pregnant Women and Children with HIV; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare; USAID/Russia; the MCHI regions' Mother and Child Health Departments; and HIV/AIDS Centers. It was also reviewed by two of JSI's core competency centers – the JSI/WEI Center for HIV/AIDS and the JSI Center for Health Information, Monitoring and Evaluation (CHIME).

In April 2005, representatives from the eight study regions received training on the special demands of conducting the PMTCT+FP Survey plus refresher training in data collection. After pre-testing, the Survey data was collected in May. Data analysis was completed in March 2006. A draft report was completed by June and the final version completed in November.

Reproductive Health Guidelines for HIV+ Women

In December 2005, MCHI began developing a set of family planning guidelines for HIV+ women after reviewing relevant international data and research on this topic. By June 2006, a first draft of the Reproductive Health Guidelines for HIV+ Women was ready for review. The final version was approved by MOHSD, the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare, and USAID and was then presented at the National HIV/AIDS Meeting in December in Suzdal and the PMTCT Conference in Moscow. Once finalized and approved by the national-level experts, the Guidelines were incorporated into the National Health Project in HIV/AIDS and 5,000 copies were printed by the MOHSD for distribution to the regions participating in the National Health Project.

Conference on Family Planning and PMTCT in coordination with MOHSD, UNICEF and other international organizations

Rather than hold one conference, it was decided to take advantage instead of multiple other opportunities to disseminate the work being done in this area. In addition to the May 2006 MCHI Final Dissemination Conference, "Improving Quality of Medical Care of Women and Infants: The MCHI Experience," where the session on PMTCT also constituted part of the concurrently occurring Eastern European and Central Asian HIV/AIDS Conference, presentations and dissemination occurred at the MOHSD's Maternal and Child Health Conference in Moscow, at the National HIV/AIDS Meeting in Suzdal, and at the PMTCT Conference in Moscow.

RELEVANT INDICATORS

Supportive Policy Environment

- PMTCT integrated in MCHI working plans in the regions: **Yes (all)**
- Number of regions institutionalized PMTCT in their official policies: **16 (all)**

Organizational Capacity

- MCHI PMTCT working group organized as a part of MCHI Interregional Working Group: **Yes**
- RSOG included PMTCT in their agenda: **Not officially**
- RSOG/MCHI meetings to follow-up on planned PMTCT activities: **No, see Section IV.A: "Legacy" Russian Partner Organization Identified**

PMTCT Practices Implemented in Antenatal Care

- Percent of antenatal clients who report that they were counseled on HIV/AIDS and STI prevention:

2004	2006
49.2 %	**51.6 %**

PMTCT Practices Implemented in Postpartum Care

- Percent of postpartum clients who report that they were counseled on HIV/AIDS and STI prevention:

2004	2006
34.1 %	**46.8 %**

PMTCT Practices Implemented in Family Planning

- Percent of family planning clients who report they were counseled on HIV/AIDS and STI prevention:

2004	2006
54.0 %	**47.4 %**

- Percent of post-abortion clients who report they were counseled on HIV/AIDS and STI prevention:

2004	2006
63.6 %	**64.2 %**

Early in MCHI when PMTCT was first being integrated into MCHI's portfolio, there was discussion of tracking the percent of HIV-infected clients who received or took antiviral treatment and the percent of newborns from HIV-positive mothers who received antiviral treatment. However, adequate baseline data were not available and these indicators were not incorporated into the monitoring and evaluation system.

CONCLUSIONS

Although not included in the original MCHI Contract, MCHI has become a major leader in Russia for PMTCT policy development and service standards of care, as well as for the overall reproductive health needs of HIV+ women. MCHI's strong technical and managerial capabilities provided the flexibility needed to allow MCHI to smoothly incorporate these major new components into their program and thus be responsive to evolving external realities and the needs of USAID/Russia. The MCHI project design provided an excellent mechanism for humanizing, "horizontalizing" and integrating the care of HIV+ women and their infants into the health care system—a need that will grow exponentially as Russia's HIV/AIDS epidemic progresses. The just recently completed PMTCT+FP Study provided valuable data for decision making to inform the development of strong future policy and service standards, laying the groundwork for the development of needed Reproductive Health Guidelines for HIV+ Women.

J. Abortion Rates Decreased and Use of Modern Contraception Increased

MANDATE

At the conclusion of MCHI, the following two **Results**, "*The abortion rate reduced in the targeted regions*" and "*Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions"* were to be achieved.

RELEVANT INDICATORS

Abortion Rate Reduced

- Number of abortions per 1,000 women of reproductive age (15-44) in cities in participating regions*****:

2003	2005
49.1	**43.2**

*****These figures are from official regional statistics and include the capital cities in 14 regions (all the participating regions but the final additional two).

Use of Modern Contraceptives Increased

- Percent of antenatal clients who report that provider discussed contraception prior to discharge from facility:

2004	2006
47.4 %	**55.0%**

- Percent of postpartum clients who report that provider discussed contraception prior to discharge from facility:

2004	2006
44.1 %	**73.2 %**

- Percent of post-abortion clients who report that provider discussed contraception prior to discharge from facility:

2004	2006
83.4 %	**95.9 %**

- Percent of clients of reproductive age currently using modern contraceptive methods in women's consultation and family planning centers:

Medical Reversible Methods	**26.4 %**	**35.0 %**
Barrier Methods	**14.5 %**	**22.7 %**

- Percent of abortion clients who got pregnant while using a contraceptive method:

2004	2006
42.5 %	**39.8 %**

- Percent of abortion clients who are planning to start using a modern contraceptive method:

	2004	2006
Medical Reversible Methods	**56.5 %**	**74.7 %**
Barrier Methods	**10.2 %**	**11.3 %**

CONCLUSIONS

Two years is generally considered too short of a time to detect changes in indicators such as contraceptive prevalence rates and abortion rates, which are also generally best measured via population-based surveys. The aggregate of official health statistics from the major urban areas of the first 14 regions certainly suggests that abortion rates in the MCHI regions are decreasing. The improvements in family planning counseling seen across a broad range of facilities, the wider access to improved services, and the provision of information through materials provided to facilities and clients as well as through mass media campaigns all support the conclusion that the MCHI activities have contributed to these documented changes.

K. Documentation and Dissemination Emphasized

MANDATE

The **Results** "*New activities included and monitored in the overall monitoring and evaluation plan. Overall project results documented and disseminated in the pilot regions and nationwide*" and *"Additional (non-intervention) regions oriented to MCHI model and up-dated replication packages"* were to be achieved via five main **Tasks**:

1. **"***Develop an educational film on MCHI practices for medical schools and facilities."*
2. *"Additional activities and results which were added under several contract modifications shall be included and monitored in the overall monitoring and evaluation plan. Overall project results should be properly documented and disseminated to obstetricians, gynecologists, pediatricians, midwives, and nurses throughout Russia by writing and*

publishing papers in influential professional journals and giving presentations at appropriate professional meetings and conferences in the pilot regions and nationwide."

3. **"***Conduct a broad MCHI Dissemination Conference with involvement of non-MCHI regions, especially those that have already participated in MCHI activities at their own cost and/or sent official letters of interest."*
4. *"Conduct a workshop to orient selected non-intervention regions interested in implementing MCHI practices, using an updated Replication Package and sharing the experience of successful intervention regions."*
5. *"Develop guidelines on MCH care and services monitoring and evaluation."*

IMPLEMENTATION

MCHI's success was aided substantially by concerted efforts to document and disseminate Project results throughout the life of the Project. The replication focus of the MCHI project design by definition supported a wide and continual dissemination of ideas and materials throughout the MCHI regions and beyond.

Initially, MCHI used a number of channels to disseminate information about the Project and the competitive selection process for participating as a region. The larger than expected application pool (39 of 89 regions applied) indicated both interest in the Project outcomes and the success of efforts to inform regions about the competition. Those regions that did apply were evaluated on selection criteria (see *Appendix D: MCHI Selection Criteria*) that included working with mass media. This attention in the selection process itself to the importance of dissemination illustrates how MCHI consistently looked for ways to promote dissemination at low or no cost to MCHI.

Ultimately, MCHI staff and health authorities in the 16 regions used media, the Internet, conferences, and other available outlets to widely share Project information and results. Although not in its SOW, as the importance of the Internet became clear and as MCHI became aware of additional opportunities that could be seized by better using the Internet for dissemination, MCHI decided to add the creation of a MCHI website to its objectives. MCHI hired a local firm to help with the design. Building on the model of the Perm Resource Center's website created under the WIN Project, a design for the MCHI website was finalized in October 2005, and the website itself was launched in January 2006 in Russian and English as www.jsi.ru. The website enables anyone – from throughout Russia, the EE/EA region, and potentially the world – to download training materials, communications materials, plans and success stories.

See for yourself!!
www.jsi.ru.

Throughout the life of the Project, MCHI staff delivered multiple presentations and wrote numerous articles that reached international as well as national audiences. *Appendix G: Dissemination of MCHI Methods and Results* presents a partial but illustrative list.

Another important channel of dissemination for MCHI models and results has been the use of formal and informal advocacy networks. Advocacy networks exist in all 16 MCHI regions, a few created by the USAID-supported Policy Project, some created independently and spontaneously, and others growing out of the MCHI-supported activities. Advocacy networks that function out of more formal organizations have occurred through the MCHI Regional Coordinating Teams and the Facility Coordinating Teams. The advocacy networks in MCHI

regions have consistently worked to disseminate MCHI methods and findings throughout the staff of Health Departments and sometimes Social Affairs Departments, as well as through various committees or councils related to women and children's health. Several regional MCHI advocacy networks work especially well with the press, including influencing journalists and public relations staff at the regional level.

Among the MCHI Regional Coordinators, networking became a common occurrence and often a method for disseminating project activities and results. These Coordinators know much about what is going on in other MCHI regions and work to share information with each other.

In 2006, MCHI's work on breastfeeding in Murmansk Oblast was featured in a La Leche League International book – *Hirkani's Daughters: Women Who Scale Modern Mountains to Combine Breastfeeding and Working.*

WIN and MCHI have widely shared their experiences with USAID and their partners in Russia, Eastern Europe, Eurasia and elsewhere. In June 2003, after the worldwide biannual JSI International Division Meeting, the first JSI Eastern Europe/Eurasia Regional Meeting was held in Washington. As previously described in Section IV.A: Legacy Russian Partner Organization Identified, JSI held its second Eastern Europe and Eurasia Regional Conference in Moscow in October 2004. Among the goals of the Conference were to share program interventions and lessons learned and to explore strategies for implementing evidence-based practices. Representatives from JSI projects in Central Asia, Georgia, Romania and Ukraine participated together with representatives from the 14 MCHI regions, MOHSD, RSOG and USAID/Russia.

In April 2005, two back-to-back meetings in Bucharest, Romania gave MCHI the opportunity to further disseminate their strategies and results. USAID/Washington sponsored an Eastern Europe regional meeting on family planning, followed by a JSI Eastern Europe Chiefs of Party meeting. The USAID regional family planning meeting grouped Ministry of Health and USAID officials, as well as USAID CA representatives, with their counterparts from throughout Eastern Europe. The JSI meeting provided more opportunities to promote the coordination, collaboration and synergy between the various JSI projects in EE/EA through sharing of materials, lessons learned and expertise. By all accounts, MCHI used these opportunities to share information and results and to gather information about next steps. A third JSI EE/EA Regional Meeting followed the June 2005 JSI International Division Meeting in Washington. MCHI was a major presenter at both the International Division Meeting whose theme was "Public Health Impact: Experiences in Scaling Up" and at the EE/EA Regional Meeting that followed. MCHI also made a presentation to USAID/Washington following the EE/EA Regional Meeting.

Finally, following the very well-received MCHI Final Dissemination Conference described below, MCHI again hosted a JSI EE/EA Regional Meeting. These two events gave representatives from all 16 MCHI regions the opportunity to share the rich experiences of MCHI with additional Russian regions, MOHSD, RSOG; and USAID/Russia as well as all JSI projects in Albania, Central Asia, Georgia, Romania, and Ukraine. In June 2006, after participating in the JSI International Division Meeting, MCHI delivered a very well-received presentation to USAID's EE/EA Regional Bureau on the Project's most significant highlights and outcomes.

Educational Film

In early 2006, MCHI signed a contract with a film company to produce a training film on FCMC to support dissemination of its key tenets. In June, filming began in Vologda Oblast covering labor, delivery, and interviews with couples. The draft version was field-tested during an antenatal training course in Tyumen Oblast and the film was finalized in December.

The MCHI Final Dissemination Conference

A Steering Committee comprised of representatives from six Project regions – Barnaul in Altai Krai, Kaluga Oblast, Perm Oblast, Primorsky Krai, Tyumen Oblast, Vologda Oblast – plus RSOG and MCHI staff began meeting in early 2006 to plan MCHI's Final Dissemination Conference.

The three-day Final Dissemination Conference, "Improving Quality of Medical Care of Women and Infants: The MCHI Experience," was held in Moscow in mid-May 2006. More than 30 Russian regions were represented among the more than 300 participants. Additional participants came from USAID, other international donor organizations, JSI's home offices in Boston and Washington, and from a range of Eastern European and Eurasian countries including Albania, Georgia, Kazakhstan, Romania, and Ukraine.

During the first two days of the Conference, regional representatives presented their results and achievements in the various MCHI component areas with the session on PMTCT also constituting part of the concurrently held Eastern European and Central Asian HIV/AIDS Conference. During the breaks, the regions also presented displays highlighting their implementation experiences and showcasing materials developed and used by each region.

The third day of the Conference was devoted to master classes on the various MCHI components: antenatal care, FCMC, exclusive breastfeeding, family planning, and youth reproductive health. Altogether, the Conference was a deeply rich experience, with many participants showing tremendous pride, enthusiasm and interest in the work being presented.

Monitoring and Evaluation Guidelines for MCH Services

Project stakeholders and others expressed considerable interest in having MCHI develop monitoring and evaluation guidelines in a "how-to" format. By May 2006, a first draft had been developed and was under review.

RELEVANT INDICATORS

None beyond above Results and Tasks.

CONCLUSIONS

MCHI has been exceptionally attentive to documentation and dissemination both nationally and internationally and has created a set of tools – IEC materials, a film, detailed replication packages, etc – that are accessible and adaptable. MCHI has become well-known and well-respected for the quality and inclusiveness of its work and has become a model for both implementing evidence-based practices and for scaling-up.

L. Hepatitis B Vaccinations in Russian Far East Supported

MANDATE

In 2004, MCHI was asked to assist USAID/Russia by taking on the Vishnevskaya-Rostropovich Foundation as a subcontractor to deliver a vaccination program for adolescents in the Russian Far East. Contract modification #2 added the **Result**, "*Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation in the Far East"* to be achieved via **Task**:

1. **"***The Contractor shall implement a Hepatitis B vaccination program for adolescents in at least one region in the Far East through a partnership with the Vishnevskaya-Rostropovich Foundation. The funds for this activity should be tracked and reported on separately*."

IMPLEMENTATION

The subagreement between JSI and the Vishnevskaya-Rostropovich Foundation was signed in November 2004, extending VRF's existing Hepatitis B vaccination program to Primorsky Krai, where the MCHI Project was already active. At the time, VRF was reportedly working with other funding sources in approximately 18 other regions. VRF reported using the same implementation strategy – utilizing the World Health Organization's "catch-up" guidelines to target adolescents who did not receive vaccine as infants – in all regions of Russia, regardless of funding source. Therefore, the addition of Primorsky Krai to the VRF portfolio provided support to an already existing but not yet nationwide program and was complementary to MCHI's work.

To reduce the incidence of Hepatitis B among adolescents, VRF built cold chain maintenance capacity and human resources by working exclusively through the existing health infrastructure. Equipment, vaccines and supplies were provided as needed and their use carefully monitored. Health workers were trained in both vaccination delivery and monitoring. Parents and school children received leaflets and schools received posters about the Hepatitis B campaign and its benefits. VRF was noted for efficient procurement and customs clearance. VRF aimed for at least a 95% coverage rate.

By December 2004, administrative procedures, including those for vaccine and cold chain procurement, were completed. Program activities began in March 2005 with a reportedly successful campaign implementation. Two no-cost extensions allowed VRF to complete the vaccination of additional cohorts and finalize the procurement of additional cold-chain and monitoring equipment. The program concluded in October 2006.

RELEVANT INDICATORS

None beyond above Result and Task (although VRF did have its own M&E plan and indicators which were included in its subcontractor reports).

CONCLUSIONS

Using already existing and successful partners such as the VRF to implement specialized activities with concrete objectives in existing Project regions likely resulted in synergy that improved health indicators for adolescents and young adults and provided good value in the efficient use of U.S. development assistance funds.

The implementation of activities, progress toward meeting expected results and deliverables, and funds for the VRF Hepatitis B vaccination program were separately tracked and reported on by MCHI as required.

M. Future of Russia Foundation "Pass-through" Monitored

MANDATE

The Future of Russia Foundation's (not MCHI's) Result, "*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 perinatal health care program at the Moscow Region Perinatal Center (MRPC) through a sub-contract with the Future of Russia Foundation"* was to be achieved by the Foundation via six specific Tasks. JSI's (not MCHI's) responsibility was outlined in the additional Task:

1. *"The Contractor shall provide administrative and financial oversight to the Future of Russia Project, and provide technical assistance as requested by Future of Russia to implement a maternal and perinatal healthcare system in the Moscow oblast and develop a state'-of-the-art perinatal health care program at the Moscow Region Perinatal Center (MRPC). The funds for this activity should be tracked and reported on separately."*

IMPLEMENTATION

At the request of USAID/Russia, JSI served as a short-term funding "pass-through" mechanism for Global Development Alliance funds that USAID wished to provide to the Future of Russia Foundation for work it was carrying out in Russia.

As requested, JSI's home office provided administrative and financial oversight from August, 2004 through October 2005. The GDA funding was originally scheduled to end in July 2005, but FORF received a three-month no-cost extension. FORF did not request any technical assistance from JSI or MCHI and, for all technical work, they reported directly to USAID/Russia.

RELEVANT INDICATORS

None beyond above Task (although FORF did have its own M&E plan and indicators which were included in its subcontractor reports).

CONCLUSIONS

JSI provided appropriate administrative and financial oversight as requested.

V. Additional Project Activities

MCHI has undertaken a number of "value-added" activities beyond the scope of the Contract that have enriched and enhanced the Project's implementation and results.

A. Website

As described in Section IV.K: Documentation and Dissemination Emphasized, as the importance of the Internet became clear and MCHI became aware of additional opportunities that could be seized by better using the Internet for dissemination, MCHI decided to add the creation of a MCHI website to its objectives, although the activity was not in its SOW.

B. National Policy: Clinical Protocol Development

In April 2006, representatives from eight MCHI regions – Barnaul in Altai Krai, Kaluga Krai, Krasnoyarsk city in Krasnoyarsk Krai, Orenburg city in Orenburg Oblast, Perm Oblast, Primorsky Krai, Tyumen Oblast, Vologda Oblast – and Moscow, together with RSOG and MCHI staff, met in Moscow to discuss and reach consensus on a range of clinical protocols covering normal birth, pre-eclampsia/eclampsia, postpartum hemorrhage, vaginal birth after previous Caesarian section, and premature rupture of membranes. These protocols were finalized, published, and then presented at the MCHI Final Dissemination Conference.

In August, the MOHSD asked MCHI to support and lead the national obstetric protocols development process and to support, participate and present at MOHSD meetings scheduled in the seven Federal Districts as part of the National Delivery Certificates Project implementation. MCHI was able to fully participate in five of these meetings. MCHI was also asked to assist MOHSD in the development of the national perinatal care strategy. In October, a joint MCHI/MOHSD workshop was convened to begin work on the national obstetric protocols. Under MCHI II, these protocols will be finalized and widely disseminated via a national conference and other avenues of dissemination.

C. Baby-Friendly Hospitals

During the WIN project, four of the five participating maternities received WHO/ UNICEF certification as Baby-Friendly Hospitals, which signifies a certain international recognition and support of their implemented changes. At the start of MCHI, Murmansk Oblast had two certified facilities and the Komi Republic had one but wanted to extend the concept to other facilities. Still other regions wanted to improve the performance of certified facilities or have a facility certified for the first time.

Integrated into their other activities, MCHI staff and consultants provided support and guidance to help the regions make desired changes. By the end of the Project, Murmansk had maintained its two Baby-Friendly Hospitals and the Komi Republic had added two more. Kaluga Oblast, Krasnoyarsk city in Krasnoyarsk Krai, Omsk Oblast, Orenburg city in Orenburg Oblast, Primorsky Krai, and Vologda Oblast had or were about to have a certified facility; and Irkutsk Oblast was working diligently on qualifying its first facility.

D. Influencing Eastern Europe: MCHI and USAID-funded Projects Outside of Russia

The project design, implementation, lessons learned, and successes of first WIN and now MCHI greatly influenced the design and implementation of several USAID-funded projects outside of Russia, especially in the EE/EA region. The Ukraine Maternal and Infant Health Project was designed in large part based on the WIN model, and nearly all the expert trainers used by the Ukraine project were trained by the WIN/MCHI expert trainers. The Healthy Women in Georgia Project also incorporated many WIN/MCHI approaches in its design and key technical staff members have visited MCHI for more in-depth technical assistance regarding curricula and training approaches. In December 2006, MCHI was invited by ZdravPlus II to share its experiences and materials with the Central Asian Republics, particularly Kazakhstan and Kyrgyzstan. MCHI's willingness and ability to provide guidance and technical assistance to other projects in the region has essentially "jump-started" these other USAID-funded projects.

In addition, the EE/EA Regional Bureau has tasked the DELIVER project (also implemented by JSI) with developing case studies of the scale-up of family planning in two countries in their region - Romania and Russia. The resulting document: *Integrating Family Planning in Russia's Health System: A Case Study of the Maternal and Child Health Initiative* will be available in spring 2007.

CONCLUSION

MCHI has been consistently resourceful, attentive, and responsive in identifying needs, responding to changing external situations, and designing "value-added" approaches to the needs identified.

The design and implementation process of the MCHI Project is an **excellent model** for similar work in other countries, especially those in the former Communist-bloc. MCHI's innovative ideas and practical approaches can be adapted by program managers and policymakers and, in fact, have already been adapted successfully in Ukraine and Georgia. Additionally, it is an excellent model for the incorporation of additional evidence-based, internationally-recognized standards of care into the Russian health care system (e.g. additional reproductive health, family planning, and HIV/AIDS interventions; tobacco; tuberculosis). Because of its client-centered, client-friendly approach, the MCHI model is also a good model for reaching traditionally hard-to-reach populations (prisons, drug rehab centers) in need of these same services.

VI. Coordination

MANDATE

USAID/Russia has consistently made real efforts to enhance coordination and collaboration among its projects in order to avoid duplication and achieve as much synergy as possible.

Consequently, MCHI was charged with "*In addition to Healthy Russia 2020, a major cross-cutting USAID/Russia health initiative, the Contractor shall closely coordinate its activities with the following USAID health activities:*

1. *American International Health Alliance's (AIHA) Health Partnerships,*
2. *Assistance to Russian Orphans (ARO) program,*
3. *Quality Assurance Project (QAP),*
4. *Policy Project, and, as appropriate,*
5. *USAID's ongoing HIV/AIDS and STIs prevention activities.*

USAID/Russia's health activities seek to promote improved, evidence-based standards in health practices and protocols nationwide. To streamline the achievement of this objective, a carefully planned and consistently applied coordination plan is essential. The Contractor shall indicate how it is planning to establish and ensure coordination with the above-mentioned and other relevant USAID initiatives.

- *The new MCH activity shall collaborate closely with USAID's* ***Healthy Russia 2020****, which serves as an information and general dissemination tool through its web portal, media campaigns and advocacy component. Healthy Russia 2020 will take the lead in mobilizing advocacy groups and policy makers in order to facilitate the promotion of newly developed guidelines and protocols. In addition to advocacy, in order to ensure continuity and consistency in the messages delivered, the Contractor shall coordinate the new MCH activities directly with those of Healthy Russia 2020, especially as they relate to health education, information, and communication interventions.*

- *The Contractor shall share materials and models developed under the new MCH activity with health partnerships managed under* ***AIHA****, and use, to the fullest extent possible, relevant materials developed by these partnerships. Many of these partnerships have focused on serving women and children.*

- *The project shall coordinate with USAID's* ***ARO*** *program training and educational activities on quality maternity care and baby-friendly hospital practices, including skin-to-skin contact between mother and newborn, early initiation of breastfeeding, minimal separation of mother and infant, which reduce early abandonment. For example, the Contractor could include the Early Intervention model developed under the ARO project in the overall replication package.*

- *The Contractor shall coordinate with USAID's* ***QAP****. This project has developed a cost-effective model of disseminating evidence-based protocols and practices that can be adapted for various medical and health care interventions and practices. This model should be assessed by the Contractor to facilitate the replication component of the*

proposed MCH activity. For example, the Contractor can include MCH related protocols, such as Respiratory Distress Syndrome and Pregnancy Induced Hypertension, developed under QAP in the overall replication package.

- *The Contractor shall assist USAID in co-ordination of USAID-funded activities on PMTCT in accordance with the Terms of reference of the USAID/Russia PMTCT Working Group. The Contractor will facilitate communication and coordination of USAID's portfolio on PMTCT with the Russian Ministry of Health and Social Development.*

In addition to USAID's internal programmatic coordination, the Contractor will collaborate with federal and regional governmental entities as well as other donors and programs in order to ensure effective project outcomes."

IMPLEMENTATION

The area, population, diversity and complexity of Russia made close collaboration and cooperation at multiple levels and with a wide variety of individuals and institutions a key component of all MCHI activities.

Healthy Russia

The majority of the MCHI materials were originally developed under WIN. As agreed, Healthy Russia 2020 reproduced the relevant WIN materials and distributed them to the MCHI regions in a timely fashion. In addition, new PMTCT materials – cue cards, brochures for clients, and leaflets for providers – were collaboratively developed. Originally viewed as a major activity in all MCHI regions to support MCHI's male involvement component, the HR 2020 Couples Campaign, originally scheduled for launch in September 2004, was postponed several times and ultimately implemented in only a few MCHI regions late in the Project.

AIHA

MCHI and AIHA frequently collaborated, especially with regard to HIV/AIDS and PCTMT. MCHI's COP visited the AIHA PMTCT Project in Odessa, Ukraine in May 2004 and the head of that project came to Russia to participate in the MCHI-hosted PMTCT workshop in Irkutsk that September. MCHI's COP participated in AIHA's planning meeting on HIV/AIDS treatment care and support. The AIHA Newborn Resuscitation Training Module is a key component of the MCHI Replication Package for newborn care. See also Section IV.I.: PMTCT and Family Planning for HIV+ Women Addressed.

ARO

The contract suggestion that MCHI might include the ARO-supported Early Intervention model in its replication package became an explicit Result under Contract modification #2 and this collaboration is described in detail in Section IV.H: Integration of ARO Early Intervention Model. See also Section IV.I: PMTCT and Family Planning for HIV+ Women Addressed.

QAP

MCHI worked directly with the QAP-created Center for Quality housed at the National Research Institute for Medical Information and Health, and the head of the Center participated in the

Irkutsk PMTCT workshop. The QAP-developed protocols for respiratory distress syndrome and pregnancy-induced hypertension are referenced in the MCHI replication packages but it was beyond the scope of the Project to explicitly train on these subjects. QAP's parent group – the University Research Corporation (URC) – will be an IFH partner for the quality component of the new USAID/Russia MCHI II project. See also Section IV.I.: PMTCT and Family Planning for HIV+ Women Addressed.

Government of the Russian Federation

As is the case in many countries, the Ministry of Health's personnel (and sometimes policies) changed over time. Early in the Project, two ministries were merged to create the Ministry of Health and Social Development. MCHI's current counterparts have been in place since June 2004 and MCHI staff had very good relationships with them. Initially, it was not always clear that the MOHSD saw MCHI as integral to its work and as part of its portfolio; MCHI may have been viewed more as externally-imposed international aid program rather than as a Russian program. However, MOHSD appeared to change its viewpoint over time, beginning in early 2004 when USAID/Russia asked MCHI to take the lead in coordinating the various USAID-funded projects with regard to PMTCT. As part of this coordination function, MCHI served as the key communication channel on PMTCT with the MOHSD. In time, MOHSD made the MCHI PMTCT guidelines national policy. Certainly the MOHSD was very laudatory at the MCHI Final Dissemination Conference. See also Section V.B: National Policy: Clinical Protocol Development.

Regional and Municipal Governments

MCHI's close, collegial and successful work with the regional and municipal governments in the 16 MCHI regions has been described in detail throughout this report. MCHI has received letters from all of the MCHI regions acknowledging and praising the collaborative work done as well as requesting that such collaboration continue.

RELEVANT INDICATORS

None beyond the contractual requirements.

CONCLUSIONS

MCHI's coordination with donors and USAID-funded CAs has been close and synergistic rather than pro forma and perfunctory. Collaboration with Russian regional and municipal government partners has been strategic and successful. Clearly, MOHSD increasingly saw MCHI as a valuable and crucial partner. Being asked by USAID/Russia to take the lead in coordinating the various USAID-funded projects with regard to PMTCT speaks to MCHI's reputation as an able and reputable "honest broker" focused on work in support of Russian families.

In addition to the groups mentioned above, MCHI also collaborated extensively with UNICEF. In its PMTCT work especially, MCHI has also collaborated with the Elizabeth Glaser Foundation and the "Globus" project.

VII. Monitoring and Evaluation

MANDATE

According to the MCHI Contract, "*The Contractor shall develop an overall monitoring and evaluation plan to measure the impact and outcomes of the activity as indicated under the "Expected Results" and "Tasks to be Achieved" sections of this document. This plan shall be used to monitor progress and provide definitive evidence of project impact in accordance with the indicated results. The plan shall include how each of the results will be measured and how the data will be collected. The plan shall further discuss quality control efforts to ensure good data collection, periodic analysis of data collected, and periodic quantitative and qualitative reports of data analysis—including baseline, interim, and final reports.*"

IMPLEMENTATION

Soon after the start of Project implementation, the MCHI monitoring and evaluation plan was prepared and submitted to USAID/Russia on schedule, including the indicators reported on in this Final Technical Report. At the same time, the strategy for implementing the Baseline Facility-based Surveys was outlined. During the WIN project, both household surveys and facility surveys that interviewed both providers and clients had been conducted. The conclusion during WIN was that the most useful data came from the client portion of the facility survey; therefore, MCHI planned from the beginning to only interview clients.

In early March 2004, several weeks after the Launch Conference, the RCT members responsible for conducting the Baseline Facility-based Surveys in their respective regions attended a two-day Monitoring and Evaluation Workshop in Moscow. The Workshop further introduced the Project's monitoring and evaluation system and trained participants in facility-based survey techniques and data entry using SSPS software. Prior to the Workshop, the survey questionnaires had been finalized and field-tested by Project experts and staff. Shortly thereafter, data collection for the Baseline Facility-based Surveys started in all 10 new regions and was completed in May. The collection of official medical statistical data at the facility, municipal and oblast levels was also begun.

Within a few months of adding Khabarovsky Krai and Primorsky Krai to the MCHI portfolio, the two new regions received monitoring and evaluation training, including the methodology for conducting their own Baseline Facility-based Surveys. The MCHI baseline database included questionnaire results from 4,545 antenatal women, 4,585 post-partum women, 3,491 abortion clients, and 4,888 clients at women's consultation clinics.

When the final two regions - Sakhalin Oblast and the Sakha Republic (formerly Yakutia) – were added to the MCHI portfolio in June 2005, there was not sufficient time remaining in the Project to conduct a baseline survey and then an endline survey. (Indeed, these two regions were heavily involved in training right up to the end of the Project.)

In preparation for the Endline Facility-based Surveys, refresher training on facility-based surveys was conducted for the regions in January 2006. Data collection and data entry started in February and was completed by the end of April. For internal reasons, Khabarovsky Krai did not

carry out an endline survey so Primorsky Krai was the only one of the "newcomers" to participate.

Special monitoring forms were also developed for periodic follow-up supervision visits to monitor progress, provide technical assistance, address implementation issues, and adjust Project activities if necessary. During these visits, the follow-up team could see qualitatively what was working, what was not working, and what needed additional work. The team was able to provide immediate feedback via small workshops or by modeling supportive supervision. In addition, the Project collected considerable quantitative data, probably more than could be effectively analyzed and used in a timely manner.

As described in Section IV.K: Documentation and Dissemination Emphasized, MCHI also developed monitoring and evaluation guidelines in a "how-to" format.

RELEVANT INDICATORS

None beyond the contractual requirements.

CONCLUSIONS

The strong monitoring and evaluation system developed by WIN, with minor modifications, also served MCHI well. The conclusion during WIN that the most useful data came from the client portion of the facility survey and that it was not necessary to also conduct household surveys and facility surveys that interviewed providers had a powerful effect. Looking to clients for feedback and information regarding actual performance essentially shifted the paradigm from a focus on the provider to a focus on the client. This paradigm shift helped to change the way in which services were delivered. It engendered greater trust between clients and providers; it resulted in a deeper understanding on the part of both providers and clients of what constituted high quality services; and it helped illuminate for providers the need to view clients as partners in the care giving process.

VIII. Project Management

MANDATE:

The MCHI Contract required that "*Within one month of signing the contract, the contractor shall provide a preliminary three-year work-plan addressing: 1) the creation of an in-country presence including office and staff, 2) determination of site selection criteria and process, 3) formalization of the Russian counterpart(s) and their partnership mechanisms (i.e., contract, MOU, etc.)—both for the entity that would be responsible for the replication component and for the one responsible for initiating the integration of new guidelines and protocols into the higher medical education curricula.*

Within two months of signing the contract, the contractor shall establish an office in Moscow and recruit all the program staff for the duration of the project.

Within four months of signing the contract:

- *A three-year work-plan shall be submitted,*
- *The sites shall be selected,*
- *The replication strategy shall be developed,*
- *Baseline data shall be collected, either from existing sources or through other instruments,*
- *A monitoring and evaluation plan shall be submitted.*

The work-plan shall cover all activities for the three-year period, including a timeline and benchmarks for each activity."

In addition, "*The Contractor is expected to prepare and submit a quarterly report to the Mission within a month into each quarter. The information shall include progress according to workplan submitted at the beginning of the project, outcomes achieved, problems encountered, and solutions suggested. The report shall also indicate resolution of any problems reported in previous reports and a list of upcoming event anticipated for the next quarter."* The Contract also specifies that there will be quarterly Evaluation and Monitoring Reports and Financial Reports as well as both mid-term and final MCHI Project Reports.

IMPLEMENTATION

The Contract Deliverables Schedule, which included all contractually-mandated requirements, was followed closely each quarter.

RELEVANT INDICATORS

None beyond the contractual requirements.

CONCLUSIONS

MCHI has fulfilled all of its contractual requirements in a timely and efficient manner. The Contract Deliverables Schedule was always totally on schedule and approved by USAID/Russia. The MCHI COP and the MCHI staff were repeatedly praised by the regions and by other key

stakeholders for their crisp and efficient management of the Project. The MCHI office in Moscow was well supported and backstopped by JSI/Boston, and MCHI was very skillful at accessing and leveraging the resources of JSI and WEI in a strategic and timely fashion.

MCHI staff's administrative and financial management of the Project was so well regarded by JSI's home office that literally every other JSI-implemented project in the EE/EA region received training from the Moscow staff.

IX. Estimates of Project Sustainability

A universal concern during project implementation was what would happen once the project ended and what would be the likely long-term impact. To address this issue, the mid-term evaluation team considered two elements thought to be major contributors to long-term impact: the extent of partner regional/municipal/facility-level contributions (financial and in-kind) to support Project interventions and the likelihood that the Project interventions would be "rolled out" or spread beyond the target facilities to include other facilities in the region.

A. Leveraging

The mid-term evaluation found that the regional/municipal/facility-level contributions (financial and in-kind) were far in excess of what was initially expected and suggested that it could be informative and useful to attempt to "capture" the degree to which MCHI had leveraged resources in the pilot regions.

In early 2006, a serious attempt was made to document MCHI's leveraging processes and achievements, with an emphasis on financial leveraging. Five of the MCHI regions were surveyed via a site visit and through the use of specially-developed questionnaires. The challenges associated with collecting this information retrospectively were considerable, but, even so, the amounts leveraged also appeared to be considerable. It was estimated that for every dollar invested by USAID in MCHI, the regions in response may have invested $6 to $12.

B. Coverage and Reach

The mid-term evaluation team attempted to assess the likelihood that the MCHI interventions would be "rolled out" or spread beyond the target facilities to include other facilities in the participating regions. An attempt was made to estimate what percentage of the region was already included in Project activities in order to understand the magnitude of each region's "roll-out" task. Doing this brought to light the wide disparity of the MCHI regions in terms of population and geographical area. The target facilities in some regions are municipal facilities only; in others, both oblast and municipal facilities are involved. Looking at catchment areas was not helpful due to overlap and the fact that oblast-level facilities define the whole region as their catchment area.

Finally, it was decided to look at the number and percentage of births occurring in Project facilities compared to the total number of births in the region. For the most part, babies born at a particular maternity have received their antenatal care and will receive their infant care at the affiliated women's consultation clinics and pediatric polyclinics. Thus, it was felt that looking at the number and percentage of deliveries was a good, albeit rough, proxy for coverage. The results, shown in Table 3, are extremely encouraging and show an increase from the mid-term calculations. Already, a very large percentage of births occur in target facilities.

Table 3: Regional Characteristics and Coverage Estimates: 2005 data

	Total Population	Oblast or Municipal Facilities or Both?	Rank by Pop (out of 89)	Rank by Area (out of 89)	Total # of Deliveries in Region	# of Deliveries at Project Facilities	% of Total Deliveries
MCHI Regions—Original 10							
Altai Krai (Barnaul)	2,607,426	Municipal	20	25	**26285**	**5157**	**20 %**
Irkutsk Oblast (Irkutsk, Bratsk)	2,581,705	Both	21	6	**28305**	**10670**	**38 %**
Kaluga Oblast (Kaluga)	1,041,641	Both	52	68	**8863**	**4810**	**54 %**
Komi Republic (Syktyvkar, Vorkuta)	1,018,674	Both	54	15	**8363**	**6770**	**81 %**
Krasnoyarsk Krai (Krasnoyarsk)	2,966,042	Municipal	13	2	**10912**	**4546**	**42 %**
Murmansk Oblast (Murmansk)	892,534	Municipal	61	29	**8432**	**4297**	**51 %**
Omsk Oblast (Omsk, Tara)	2,079,220	Both	25	31	**21491**	**5120**	**24 %**
Orenburg Oblast (Orenburg)	2,179,551	Municipal	24	32	**22536**	**3962**	**18 %**
Tyumen Oblast (Tyumen, Tobolsk)	1,333,800	Both	40	3	**16373**	**8362**	**51 %**
Vologda Oblast (Vologda, Cherepovetch)	1,269,568	Both	42	28	**12999**	**4089**	**31 %**
MCHI Regions—First Additional 2							
Khabarovsky Krai (Khabarovsk, Komsomolsk-na-Amure)	1,436,570	Both	35	5	**15379**	**6973**	**45 %**
Primorsky Krai (Vladivostok, Nakhodka)	2,071,210	Both	26	26	**21356**	**6781**	**32 %**
MCHI Regions—Second Additional 2							
Sakhalin Oblast (Yuzhno-Sakhalinsk)	546,695	Municipal	70	38	**5983**	**2988**	**50 %**
Sakha Republic (Yakutia) (Yakutsk)	949,280	Municipal	58	1	**13603**	**3708**	**27 %**
WIN Regions –Original 2							
Perm Oblast (Perm, Berezniki)	2,819,421	Both	15	27	**28552**	**7663**	**27 %**
Novgorod Oblast (V. Novgorod)	694,355	Both	69	51	**6210**	**3519**	**57 %**
TOTALS	**26,487,692**				**255,642**	**89,415**	**35 %**

As can be seen in Table 4, the MCHI facilities in one region already cover more than 75% of the region's births. Another six regions cover between 50% and 75% of their total births and an additional six regions cover between 25% and 50%. Only three regions cover less than 25 %, two of which are regions where MCHI worked only with municipal facilities.

Table 4: Regions Grouped by % of Total Deliveries Occurring in MCHI Facilities

> 75 %	50 – 75 %	25 – 50 %	<25 %
Komi Republic	Kaluga Oblast	Irkutsk Oblast	Altai Krai
	Krasnoyarsk Krai	Vologda Oblast	Omsk Oblast
	Murmansk Oblast	Khabarovsky Krai	Orenburg Oblast
	Tyumen Oblast	Primorsky Krai	
	Sakhalin Oblast	Sakha Republic	
	Novgorod Oblast	Perm Oblast	

It is not known what percentage could be considered a "critical mass" after which roll-out would be assured, but the likelihood appears high for most if not all of the MCHI regions. Anecdotally, many regions report various plans and efforts already underway to extend the new MCHI approaches beyond the target facilities.

> **"We really feel we need to extend our work to the whole region."**
>
> *Presenter, Irkutsk Oblast, at MCHI's Final Dissemination Conference*

As was described in Section IV.A:Legacy Russian Partner Organization Identified, one of the least covered regions – Omsk Oblast at 24% – will be working with IFH as part of MCHI II to roll out the MCHI interventions throughout that entire Oblast and will provide a significant amount of its own monies in matching funds.

CONCLUSIONS

It is highly likely that the evidence-based interventions introduced by MCHI will be sustained in those facilities beyond the life of the Project. It is also highly likely that adoption of those interventions will be rolled out or spread throughout most, if not all, of the target regions.

With regard to Russia as a whole, MCHI works in 16 of Russia's 89 regions. These 16 regions encompass 26 million people, or 18 % of Russia's total population of 143 million, a not insignificant reach in a richly diverse multi-ethnic country that covers 11 time zones.

X. Final Conclusions, Lessons Learned, and Needed Next Steps

USAID's long range purpose in funding the Maternal and Child Health Initiative has been realized: a strong, credible, registered, indigenous **Russian "legacy" organization** with proven broad-range expertise – the Institute for Family Health – now exists and is well-positioned to continue the promotion and provision of MCH innovations in Russia by partnering with and implementing programs for both international and Russian donors. IFH has already attracted considerable funding from multiple sources for the next three years with two implementing partners pledging additional millions of their own in matching funds. Certainly this is an impressive beginning!

√ *Lesson Learned:* The transformation of MCHI from an external donor-funded project to the Institute for Family Health, a self-sustaining indigenous Russian NGO, is a success story that will hopefully encourage and inspire the legions of committed, hard-working public health professionals in Russia and elsewhere who have dedicated themselves to improving the health and well-being of their fellow citizens.

√ *Lesson Learned:* Despite its inability to continue on as the Russian "legacy" organization, RSOG was a very appropriate and worthy partner for implementing the MCHI Project.

As implementation strategies, MCHI focused on **process as well as content** and chose strategies that not only stressed evidence-based medicine but that also offered a **complete paradigm shift** from focus on the provider to focus on the client, a shift that literally transformed the way in which maternal and infant services were delivered.

As a result, the adoption and integration of **internationally-recognized, evidence-based standards** has occurred at a very impressive pace across an impressive range of political and health institutions actively involving an impressive number of people over an impressive geographic area. The active involvement of a variety of stakeholders—health officials, policymakers responsible for decision making and resource allocation, and experts and providers from all levels of the health system—was cultivated from the very beginning. This helped establish full ownership for the innovative changes being introduced and helped motivate many to work towards the expansion and sustainability of the program.

√ *Lesson Learned:* MCHI basically created a **community of change agents** by defining its stakeholders broadly and keeping them actively involved.

√ *Lesson Learned:* By identifying and supporting **"catalyst" institutions and individuals**, MCHI helped multi-level leadership implement **bold, rapid, substantive changes**. The amount of change that has occurred and the potential for continued achievement and further expansion within the target regions is great.

Inter-linking components and multi-level focus gave the Project's implementation strategies **strength, breadth, adaptability and flexibility.** By building on the successes of WIN and

adapting additional materials from CDC, WHO, UNFPA, UNICEF and other CAs; MCHI was able to promote evidence-based interventions with efficiency. The **capacity building** at the regional level is substantial and has laid the foundation for further replication. The improvements in the Project's Results Indicators seen over a relatively short time interval are both impressive and heartening.

√ *Lesson Learned:* The MCHI **process – participatory, interactive, kind, respectful –** was as important as the content. Throughout, explicit efforts were made to carry out implementation in a participatory, transparent, low hierarchical manner. In effect, an effort was made to model with the regions the client-centered, mother-friendly, baby-friendly, youth-friendly, family-friendly approach that WIN/ MCHI was striving to introduce into Russia's reproductive health services. The training component especially modeled this approach. The participatory, interactive training techniques were widely appreciated, as was the interdisciplinary approach modeled by the composition of the trainers as well as by the mix of participants in the courses. Course participants described the trainers as being kind, respectful, interactive, energetic, highly professional and accessible – welcome compliments given the effort that both WIN and MCHI devoted to developing a strong cadre of all Russian trainers.

> **"The Project has shown that we can implement any program. There is no way back as we ourselves have changed."**
>
> *Chief Physician, Maternity Hospital #2, Krasnoyarsk City at MCHI's Final Dissemination Conference*

√ *Lesson Learned:* In terms of **content**, the evidence-based approach literally became a credo and supported the health care professionals in their roles as change agents as they introduced and implemented evidence-based practices. At the regional level, this **dual focus** on both process and content was **very empowering** and contributed substantially to the high degree of capacity building that occurred.

√ *Lesson Learned:* The **selection process** (incorporating an element of self-selection which promoted commitment and built in readiness) and criteria worked extremely well and were key contributors to the Project's robustness. The competitive element was **innovative and positive.** The co-financing requirement was also motivating. Requiring letters of support from municipal and regional authorities and from the regional RSOG branch helped instill a broad sense of ownership from the beginning. The requirement that the **facilities chosen be an inter-related set** of maternities, women's consultation clinics, children's polyclinics, family planning centers, and HIV/AIDS centers helped to **horizontalize** previously vertical institutions and to standardize the content and continuity of care.

Needed Next Step: The regions see a significant need for a **federal *prikaz*** that supports MCHI interventions in order to facilitate and enable the further rolling out and adoption of MCHI practices throughout the regions. Many non-Project sites were eager to adopt Project approaches but were concerned about being in violation of federal mandates without the "protection" of being a designated MCHI facility. For example, authorities are cautious about allowing partnership deliveries because they are in violation of the federal regulations.

The Inter-regional Working Group on Youth Reproductive Health was functional and appeared effective. Although many more than two regions demonstrated a specific interest in youth programming, their functioning programs differed widely, and although MCHI did develop useful Youth Programming Guidelines, it is too early to assess the extent to which they were put into practice.

- *Lesson Learned/ Needed Next Step:* Clearly there is great interest in youth and a deep recognition of the importance of addressing youth's special needs. The task is not an easy one but it would be a wise choice for any donor investing in Russia to consider a focus on youth.

Considerable attention has been given to increasing **active male participation** and support at multiple junctures. Adult males and youth have visibly benefited from **improved physical and emotional access** to reproductive health care in MCHI facilities.

√ *Lesson Learned:* Regardless of how well-intentioned both parties were, having an independent entity (HR 2020) essentially responsible for MCHI's IEC/BCC component did not work well. At critical junctures, MCHI did not have the right or responsibility to implement or carry out IEC/BCC activities that would most likely have strengthened the Project. Collaboration is certainly valuable but, for maximum impact and efficiency, a project needs to be in control of its key

The introduction of internationally-recognized, evidence-based standards for selected maternal child health interventions into the **pre-service and post-graduate curricula** of training institutions for physicians, nurses and midwives has been initiated in all of the MCHI regions having such institutions, as well as in a major state medical academy in Moscow. Faculty members from regional medical schools have been an integral part of all MCHI components at multiple levels as committee members, trainers, and participants.

- *Needed Next Step:* To move beyond these important first steps will require a much more focused and explicit program, to which Russian institutions would likely be highly receptive.

Although updated in the Project's final year, the **new family planning curriculum** has been well-received and should still be very useful to many, given its **user-friendly** structure and approach. The small pilot component to extend family planning activities into rural rayons in two oblasts is still in its early implementation phase. Additionally, the pilot oblasts had to formulate their initial implementation plans with almost no data specifically relevant to rural couples. The household survey carried out in Vologda has now provided some helpful information that may suggest needed strategic modifications.

- *Needed Next Step:* A thorough evaluation and reassessment after at least a few more months of implementation would do much to inform future rural-focused activities.

Although not included in the original MCHI Contract, MCHI has become a **major leader in Russia for PMTCT** policy development and service standards of care, as well as for the overall reproductive health needs of HIV+ women.

- √ *Lesson Learned:* MCHI's strong technical and managerial capabilities provided the flexibility needed to allow MCHI to smoothly incorporate these major new components into their program and thus be responsive to evolving external realities and the needs of USAID/Russia. The MCHI project design provided an excellent mechanism for **humanizing, "horizontalizing" and integrating the care of HIV+ women and their infants** into the health care system, a need that will grow exponentially as Russia's HIV/AIDS epidemic progresses.

- √ *Lesson Learned:* The just completed PMTCT+FP Study provided valuable **data for decision making** to inform the development of strong future policy and service standards, laying the groundwork for the development of needed Reproductive Health Guidelines for HIV+ Women.

Coordination with donors and USAID-funded CAs was **close and synergistic** rather than pro forma and perfunctory. Collaboration with Russian regional and municipal government partners and with the MOHSD has been strategic and successful.

- √ *Lesson Learned:* Again, MCHI created a **community of change agents** by defining its stakeholders broadly and keeping them actively involved.

MCHI has been exceptionally attentive to documentation and dissemination both nationally and internationally and has created a set of tools – IEC materials, a film, detailed replication packages, etc. – that are accessible and adaptable. The MCHI website includes many of these tools in Russian and in English. MCHI has become well-known and well-respected for the quality and inclusiveness of its work and has become a model for both implementing evidence-based practices and for scaling-up.

- √ *Lesson Learned:* Planning for replication and dissemination from the beginning pays off. The positive momentum that MCHI was able to create resulted in regions seeking to be part of the change process.

- √ *Lesson Learned:* Both sustainability and replicability are key WIN/MCHI success stories.

The management guru Peter Drucker once said: "Management is doing things right; leadership is doing the right things." MCHI exhibited strong leadership skills as well as strong management skills by **continually revisiting both the content and the process** of their interventions. In terms of doing the right things, for example, MCHI smoothly incorporated PMTCT as a major new component and thus was able to be responsive to evolving external needs. They also quickly recognized the dearth of available information and designed a PMTCT+FP Study to provide needed data for decision making to inform the development of relevant policy and service standards. Again, when beginning the rural family planning pilot, the need for additional Russia-specific data-based information was recognized; in response, MCHI helped arrange for a locally

conducted population-based household survey (including a male component) in Vologda Oblast similar to those conducted during the WIN Project.

In terms of doing things right, MCHI conducted an internal mid-term evaluation which, among other actions, led to the decision to revise and update the family planning curriculum with counseling skills as its organizational backbone. Using the *WHO Medical Eligibility Criteria for Contraceptive Use* as its evidence-based content foundation, the new curriculum also stressed informed choice, the health and human rights aspects of family planning, emergency contraception, STIs, HIV/AIDS, and PMTCT.

√ *Lesson Learned:* The design, content and implementation process of the MCHI Project is an **excellent model** for similar work in other countries, especially those in the former Communist-bloc. MCHI's innovative ideas and practical approaches can be adapted by program managers and policymakers and, in fact, have already been adapted successfully in Ukraine and Georgia. Additionally, the MCHI Project is an excellent model for the incorporation of additional evidence-based, internationally-recognized standards of care into the Russian health care system (e.g. additional reproductive health, family planning, and HIV/AIDS interventions; tobacco; tuberculosis). Because of its client-centered, client-friendly approach, the MCHI model is also a good model for reaching traditionally hard-to-reach and/or stigmatized populations (prisons, drug rehab centers, institutionalized youth) in need of these same services.

"The Government of the Vologda Oblast …assumes that the current Project can become 'a bridge of friendship' between Russian and American people."

I.A.Pozdniakov, First Deputy Governor of the Vologda Oblast in a letter to the Mission Director of USAID/Russia