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

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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.

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

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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.

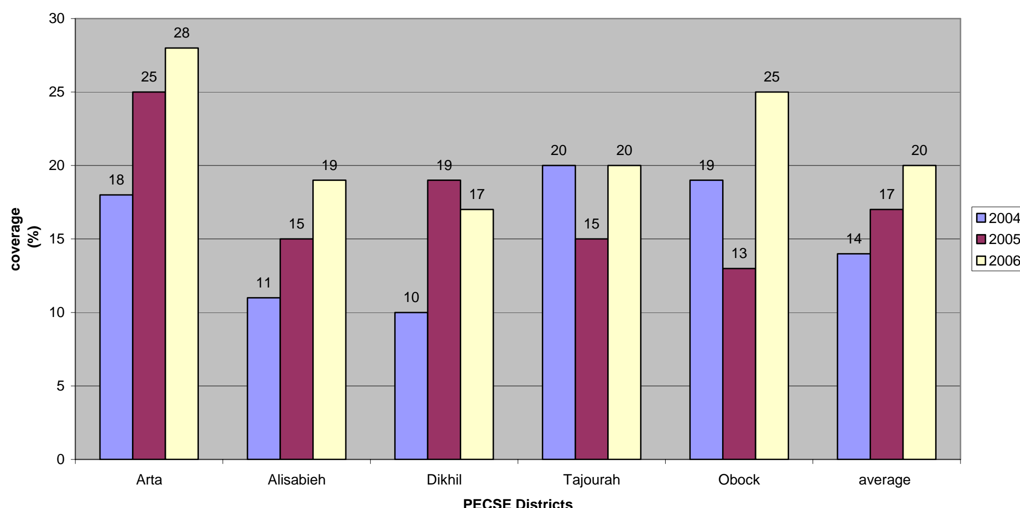
A far-reaching impact of the project's community mobilization work has been the change in law to reflect the legal existence and recruitment by the Ministry of Health of the Community Health Workers. The Ministry's appropriation of community mobilization as a key component of health improvement has been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

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.

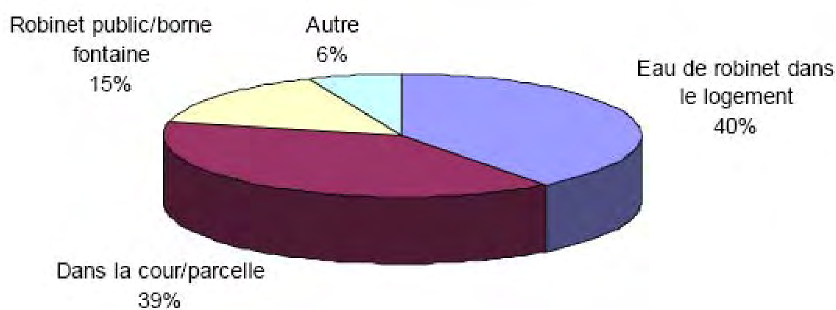
Administratively, Djibouti divides the country into health management zones of Djiboutiville, and five health districts of Arta, Ali Sabieh, Dikhil, Obock and Tadjoura. Four of the five districts have district hospitals; Arta, closest to Djiboutiville, does not have a district hospital. At this time, 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.

IR 1: Increased Supply of Essential Health Services

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

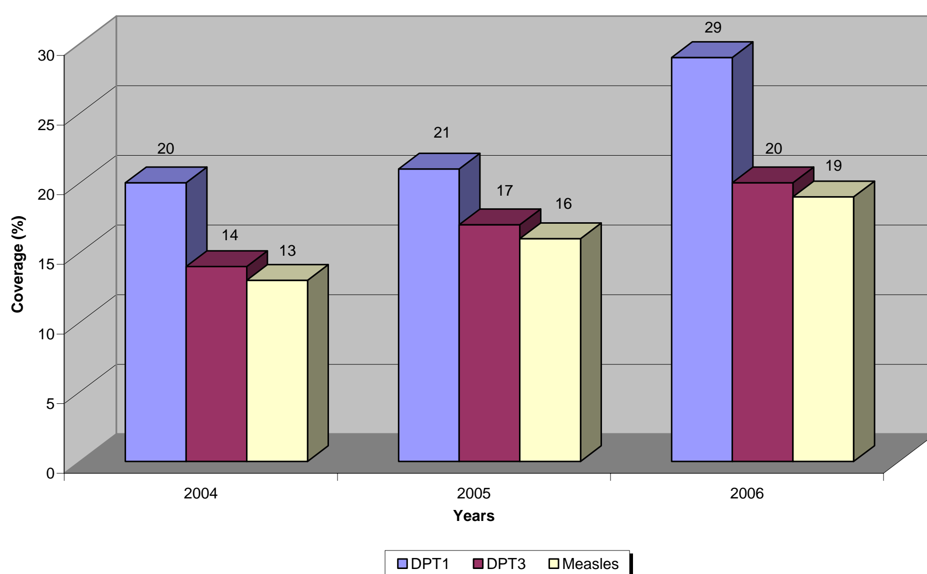
Indicator 1: DPT 3 Coverage

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.

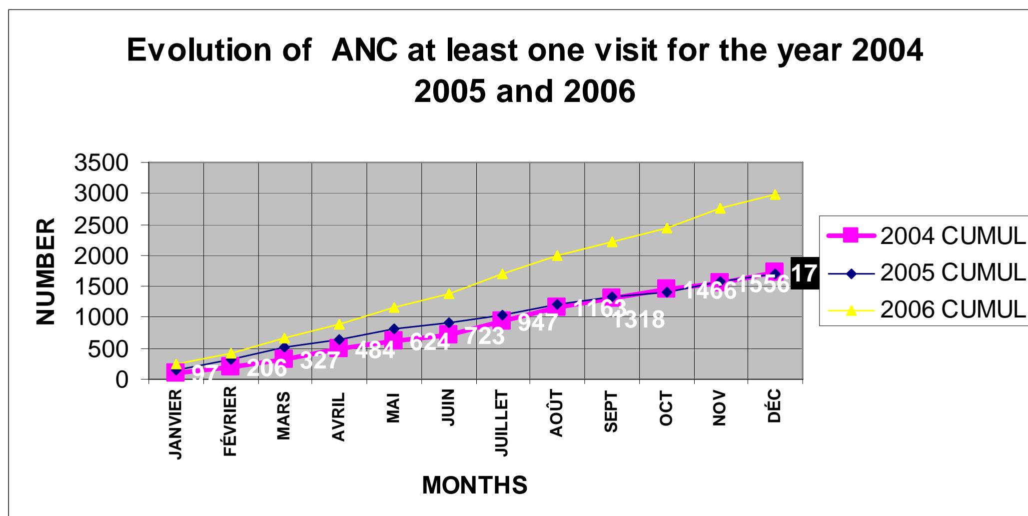
[2] Enquete Djiboutienne a Indicateurs Multiples, Rapport Preliminaire Avril 2007. Ministere de la Sante et Ministere des Finances, de l’Economie et de la Planification.< Republique de Djibouti..



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

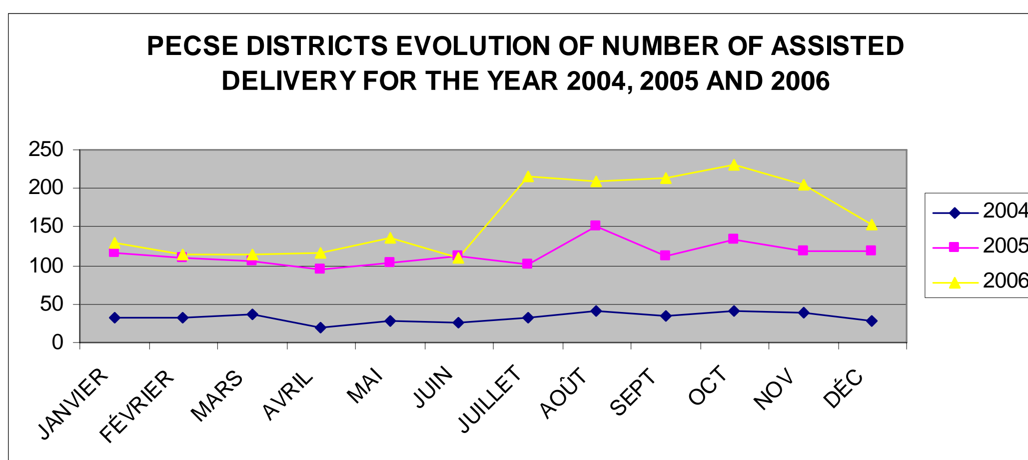
The basic package of services include: Immunization, growth monitoring, breastfeeding promotion, antenatal services, assisted deliveries and /or family planning. The current numbers of facilities which have been rehabilitated by PECSE are 17 of 23 and completely equipped are 23 of the 23. Training of 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

<u>ANNEX IV</u> 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