

PN ACF-003
101390

THE MCH/FP HEALTH CENTER IMPROVEMENT MODEL

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

as demonstrated in the

OPTIONS FOR FAMILY CARE PROJECT

Republic of Yemen, 1995 - 1998

The Options for Family Care (OFC) Project is
funded by the United States Agency for International Development

Contract No 279-C-00-95-00516-00
was an activity funded under OFC, implemented by John Snow, Inc
in cooperation with the Ministry of Public Health of the Republic of Yemen

A

**THE MCH/FP HEALTH CENTER IMPROVEMENT MODEL
TABLE OF CONTENTS**

I	Description of the MCH/FP Health Center Improvement Model	1
	1 Establish a sustainable training mechanism for increasing the number of female MCH service providers	2
	2 Improve the quality of facilities, equipment, and standards of care at health centers	3
	3 Promote community and individual participation to improve and sustain health center training, clinical service, and management activities	3
II	Development and Implementation of the Model .	4
	1 Establish a sustainable training mechanism for increasing the number of female MCH service providers	4
	2 Improve the quality of facilities, equipment, and standards of care at health centers	7
	3 Promote community and individual participation to improve and sustain health center training, clinical service, and management activities	18
III	Constraints of the Model and Lessons Learned	24
	A Constraints Problems encountered and solutions used	24
	1 Establish a sustainable training mechanism for increasing the number of female MCH service providers	24
	2 Improve the quality of facilities, equipment, and standards of care at health centers	25
	3 Promote community and individual participation to improve and sustain health center training, clinical service, and management activities	27
	B Lessons Learned	30
	1 Establish a sustainable training mechanism for increasing the number of female MCH service providers	30

2	Improve the quality of facilities, equipment, and standards of care at health centers	32
3	Promote community and individual participation to improve and sustain health center training, clinical service, and management activities	35

Attachments

- Sample Community Partnership Agreement
- MOPH guidelines for Community Midwife Trainee Selection Criteria
- List of Equipment and Instruments Needed for the Selected Health Centers (including Training Centers)
- Training Materials Provided to Community Midwife Trainers
- The Community Midwife Curriculum Content
- MCH/FP Standard Equipment and Furniture in a Referral Hospital
- Protocols and Checklists
- Step-by-step Guidelines
- HMIS Supervisory Protocol and Checklist
- 1995 Service Delivery Point (SDP) Needs Assessment (including fee collection information) & Health Need Assessment at the Governorate Level

7

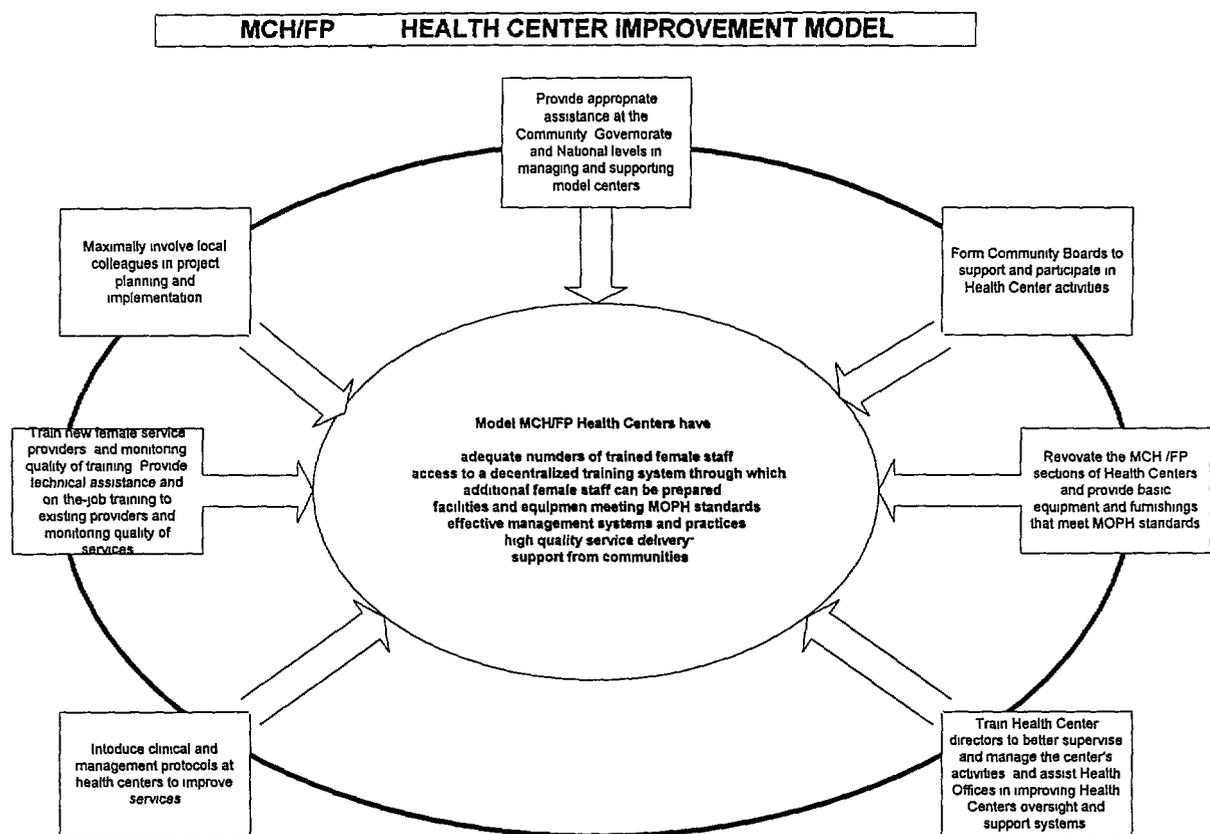
C

I. Description of the MCH/FP Health Center Improvement Model

This document describes a Model for the improvement of maternal and child health services in Yemen, as it was developed and implemented by the USAID-funded Options for Family Care (OFC) Project during 1995 - 1998. In August 1996, USAID adopted a Special Objective to guide its health care development assistance in Yemen: "Improved quality and use of integrated MCH/FP services in 22 health centers in three governorates." This Model was designed not only to improve quality and use of MCH services during the term of USAID assistance, but also to demonstrate a Model that could be used by the MOPH in future efforts to continue to improve maternal and child health. In the description that follows, the Model is described in generic terms, rather than as a "project description", so that readers can more readily adapt the descriptions, lessons learned, and recommendations to new and different circumstances. For clarity, however, it is sometimes necessary to refer to activities, inputs, or decisions that arose from the funding agency and/or the OFC Project staff. Thus, it should be understood that references to the "project" refer to the USAID-funded OFC project, and that references to "project staff" refer to staff of the organization contracted by USAID to undertake the test of this Model.

The MCH/FP Health Center Improvement Model is a set of inter-related activities that can result in higher quality and more sustainable MCH services at health centers. The Model was designed to address specific weaknesses in the health care delivery system in a synergistic fashion, recognizing that MCH/FP services in towns, villages, and rural areas are substandard for three principal reasons: inadequate numbers of service providers (especially female providers), poor quality of facilities and equipment, along with substandard clinical and management practices, and lack of community commitment to and participation in the health care system. Since these weaknesses are related, efforts to improve one of them in isolation from the others would not be effective. For example, newly trained providers must have adequate facilities in which to work, community support is required for maintenance of facilities, and higher quality services are required to generate community support to achieve better utilization of the MCH/FP services by the clients.

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



The Model consists of three sets of activities designed to improve the delivery of MCH services

1 Establish a sustainable training mechanism for increasing the number of female MCH service providers

Eighty-five percent of the Yemeni population lives in rural areas where there is a general lack of female health care providers at a limited number of rural health centers. Given the cultural preference for females to seek services from female health care providers, increasing the number of such providers is essential to enhancing women's access to services. Thus, the first component of the Model is to establish a mechanism through which additional female providers can be trained. This component was designed so that the training could be done in decentralized training centers, consistent with the

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

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

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

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

The Government of Yemen, through the Ministry of Public Health, wishes to provide basic health care services to the people of Yemen. Since government resources are limited, the MOPH 5 year plan indicates that Yemeni communities must take much greater responsibility for, and contribute their own resources to the task of, improving their health. In this component of the Model, communities are requested to take on this responsibility and to contribute their resources in support of specific health center activities, such as the decentralized training component of the Model. Communities are provided with guidance and support during this process, but are ultimately expected to independently manage their inputs to the health care system with the assistance and guidance of MOPH. To begin this process, the Model utilizes a mechanism called the Community Partnership Agreement, which formally establishes partnerships among the MOPH (central and governorate health offices), health centers, communities, and the donor-funded project. A written agreement specifies how each party will contribute specific inputs to improve MCH/FP services in the short term and sustain those improvements in the long term.

II. Development and Implementation of the Model

This section describes in detail how each component of the Model was implemented and tested

1 Establish a sustainable training mechanism for increasing the number of female MCH service providers

OBJECTIVES

In developing the Model, the following objectives were pursued in supporting training for new female service providers

- to increase the number of trained midwives available in under served areas
- to demonstrate a mechanism for the decentralized training of these providers, as highlighted in the MOPH national Community Midwifery Training Plan
- to assist the MOPH and HMI in *improving their* institutional capacities to support training programs
- to deliver training of the highest quality possible in the Yemeni context

IMPLEMENTATION

Introduction

The demonstration of the MCH/FP health center improvement model has been successful in the following ways the decentralized training of female health care (community midwives) providers can be carried out successfully in remote rural locations, introducing training at rural health centers increases the availability and quality of services, it is possible to increase the number of female service providers including centers previously without MCH services, and, the training can serve as a tool to increase community involvement in health care

Preparation of Decentralized Training Sites

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

All training centers required renovation of clinical facilities and the creation of space for didactic instruction. Space was renovated to provide practical clinical training and theoretical classroom training. A full discussion of the renovation process is contained in section 2 below.

Recruitment and selection of candidates for training

Identification and recruitment of community midwife candidates was a task assigned to communities and health centers as their first responsibility under the Community Partnership Agreements. Numerous meetings were held with the community and health center staff to accomplish this (see section 3 below). Candidates from both the immediate area of the training center and from the surrounding district were identified by health center staff, community members and local leaders. Application forms, developed in cooperation with the HMI and the Health Office, were distributed to the center. At the request of the health office, MCH supervisors were required to collect and submit the applications to the health office.

Governorate selection committees were established comprised of a Health Office administrator, MCH Director, HMI staff, and representatives of the central MOPH/ MCH section. Having a specific application process and an objective selection committee proved to be very important in controlling what was often a highly competitive and political process of selecting trainees.

Candidates were required to take a written examination, and the selection committee then conducted individual interviews. It is important that the selection process be transparent, and that the MOPH and HMI be responsible for applying criteria and selecting the candidates.

Recruitment of trainers for training centers

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

With USAID and other donor support, a three-month TOT course was designed and implemented to familiarize trainers with the newly developed eighteen month Community Midwife training curriculum.

Preparation of training sites

The selection of centers as training sites was contingent upon each community's willingness to provide housing for the trainees and trainers who were not from the immediate area. According to the Partnership Agreement, preparation of the training sites was to be a joint effort of the community and the project. The project was responsible for renovating and equipping the health facilities (and in one case the hostel) and providing furniture for the trainers, while the communities were responsible for providing and preparing the accommodations of the trainers and trainees. This included the housing itself, with basic kitchen and toilet facilities, and water and electricity.

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

The Training

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

Practical training in deliveries

A critically important aspect of the Community Midwife training is the attendance by each trainee of at least twenty deliveries, and the concurrent training in the care of high risk cases and deliveries. Many decentralized training centers do not have adequate volumes of deliveries to accommodate these certification requirements, since the typical class of twenty trainees would require 400 deliveries. Therefore, it was necessary to temporarily move groups of trainers and trainees to higher delivery volume facilities, such as urban hospitals. Each groups of trainees moved to temporary sites for this practical clinical training for periods ranging from 1-3 months, depending on the volume of deliveries.

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

Trainers' supervision, support and monitoring

Providing adequate support and supervision to this type of training program requires substantial time and effort. Coordination with and involvement of MOPH and HIM is critical in this process, particularly in resolving logistical and other problems. Two training supervisors were hired as consultants to supervise and assist the trainers, augmenting the support provided by project clinical and governorate staff. Their roles included supporting both the practical clinical skills training, the theoretical classroom learning, and supporting, coaching and supervising the trainers and the training program. One consultant took primary responsibility for the theoretical and training content while the second focussed on practical MCH/FP training.

Support to HMIs

Assistance should be provided to each governorate HMI, both to bolster their own training activities and to enhance their ability to supervise training governorate-wide. Under the MOPH plan for training community midwives, HMIs are assigned the essential task of supervising the decentralized training. Governorate HMIs received minor renovations and training equipment. Additionally supervisory and support visits should be made in coordination with HMI staff. However, a lack of funds for supervisory per diem and absence of a clear role in supervision of the decentralized training served as barrier for HMI supervisors to accompany training supervisors on their site visits.

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

Introduction

This component of the model has improved the delivery of MCH service at health centers through a process which resulted in, equipping, furnishings, and renovating 28 health facilities, defining and improving areas for MCH service delivery in the health centers, introducing and establishing the concept of "minimum quality standards" at many centers for the first time, establishing a reliable and useful health management information system (HMIS) which is used in decision making. It also included improving Health Office and HMI supervision of rural health center operations, improving internal health center supervision and management through team work, linking curative and preventative services, greater definition of center responsibilities, staff roles, and community contacts.

CLINICAL EQUIPMENT AND FURNISHINGS

OBJECTIVES

In the MCH/FP Health Center Improvement Model, provision of new equipment and furnishings

enables and motivates health center staff to provide higher quality services which tends to attract clients. Having functional clinical equipment and furnishings allows for work to proceed smoothly and efficiently. The following objectives were pursued in the provision of clinical equipment and furnishings:

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

IMPLEMENTATION

For each target health center, an equipment needs assessment was conducted, by comparing the equipment available on-site with the MOPH list of standard equipment (see attached) for MCH centers. In some cases clinical staff identified additional or alternative needs. A list was compiled by center of those items which were missing, in poor condition, or present in insufficient quantity. This formed the basis for the list of items to be procured. Selected items were also listed for health units associated with target health centers, in order to assure that newly-trained community midwives had appropriate equipment to work with. Equipment was procured using standard medical equipment catalogs, such as the one used by UNICEF. The advertising, bid collection, ordering, delivery, and shipment process was quite time-consuming, lasting approximately ten months. Basic furnishings (see attached) for health centers (e.g., desks, chairs, supply cabinets, file cabinets) were procured from local (Yemeni) manufacturers.

Following delivery of the equipment, project staff visited the centers to assist in assembly of some items and in training of staff in the use of equipment that may not have been familiar. Follow-up training and oversight was provided and necessary to assure that equipment was being used and maintained properly.

FACILITY UPGRADE

OBJECTIVES

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

objectives of facility renovation were

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

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

IMPLEMENTATION

Assessment of facilities

The first task was the development of a list of necessary MCH/FP services that should be included in the health center, using MOPH standards, and estimation of the minimum square meters of space required for each service. Existing MCH/FP facilities in each health center were then assessed according to these standards by the health center director, health office staff, project staff, and a consulting engineer. In virtually all centers, current space was inadequate to accommodate basic services. Sites selected for decentralized training also required the identification of appropriate classroom space.

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

Preparation of specifications

Since the management of renovations requires special expertise and experience, a consulting engineer was hired to provide advice on the feasibility of the renovations proposed (e.g., structural issues, cost considerations, alternative solutions), to prepare detailed specifications for bidding purposes, to review contracts for potential problems, to supervise work in progress, and to provide certifications of completed work. The engineer hired prepared specifications and drawings based on the assessments described above. Since most health center staff, health office

staff, and contractors were unable to read English, it was necessary to translate the all documents related to the renovation into Arabic. This was done by the office of the consulting engineer since the vocabulary used in the documents would be difficult for a translator unfamiliar with building and contracting.

Review of specifications, revisions, and approval

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

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

Identification of contractors

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

Potential contractors were contacted by the governorate offices, notifying them that specifications and bidding documents were being distributed. A covering letter included a due date and a date for the opening of the bids, and that the bid price, responsiveness to specification, and performance references would all be considered in the bidding process.

Preparation of bids by the contractors

Contractors were required to visit the sites in order to prepare their bids. They were willing to do this since it was in their interest to attach an adequate price to each of the items specified. Questions about the specifications were directed to the consulting engineer for clarification.

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

Selection of the contractors

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

Standard contracts were used in all governorates. After selection of the contractor, an appointment was made by the consulting engineer to visit the site with the contractor before work began to ensure that all details were clear. During these visits, some minor changes were usually made to the specifications. Once the final details were worked out, the contract in English and Arabic was sent for review and signature by the contractor. A health official, either the DG and or the HO engineer was also given copies of the contract and asked to sign as a witness.

Supervision of the renovation work

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

Initial inspection certificates were issued to sites when the work was completed. After issuing the initial inspection certificate and verification by the consultant engineer, the contractors were paid all money due to them except for 10% of the contract amount. Notes were made for minor items not fully addressed by the contractor. Once the contractor notified the local project office that these minor items were addressed, a visit was scheduled by the Sana'a Office to send the consulting engineer to conduct the final inspection. Final inspection certificates were issued.

when all work was completed and there were no outstanding items. Notes from the previous initial inspection were reviewed to ensure that the contractor fulfilled all commitments.

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

CLINICAL TECHNICAL ASSISTANCE

OBJECTIVES

The clinical technical assistance provided to support the Health Center Improvement Model was designed around the following objectives:

- to upgrade the quality of service delivery by introducing or reinforcing clinical standards and guidelines
- to increase provider skills and knowledge
- to promote increased use of health facilities by clients

IMPLEMENTATION

A variety of approaches were used to provide this assistance:

Protocols and guidelines

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

- Delivery
- Antenatal Care

- Vaccination
- Diarrhea Control/ORS
- Family Planning
- Postpartum Care
- Infection Prevention
- Registration and Record keeping

These guidelines (see attached) were circulated to the MCH departments of governorate Health Office for comment, resulting in some minor modifications. The guidelines were then printed on brightly colored paper (a different color for each service area) and permanently sealed in plastic for posting in the appropriate service delivery area. These guidelines are meant to guide and remind experienced service providers of the step-by-step procedures in the particular area of service delivery.

Short-term, in- service training workshops

Two workshops were conducted to increase the skills of midwives and community midwife trainers from target health centers. Participants in these two-week workshops were provided with theoretical and practical training in episiotomy, suturing, use of the partograph for monitoring labor, family planning counseling, and IUD insertion. The workshops resulted in improved availability of family planning services and higher quality MCH care at these sites.

On- site, in-service and on-the-job training

On-site, in-service training which included both classroom instruction and coaching during service delivery, was provided and felt to be more effective in many situations. These were then followed up on regular technical assistance to providers and support to the trainers. In some cases staff trained through these in-service training activities then provided on-the-job training to other staff.

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

The importance of outreach to increase contact with potential clients is clear, so project staff

worked both with existing providers and community midwife trainees to encourage and facilitate home visiting. It is important to emphasize with providers, center directors, and community members that outreach must be a part of the established routine of every health center.

MANAGEMENT IMPROVEMENTS

OBJECTIVES

The Health Center Improvement Model cannot be viewed as a stand-alone effort at the health center level -- all initiatives must be coordinated through all tiers of the health care system, including the central MOPH, health offices, health centers and other service facilities, and communities. Accordingly, the following basic management objectives were established:

- to support MOPH initiatives and to incorporate them in to overall center management
- to establish Governorate Teams that work within existing Health Office structures to support District/Health Center MCH initiatives,
- to strengthen Health Office supervision and oversight of MCH/FP initiatives within the respective Governorates,
- to introduce guidelines, standards and systems for improving the management of MCH/FP services within a Health Center context,
- to strengthen community involvement in the management of District/Health Center health services,
- to improve the management and integration of MCH/FP services within District/Health Centers

IMPLEMENTATION

The need for management improvements within MCH/FP service systems was identified in the design of the Model. On-site assessments of hospital and health center management at each target health center identified specific areas requiring improvement included:

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

Health Management Information System (HMIS)

While health information pertaining to MCH services was generally available through the MOPH data collection system, most health officials (at all levels) questioned the accuracy and utility of this data. Therefore, the development of an information system was seen as one of the necessary first steps in improving management of MCH/FP services.

The MOPH MCH Division developed an improved MCH/FP HMIS, with technical input from various assistance agencies. New standardized forms, cards and registers were designed, data collection procedures were simplified and made more logical, and some information of dubious usefulness was eliminated from the system. Next, health office staff were trained in the use of the system. Teams of project and health office officials subsequently provided practical training to health center personnel at sites in the governorate providing MCH/FP services. Attending the on-site training were MCH personnel, Health Center Directors and doctors at the health center training locations. A protocol and checklist for assessing the quality of data collection was developed and used by staff and health office personnel to ensure the accuracy of the record keeping and reporting. (See attached)

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

- routine on-site monitoring by Governorate Teams (including project staff and health office officials),
- monthly monitoring of health statistics by health center MCH staff (graphs charting several important clinical indicators were utilized both to introduce the concept of monthly monitoring for management purposes as well as to ensure that staff were attending to those interventions that were more likely to improve those indicators),
- Priority setting and planning initiatives established through Management Training Workshops

Management Training

As the project progressed, it became clear that management training should focus on those issues that most directly address the quality of services, and on the organizational relationships that support services. This is in contrast to the original training plan, which would have provided more general management training to senior personnel at the central MOPH and at each health office. The programmatic targets for MCH/FP contained in the Ministry's Five-Year Plan would have been used as the basis for forming broad management plans at the central and health office levels to meet those targets. While this type of training would certainly be useful, it would not have addressed the very specific, day-to-day operational problems which impede the quality of

services at the health center level. Nor would it have focussed on the relationships between the health offices, health centers, and communities which are vital to the present management and future improvement of services.

Thus, the training focus was shifted to a more practical examination of the management problems that face health centers on a daily basis.

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

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

Key strategies within the training were to

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

The five day management training workshops were held once in Hajjah, Hadramaut and Hodeidah Governorates. The fourth workshop in this series was a Health Office Director Generals' Meeting. The purpose of this meeting was to

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

Management Evaluation

The Management Workshops were followed up through bi-monthly on-site review. A management evaluation emphasizing overall MCH management was undertaken to review the progress made by each health center in implementing their plans. This evaluation was presented as a "competition". Accordingly the health centers undertook a re-examination of their services.

in order to adequately prepare for the process

The primary objectives were to enable the Health Office to

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

Major evaluation areas included

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

A one page report was distributed identifying both strengths and areas requiring improvement, including a comparative matrix on how centers scored in comparison to other locations in the Governorate

Fee Collection Training

A major initiative from the Yemeni Government has been to explore methods and systems for decentralizing programs and activities, and empowering communities to “share” in the operation of traditional government institutions and programs. The Ministry of Public Health, developed a number of concept papers which led to the MOPH “Cost Sharing Program”. The Cost Sharing Program has a number of components, one of which is the retention of fees collected at the district/health center for the purpose of providing incentives for health workers and for the purchase and maintenance of needed supplies, materials and equipment.

The project’s initial (1995) management assessment (see attached) included an examination of user fees collected by health centers. The survey reported vastly different procedures for collecting fees in the health centers, with few controls for “non-government” fees (fees charged above those prescribed by the government).

To implement a pilot cost sharing program a fee collection training program was designed that

would be consistent with any initiative finally adopted by the MOPH. As a starting point, a rapid examination was conducted of fee collection at the health centers. Project staff then met jointly with the Director Generals (MOPH) in the Hodeidah and Hajjah Governorates to review the findings of this examination and to determine what corrective action was required. Based on these discussions and with the approval of the DGs, a 2 - 3 day training program was developed for improving the bookkeeping procedures and financial control mechanisms used in the health centers, and was conducted at each center.

A program for follow-up visits was also scheduled. A Yemeni financial expert, with experience in the Hodeidah Health Office, was selected to conduct the training. A simplified financial record-keeping system was introduced which provided for improved management of both revenue (including any revenue increases which might result from the Cost Sharing Program) and expenses (including additional expense items, such as salary supplements or facility maintenance, that might become part of the Cost Sharing Program).

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

OBJECTIVES

In order to increase the level of individual and community participation in health centers, the following objectives were pursued in this component of the Model:

- To identify methods and mechanisms for community support
- To develop, implement, and monitor partnership agreements which identified the roles and responsibilities of the project, the community, the health center, and the governorate health office in improving the quality and quantity of MCH/FP services
- To facilitate the establishment of local health committees to support health centers

IMPLEMENTATION

Introduction

The community participation component of the model has demonstrated its ability to improve health center services and training in the following ways:

- Communities committees can actively and effectively support and work with the local health facility to solve problems and improve services
- Communities can develop and implement action plans in cooperation with the health facility

- The community began to be a resource for the local health center
- Fee collection procedures were improved in a manner consistent with MOPH future cost sharing guidelines, financial management and transparency improved, and resources available to the health center increased

Introductory Meetings with Communities

At each site the health center arranged an introductory meeting with the community to discuss the project, its objectives and its planned activities to improve quality of MCH/FP services. In nearly every center, the director took the lead role in organizing this introductory meeting. In order to encourage the directors to begin, it was suggested that they invite people that they knew and respected, people who use the health center, and those that they knew were interested in health issues.

The focus of this initial meeting was to introduce the project to the community, its objectives, and its emphasis on facilitating the improvement of MCH/FP services in the center (e.g., focus on preventive rather than curative services). The project was described according to its major components of training, clinical/management improvements, and community participation, with explanations of the rationale for each component. Following the project presentation/overview, the community members and health center staff shared their thoughts about community participation. The types of participants varied in each meeting but generally included health center staff, teachers, local merchants, farmers, pharmacists, local government representatives, leaders of political parties, local community leaders (sheikhs). The most active participants in the meetings were usually the local community leaders. Many confirmed the importance of community participation in improving the services at the health center and agreed that the government does not have adequate resources to fulfill the needs of the center and the community.

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

- the lack of individual and community resources to support center and participate in center or project activities,
- the need for services not being adequately provided by the centers, among priorities identified were laboratory services, medical specialists,
- the lack of adequate government support to provide qualified staff, essential drugs, equipment, and continued maintenance of the center,
- that health centers had poor leadership, management, and lack of staff commitment,
- that mismanagement of funds and potential corruption could result from charging patient fees,
- the perception that it is the government's responsibility to provide health services and the community does not have the resources to provide them on its own,

- that community contributions to the centers would be mismanaged or misused,
- that the Government side (Health Office or central MOPH) would not honor its commitment

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

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

A “baseline” level of community contributions that were required was established.

- Recruitment of candidates for community midwife training,
- Furnished accommodations for trainees and trainers in sites where community midwife training centers were to be established,
- Contribution toward stipends for trainees while in training (25% of the MOPH recommended stipend, equaling 500 YR/month/trainee),
- Establishment of health committees to finalize, approve, and follow-up community inputs identified in the partnership agreements and to act as a liaison between the community and the health center. It was envisioned that the health committee would eventually take on the role of helping the center identify priorities, and develop plans and activities for the future (i.e., beyond the project period).

Development and Signing of Partnership Agreements

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

These agreements were drafted, signed and implemented quickly so that other sequenced events (community midwife training, renovations and clinical equipment) could begin.

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

The signing of the agreements was usually done at large community gatherings where the terms of the agreement were read aloud for all to hear. Representatives of each partner organization would then sign.

Introducing Health Committees

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

It was consistently communicated that it was up to the community and the health center to decide on membership. Criteria for selecting committee members include items such as, status as a respected member of the community, history of community service, interest and knowledge of health and health related services, and ability to take time to attend meetings. The importance of including local government representatives from the communities was noted early on. Although some were not necessarily supportive or interested in the activities of the center, it was important for them to keep informed about health center activities for a variety of reasons, including their linkages with local government systems, objectivity and leverage in dealing with local political problems, and official accountability for following up on community commitments.

Forming health committee prior to the drafting of the community participation agreements has advantages such as building community understanding, advocacy and support for preventative MCH services, building the knowledge and the capacity of the community group from the outset making sure the community buys into the project activities and will take ownership ensuring sustainability. The major disadvantage is this is a time consuming process which must begin with the initial assessment. If it is not possible to first develop the committee, each partnership agreement should include a written commitment by the community to form a committee. This reinforces the emphasis on building trust between the health center and the community and improving accountability of the health center.

Establishment of Health Committees

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

As mentioned earlier, centers did not always form committees before the community participation agreements were signed. However, forming the committee early on has distinct advantages such as

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

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

Strengthening Health Committees

To enhance sustainability of community board structures it is important too conduct some committee “board development” activities to assist the committee to define their roles and responsibilities and set priorities. Therefore, health committee workshops were initiated, the purpose of which was to

- Raise the committee members’ awareness of local health problems, prevention of these problems, and the importance of defining roles for both the health center and community in addressing problems. Many of the committee members were focused on adding curative services to the centers and demonstrated limited understanding of the health centers role in prevention.
- Better define its role and responsibilities in the community and to define operating procedures, such as when to hold regular meetings, how to formalize decisions, how to elect new members, etc.

- Facilitate the development of a workplan for the future, making sure the workplan included activities which addressed the community's agreed-upon priorities. Most of the committees had identified many problems in the center, but had trouble prioritizing these problems and organizing activities to begin to solve them. The workshops helped them develop a workplan that would focus their work, assign responsibilities, and give them reasonable target dates for completion.
- Emphasize the importance of teamwork and problem-solving in developing and carrying out their workplan. It had become apparent that health centers and the committees tend to rely heavily on very few members rather than trying to distribute responsibilities and involve more individuals in the problem-solving process.

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

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

The sustainability of the health committees is difficult to predict. Committees with the greatest chance of sustainability are those which are meeting on a regular basis, those with strong leadership, and those working out problems and issues without outside intervention.

III. Constraints of the Model and Lessons Learned

This section describes constraints encountered during implementation of the MCH/FP Health center Improvement Model, and suggests approaches to solve these problems

A Constraints Problems encountered and solutions used

1 Establish a sustainable training mechanism for increasing the number of female MCH service providers.

Decentralized training of this magnitude and complexity had little precedent in Yemen. Dealing with the many problems that arose required substantial time and energy from managers and supervisors. Recognition of these problems and approaches to their solution will be important to the MOPH as it assumes more direct responsibility for training activities in the future

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

Solution A variety of “stop-gap” measures to ameliorate these problems can be used, including the provision of supplementary reference materials, and most significantly, the provision of technical assistance and in-service training to trainers. While future training efforts might benefit from these supplementary materials, lesson plans, and testing materials, a worthwhile effort for a future donor would be the improvement and expansion of the curriculum. This would enhance quality and consistency of the training. In addition, the need for frequent, skilled supervision of the training cannot be over-emphasized. In this demonstration of the Model, two experienced training consultants were used to assist in developing lesson plans, improve didactic and practical training techniques, and to monitor the training to assure the highest possible quality standards.

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

- **Need to replace trainers** For a variety of reasons, trainers are not always able to remain at their assigned centers for the duration of training. Personal or family problems led to the resignation and/or reassignment of a number of trainers during the course.

Solution In the first instance, trainers should be assigned to centers where they will be

more likely to remain. Proximity to their homes and familiarity with the community are factors. Provision of ongoing support (both professionally and personally) also helps. Since some attrition is inevitable, however, it is important to continue the recruiting of trainers even after the commencement of training and to conduct “mini-TOTs” to prepare new trainers to take over in mid-course. Trainers identified in this process can be held “in reserve” so that training is not disrupted by the abrupt departure of a trainer.

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

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

- **Follow-up with communities and logistical support** Follow-up with communities to assure their continuing contributions to the training according to the Community Partnership Agreements was a labor-intensive process for project staff. Similarly, the resolution of day-to-day problems (e.g., water and electricity availability) required substantial staff time.

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

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

Solution Trainees can be taken to other, higher volume facilities, and the number of on-site deliveries can be maximized by increasing outreach efforts. This, like other training-related activities, requires substantial effort for planning and execution, and must be a part of the planning for any decentralized training activity.

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

- **“Hidden” problems in renovation work** Additional work was required at many centers when hidden problems were identified after the renovation began. Some of this was due to faulty or unclear specifications, but most were attributable to the poor maintenance.

record of the centers and problems that could not have been identified during the preparation of specifications (for example faulty wiring, broken pipes underground)

Solution Contractors must be required to submit requests in writing regarding additional work. These can then be reviewed and approved by project staff with guidance and advice of the consultant engineer. When dealing with old or poorly maintained buildings, a reserve fund should be maintained for these types of problems.

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

Solution Incorporate on-job training, use of standards, and practical teaching about the equipment on clinical visits. Clinical staff must be prepared to spend time, and repeated visits, to demonstrate how to use equipment. Translations of the instruction manuals should be provided so that care, maintenance, and use are understood and is sustained.

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

Solution After examining client flow and related issues, clinical staff are able to work with center staff to make adjustments to improve the situation. The key is to be attuned to the needs of clients and providers, and to be flexible in approach.

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

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

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

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

related to project activities

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

Solution Here again, the ultimate solution is beyond the scope of any time-limited donor project, although efforts are ongoing to reform the national system and to improve governorate level supply systems. More limited success can be achieved by ensuring that health center staff give more attention to inventory, re-ordering, and supply issues.

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

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

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

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

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

- **Trust is not automatically present between all parties** When entering a community for the first time the community needs to learn that the people coming to work with them are sincere. Past experiences of the community with outside assistance may not have been positive.

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

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

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

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

Solution Staff attending community meetings should stress the importance of female “input” into the planning for improving health care. (Sometimes, this must be introduced slowly by, for example, asking men to consult their female relatives about their health care needs and their experiences with the health care system.) In communities more open initially to female involvement, and in all centers eventually, a variety of “woman-friendly” strategies can be used. These include approaching school teachers or other women in the workforce, including midwives and *murshidat* in meetings to encourage other women to join, holding meetings in the health center during working hours, and requiring female representation on committees before scheduling some important activity.

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

Solution Problem cases should be referred to the health office, HMI, and central MOPH to handle. Projects should insist on, and establish systems for, fair and transparent treatment of all trainees, but foreign agencies cannot be the enforcement mechanism.

- **Remote rural communities were in most need of community midwives but had the fewest candidates** These communities had few candidates that met the minimal

education requirements. These also tended to be the more conservative communities, reluctant to send young women for training.

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

- **Enforcing community commitments** Although the project continued to make follow-up visits to ensure that the local communities lived up to their commitments, trainers, trainees, and health center staff were encouraged to solve problems on their own. This proved difficult at first, because they were not from the area and young women may not be accustomed to solving complex problems on their own.

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

B Lessons Learned

1 Establish a sustainable training mechanism for increasing the number of female MCH service providers.

Preparation, operation, and supervision of decentralized training centers is complex and labor-intensive Managing the training centers proved to be one of the most time and energy consuming aspects of the Model. It required constant follow-up and all problems encountered, at least initially, were referred to project staff rather than being handled by the centers or communities involved. Communicating and demonstrating problem-solving skills to the trainers, trainees and health center directors had begun to yield positive results by the end of the project.

Training site selection should take a variety of “success factors” into account The training sites that operated with fewest logistical problems and therefore with fewer distractions from training quality tended to be those that

- had previously been used as training sites,
- had reliable supplies of water and electricity, better transport, more accessible markets, and more accessible sources of clinical supplies,
- had more experienced and skilled directors which are able to solve problems and generate community support

Candidates for midwifery are not available in all areas The educational levels of women vary across geographic areas of Yemen, and some areas lack women with the educational qualification to enter midwifery training. This problem can be dealt with in at least three ways: 1) Training in areas can be deferred until such time as the educational level of women rises, 2) Attempts can be made (including, perhaps, incentive systems) to find trained midwives willing to live and work in these areas, or 3) Lower-level providers which require lower educational levels (e.g., *murshidat*) can be trained.

Selection of trainees is subject to local politics Participation in training programs is sometimes seen as a prestige-conferring benefit and immediate economic benefit (through stipends) rather than as a means to gain skills or a job. Despite a rigorous, objective selection process in this project, a few trainees were present who were in the training for the prestige, and who may never become midwives. In some instances, when the participation of these trainees was challenged, the traditional local authorities intervened and made it difficult for training to continue.

Finding skilled trainers for decentralized community midwife training is difficult For important reasons of capacity-building and sustainability, this project decided to use as many Yemeni midwives as possible as trainers. The relatively small numbers of skilled trainers available, and the reluctance of many of them to move to remote locations, made this decision difficult to implement. As a result, trainers were variable in midwifery skill levels and in teaching skills. It is unclear whether higher salary levels would motivate some additional highly

skilled trainers to accept remote teaching jobs. Based on experience, having the right trainers was a key success factor. Having trainers with the right skills and personality can make up for problems in many other areas.

The MOPH-sponsored training of trainers (TOT) prior to the commencement of training was essential, but had some serious shortcomings. Given the variable skill levels of trainer candidates, the MOPH's insistence on a three-month TOT was well conceived. Many trainers gained valuable skills, the lack of which would have seriously compromised the community midwife training. However, the curriculum for midwifery training, assembled quickly in advance of the TOT, was little more than a syllabus, and did not provide the less experienced trainers with the detailed guidance (e.g., lesson plans) that they needed. The trainers' clinical skills generally need to be improved. The next TOT should cover basic midwifery skills. (MOPH plans for a nine-month TOT course, if well-executed, should address this problem.) In retrospect, the number of participants in the TOT (50+) was probably too great to allow for effective practical training and participatory learning.

Frequent, high-quality supervision of decentralized training is essential for quality assurance and logistical support. The technical and practical problems associated with decentralized training argue strongly for well-organized, regular supervision at training sites. Project governorate staff, clinical staff, and training consultants collectively spent a very high percentage of their time solving logistical problems, helping prepare lesson plans, giving on-the-job clinical training, and evaluating trainer and trainee performance. This resulted in training of high quality (by local standards) which could not have been realized without these supervisory efforts.

Housing for trainers and trainees is an important issue for both groups, and for the quality of training. One of the community contributions to the training was housing. The quality of the housing was variable, as was the on-going support provided by communities. Where housing problems occurred regularly, trainers, trainees, and staff were frequently distracted by negotiating or directly solving these problems.

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

The need for practical training in deliveries and dealing with clients needs to be emphasized. Many health centers lack the volume of MCH/FP clients necessary to gain practical skills. Two options exist to address this problem. Organizing off-site training at sites with high volumes and seeking clients at the training/health center sites through outreach and home visits. Both worked in the case of the MCH/FP Health Center Improvement Model and both required substantial effort to organize and implement. The advantage to off-site training is that the needed

experience can be gain quickly. The advantage to outreach and home visiting is that it develops links with the women clients and their families which were found to increase the usage of the MCH/FP services, in many cases by first time clients who began using to the center. Both require additional resources, and if sufficient resources are available both are recommended. Future rounds of training need to coordinate this off site training on a nationwide basis, to minimize competition for placement at the few appropriate high-volume centers.

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

Clinical Improvements

The process of identifying and procuring clinical equipment is complex, time consuming, and needs to be approached with careful research. Within budgetary constraints, the project was careful to identify clinical equipment for MCH centers from international sources using standard catalogs. Despite this, some of the items procured were of poor quality, or were inappropriate for local conditions. One approach that might have helped would have been to investigate local health centers that were functioning well, and to obtain detailed source information on their equipment. This may not have addressed issues of U S source and origin, however, so more detailed U S investigation of product quality should also have been undertaken. Longer lead time in procurement (a minimum of one year) would have allowed for more orderly distribution, with better training of staff in the use of equipment.

Care must be taken when procuring locally-manufactured furnishings for clinical sites

In order to conserve contract funds, shorten procurement time, and support the local economy, the project procured furnishings for clinical sites from local manufacturers. Some of the items procured turned out to be of poor construction and general quality. If local manufacturers are used, the purchaser must go to extra lengths to insure that items will be of acceptable initial quality and long-term durability.

Follow-up of use and maintenance of equipment is required. Visits to the field by governorate and clinical staff to check equipment have been valuable in assessing its use, care, and presence. Do not assume that all providers will immediately be able to utilize the skills taught. A few providers at some sites were unable to use or maintain the equipment properly. When this was discovered the staff emphasized this by reinforcing it in follow-up training and technical assistance. One successful method was to maintain a training register at each site, identifying those trained, in what subject, and when.

Facility renovations require appropriate expertise and constant monitoring. Extensive renovation work requires supervision by an experienced professional from the outset -- someone with direct experience in supervising the type of work to be undertaken. Contract specifications must be clear and complete to avoid bids that are incomplete and subsequent cost overruns. Stringent time frames with penalty clauses should be built into all contracts,

Health center and health office staff and community health committees must be in agreement with renovation work to be undertaken Getting everyone's agreement (in writing) takes longer, but avoids longer-term problems of unfulfilled expectations. The involvement of the health office engineer is particularly important, since his job is oversight of construction/renovation and since he will have substantial contacts with contractors. As with most activities, local politics can be important, so it is crucial that the contractor selection process is objective and transparent. Within those limits, however, it is wise to give special consideration to any local contractors who are reputable and known to the community where work will be performed.

If possible, add some renovation benefits for non-MCH sections of the health center Renovations should not be limited to the MCH section, as this may be seen as favoritism. If possible renovating other service sections will maximize referral, promote team building, and inter-departmental cooperation.

Careful planning and scheduling of clinical technical assistance increases effectiveness Clinical technical assistance was improved by preparing a detailed plan and schedule for on-the-job training activities within clinical supervision and monitoring visits. This gave both trainers and health center staff a focus for each visit's activities. The scheduling also helped clinical staff and governorate-based staff organize follow-up and subsequent monitoring of skills introduced.

Clinical technical assistance staff need to be uniformly skilled and experienced While the clinical staff hired for the Sana'a office were all highly experienced, skilled professionals, this same level of talent was not available at the governorate level. Local clinical staff were hired, in part, as a means of building capacity for the future. Unfortunately, their lack of experience limited their ability to contribute high quality technical assistance, and was a further demand on the time of Sana'a-based clinical staff.

On-site training has better results when it is participatory and practical In this method of conveying information, it is necessary that the providers first understand the theory behind the practice, and then successfully carry out the practice as part of the training. This provides for more sustainable skills -- where the new methods become a permanent part of the practice. On-site training also allows for more providers at the site to receive the training directly, not just the few who might be selected for off-site training. However, continued follow-up and supervision are necessary to maintain the use of new skills. It is time consuming but necessary to check skills and standards maintenance on each successive visit in order to establish the practice. Systematic evaluation is also required to indicate if more training is needed, and to revise training techniques.

Institutionalizing clinical training and supervisory capacity is a long-term effort Project plans to establish governorate training teams which would be able to independently carry out both on-the-job and more structured training were not successful. We believe that this failure is symptomatic of a larger problem that health office staff have little incentive and resources to

make routine field visits for training, supervision, or other purposes. Factors which contribute are lack of transport, lack of funds for per diem, the very short Yemeni work day, cultural/familial barriers to travel by some female supervisors, low salaries, and leadership which does not insist on the performance of specific job duties. Until these problems are solved, health centers outside of governorate capitals will continue to suffer from poor supervision and training, and service quality will suffer as a result.

Outreach to clients (especially women and children) is essential to improve and expand service coverage, but is difficult to provide and sustain in many cases. Poorly compensated and poorly motivated service providers, especially female providers who are culturally encouraged to remain “in the background”, are understandably reluctant to leave health centers and make home visits. For similar reasons and a host of other factors, however, female clients are often reluctant to leave home to seek services. Verbally encouraging providers to do outreach -- and helping them make schedules and plans to do so -- had little effect. What was effective was having project staff, especially female staff, initiate outreach visits with providers and demonstrate that it was possible to do so. Whether this behavior can and will be continued after the project is uncertain. However, we have learned that when outreach is initiated in this way, providers are more likely to continue the activity at least in the short run, and that women clients had established personal links to the center and began visiting, some for the first time.

Management Systems Improvements

It is difficult to improve health services when critical health personnel (doctors, lab and x-ray technicians), equipment, drugs and supplies are missing. Balancing resources between centers is important. Centers that have a full complement of doctors and facilities attract clients. Minimum levels of staff should be provided at each center. This includes at least one doctor per center.

Management improvement efforts should first focus on the service delivery point. The model's experience was that focussing at the health center level, with some support for management issues at the health office level, and less support for management issues at the national level, produced improved quality of services. This approach also supported the MOPH's decentralization policy. Management improvements at the different levels are interrelated. To some extent, all improvements at the local level require corresponding improvements in higher level support and supervision systems. Nevertheless, the purpose of the health care system is to provide services to clients, and the initial focus should therefore be on building capacity at the service delivery level. Additional support can then be directed to each successive higher level as time and resources permit.

Health centers must be empowered and prepared to solve many of their own problems. While assisting health office support to health centers should be a major goal of any project, in reality health centers should be prepared and equipped to solve as many of their own problems as possible through decentralization of authority, responsibility and resources. Health offices do not

currently have the capacity to fully assist or supervise health centers

Health workers are willing to make corrective changes While the management of health systems is weak throughout Yemen, health center and hospital personnel are generally quite capable and willing to make corrective changes when good ideas are suggested and they are given appropriate training. The problem, in many cases, is to ensure that a support system is established to follow-up and assist these individuals after training. Support and follow-up should be provided by a combination of project sponsored staff and health office personnel, since project involvement is in itself not sustainable

MCH programs must be integrated into health center management Cultural and gender issues have tended to separate or marginalize MCH activities, which are largely preventive, from the mainstream of curative hospital/health center management. Accordingly, one goal of MCH-focussed projects should be to pursue activities which facilitate the integration of MCH activities, such as assessing the degree of emphasis given to curative vs preventive care by center management, and forging better relations (interpersonal and systemic) between MCH staff and other center staff. Until there is effective communication and management interaction within a health center, it is difficult to pursue qualitative and quantitative improvements in health care delivery. Basic to this principle is the development of regular staff meetings among departments and a team approach to decision making and problem solving at each center

Motivation is key to make changes The problems faced by Yemeni health workers are substantial -- not the least of which is low pay and lack of recognition for improved work performance. Therefore, programs designed to introduce change must recognize this reality and design reward systems that recognize improvement. While increases in compensation would undoubtedly be useful, other mechanisms might be just as effective and more realistic, such as community-sponsored awards and recognition for good performance

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

Community involvement is a key to improving health care delivery Until there is health center solicitation and acceptance of community interaction, the chances of improving community confidence in health care delivery, and in providing assistance to the health center, will be limited. Experience suggests that community interest in and support of preventive health activities can be generated through multiple contacts with community representatives, extensive negotiations of the specific inputs to be made by the communities, demonstration that community inputs result in specific benefits to the community, and frequent follow-up to assure that commitments are met

The Community Partnership Agreement is an effective way of formalizing community

participation, as well as the inputs to be made by the health center, health office, and any outside group. It “gets everyone on the same page” in the beginning, and then provides an effective mechanism for follow-up. It is not a panacea, however. Staff spent enormous effort trying to ensure that signatories to the Agreements lived up to their promises. Occasionally, drastic action was required (such as stopping renovation activities) to ensure that commitments would be fulfilled.

Communities do not “automatically” perceive MCH services as a high priority. Curative health services, water projects, road improvement, all are valued by communities presumably because of the immediate, tangible benefits they provide. Preventive health services, including midwife training programs, offer benefits of a more “conceptual” nature, and it therefore may be more difficult to persuade communities to devote scarce resources to supporting them. The universally male leadership may be insensitive to programs that can be seen as mostly benefiting women. Also, trainers and some trainees were outsiders in the community and leaders did not feel an immediate responsibility toward them.

The importance of sheikhs and parliamentarians in local health care programs cannot be minimized or ignored. Particularly in the more traditional areas of north Yemen, leadership and power tends to be vested in a very few men. What is called “community participation” in these areas often seems more like “sheikh participation.” It is certainly true that community-based activities in these regions absolutely must have the active support of these leaders, who in many cases do not delegate much of their authority or decision-making.

Community leadership is critical, and the leaders must be identified. Even in less traditional areas, activism is often dependent on a few people who are very energetic and involved. Unfortunately, these people also tend to be very busy and/or out of town, so leadership capacity-building is also important.

The history of poor services in health centers is hard to overcome. The health centers that serve many communities have been so bad for so long that people dismiss them. This project worked hard on motivational messages to community and health center alike, trying to convince everyone that things could get better if everyone worked together. This approach was successful in large measure, but requires follow-up to sustain improvements and community involvement.

Women can be active members of community health committees. Most communities at first discouraged the idea of inviting women to join health committees. But aggressive tactics to involve women paid off, with many committees including women in their membership by the end of the project. Some of the factors making it more likely or conducive for women to join committees are convenient meeting times, “neutral” meeting sites such as the health center or a local school, having more than one female participating, and the involvement of a well respected local community leader.

Health center directors generally support increased community involvement. Once initial

community meetings took place, none of the center directors or staff objected to community involvement in the center activities. Not only were directors and staff pleased with the increased resources coming as a result of Partnership Agreements, but community involvement also seemed to please the director and staff by giving them more status and attention.

Fee collection issues are very controversial subjects at health centers. Management improvement initiatives in “fee collections” have revealed a deep sensitivity over fees collected in health centers. This reality is a clear indication that the MOPH-designed Cost Sharing Program may not be easily accepted or adopted at the local level. Therefore, extensive sensitization, community involvement and training will be required if the program is to achieve its objectives.

Sample Community Partnership Agreement

PARTNERSHIP AGREEMENT

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

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

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

Summary of Major Activities

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

Division of Responsibilities

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

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

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

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

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

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

training of trainers) for the MCH staff

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

Addendums to this Agreement

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

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

Agreement

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

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

Al Marawa'a Center
Director

Signature

Date

Al Marawa'a Community
Representative

Signature

Date

Options for Family Care
Representative

Signature

Date

Hodeidah Governorate
Health Office General Director

Signature

Date

MOPH guidelines for Community Midwife Trainee Selection Criteria

Community Midwife Trainee Selection Criteria

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

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

List of Equipment & Instruments Needed for the Selected Health Centers

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

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

27

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

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

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

TEACHING AIDS AND MATERIALS
PROCUREMENT FOR TRAINING CENTERS

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

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

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

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

Please ship via air freight Thanks

Training Materials Provided to Community Midwife Trainers

Training Materials Provided to Community Midwife Trainers

Books

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

Copied and provided

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

The Community Midwife Curriculum Content

The Community Midwifery Curriculum Content

Unit 1 Basic Training

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

Unit 2 Antenatal care

Antenatal care from ovulation through delivery

Unit 3 Delivery and Labor

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

Unit 4 Post delivery care

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

Unit 5 Child care

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

Unit 6 Management and Supervision

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

MCH/FP Standard Equipment and Furniture in a Referral Hospital

MCH/FP Standard Equipment and Furniture in a Referral Hospital

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

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

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

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

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

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

	Refrigerator with Freezer	1	
	Gas Cylinder	2	
	Dial Thermometer	1	
	Vaccine Carrier Daily	3	
	Vaccine Carrier Monthly	1	
	Ice Pack	8	
	Kidney Basin	1	
	Ampule Cutter	2	
	Waste Bin	1	
	"Sharps" Disposable Unit	1	
	Syrings & Needles		
	Tray	1	
REHYDRATION/NUTRITION/GROWTH MONITORING ROOM			
	Table & Chair	1	
	Client Seating	10	
	Infant weighing Scale	1	
	Thermometer	3	
	Thermometer Jar	1	
	Demonstration Table	1	
	Cup	20	
	Spoon	20	
	Droppers 10 ml	10	
	Supply Cupboard	1	
	Waste Bin	1	
	ORS Package		
	Thermus Jar (5 liters)	1	

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

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

Protocols and Checklists

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

Objectives

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

Use of the Checklists

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

Scoring on the Checklists

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

OPTIONS FOR FAMILY CARE
MCH FACILITY AND EQUIPMENT SUMMARY CHECKLIST
 Lower Level Result 2 Indicator 2

Governorate _____ Health Center _____ Date of Appraisal _____ Evaluator _____

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

69

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

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

1 Appropriate equipment, furniture, supplies available in each room

REGISTRATION ROOM

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

SCORE

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

PRENATAL ROOM

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

SCORE

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

DELIVERY ROOM

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

SCORE

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

PRE/POST DELIVERY

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

SCORE

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

ORT/HEALTH EDUCATION

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

SCORE

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

FAMILY PLANNING

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

SCORE

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

VACCINATION

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

SCORE

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

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

2 Storage in each room is sufficient

SCORE

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

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

0= Cabinet is absent or unusable

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

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

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

4 Facility structures are in working condition

SCORE

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

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

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

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

SCORE

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

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

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

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

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

SCORE

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

7 2 Bathrooms are available, clean and functional

SCORE

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

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

SCORING FOR CLINICAL PROTOCOL CHECKLISTS

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

REGISTRATION

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

DELIVERY (total number of 'yes' marked)

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

FAMILY PLANNING (total number of 'yes' marked)

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

PRENATAL (total number of "yes" marked)

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

VACCINATION (total number of 'yes' marked)

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

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

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

Weight and growth card

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

Administering ORS fluids

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

Health Education

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

POSTPARTUM (total number of 'yes' marked)

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

INFECTION PREVENTION (total number of 'yes' marked)

Boiler

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

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

Autoclave

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

Dry Oven

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

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

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

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

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

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

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

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

5 Provider maintains room environment in which is conducive to work
SCORE

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

6 Provider treats clients with respect and facilitates communication
SCORE

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

SCORING

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

MCH FACILITY AND EQUIPMENT SUMMARY CHECKLIST (total 105)

63 POINTS = Meets minimum standards (60%) passing

74 POINTS= Slightly above minimum standards (70%)

84 POINTS= Well above minimum standards (80%)

95 POINTS= Standards are excellent (90%)

MCH SERVICE QUALITY SUMMARY CHECKLIST (total 81)*

49 POINTS = Meets minimum standards (60 %) passing

57 POINTS= Slightly above minimum standards (70%)

65 POINTS= Well above minimum standards (80 %)

73 POINTS= Standards are excellent (90%)

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

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

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

presence of items

90-100% = 5

80-89% = 4

70-79% = 3

60-69% = 2

50-59% = 1

less than 50% = 0

Performance checklist for postpartum care

Health facility _____ District _____
 Governorate _____

Name of service provider _____ Date _____

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

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

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

Name of supervisor _____

Performance Checklist regarding Weighing Children, ORS and Health Education

Health facility _____ District _____

Governorate _____

Name of MCH-service provider _____ Date _____

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

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

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

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

Name and signature of the supervisor

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

Health facility _____ District _____

Governorate _____

Name of service provider _____ Date _____

Name of counseling provider (if different) _____

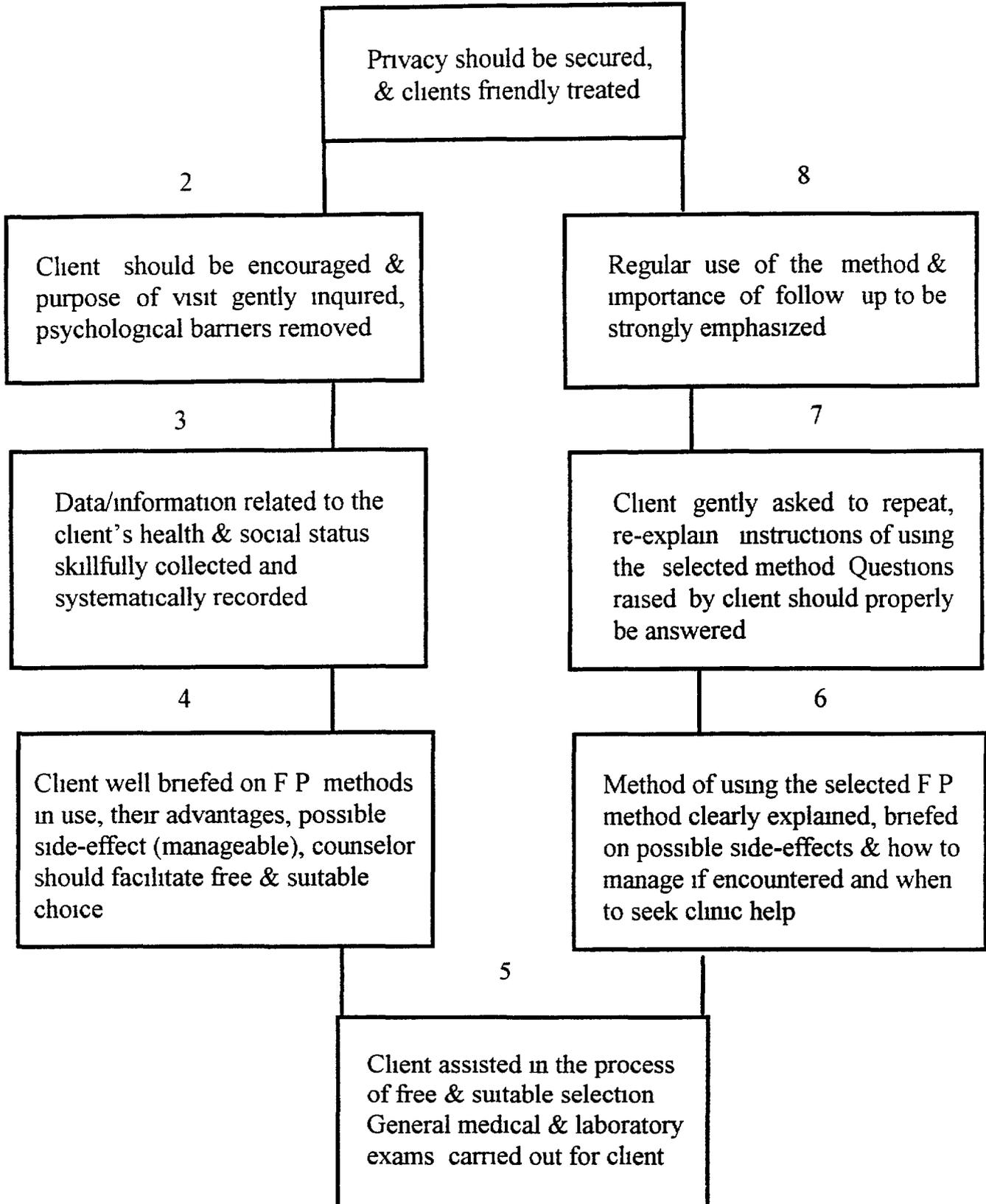
S N	Duties , functions , roles	✓	x	Remarks, Actions
1	Room tidy & clean			
2	Contraceptives & illustrations for health education are available			
3	Privacy for the patient is followed			
4	Greets the clients with kindness and respect			
5	Asks the client her purpose in the visit			
6	Took necessary information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

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

Name & signature of supervisor

Steps followed in F.P. Counseling

1



Performance Checklist for Registration Services

Health Facility _____ District _____

Governorate _____ Date _____

Name of service provider _____

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

Name of Supervisor _____

Performance checklist on prevention of infection
and aseptic techniques

Health facility _____ District _____
Governorate _____

Name of service provider _____ Date _____

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

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

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

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

Name & signature of supervisor

Infection Preventing Techniques

- Decontamination

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

- Cleaning

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

Then properly rinsed with clean water.

- High - Level Disinfection (acceptable methods)

a- Boiling in a covered container for 30 minutes

b- chemical solutions by immersion for 20 minutes in

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

- sterilization (preferable methods)

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

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

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

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

Step one in Infection Prevention ProcessDecontaminationDecontamination Procedure

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

Decontaminating examination bed/table

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

How to prepare the proper chlorine solution CONCENTRATION

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

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

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

ie ratio of water to chlorine concentrate is 9 to 1

step 2cleaningcleaning procedure

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

step 3I High - level disinfection by boilingProcedure

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

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

II High - level Disinfection by chemicals

Procedure

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

step 3 continued

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

A- High - pressure steam

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

(121 C = 250 F)

B- Dry heat

1. Decontamination, cleaning, rinsing and drying as usual
2. Leave cover off so heat can reach all parts of items to be sterilized
3. Instrument tray is then put inside the oven and left for one hour at 170 C or 2 hrs at 160 C
4. Using sterilized forceps, items are picked up and collected into a sterile container with a cover
5. Items should be wrapped as soon as they cool and they can be stored for one week

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

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

Performance Checklist on Immunization

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

S N	Duties , functions	✓ x	Remarks, Actions
1	The room was tidy and clean		-
2	Educational audio-visuals were available		
3	Needed supplies were prepared		
4	Immunization cards & registers were available		
5	Privacy was accounted for		
6	An electric (or gas) refrigerator was working & in place <ul style="list-style-type: none"> • kept clean (inside, outside & at the back) • the inside temperature was kept at 2 C to 8 C • the daily refrig temperatures were plotted on the specific chart • ice thickness did not exceed 0.5 cm • ice-boxes were not less than four • only vaccine (& sera) were kept inside • bottles filled with coloured water were put on the bottom surface & the inside shelves of refrig door to sustain the inside coolness while being repeatedly opened all vaccines were potent		

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

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

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

Name and signature of the supervisor

Performance Checklist on Antenatal Service Delivery

Health facility _____ District _____

Governorate _____

Name of MCH-services provider _____

Date _____

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

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

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

Name & signature of the supervisor

Performance checklist on labour & delivery services

Health facility _____ District _____

Governorate _____

Name of MCH-service provider _____

Date _____

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

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

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

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

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

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

Name & signature of supervisor

Step-by-Step Guidelines

**FAMILY PLANNING
PERFORMANCE STEPS**

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

**FAMILY PLANNING
PERFORMANCE STEPS**

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

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

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

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

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

**POSTPARTUM CARE
PERFORMANCE STEPS**

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

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

POSTPARTUM CARE
PERFORMANCE STEPS

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

STEPS FOR PERFORMING VACCINATION

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

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

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

125

STEPS FOR REGISTRATION SERVICES

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

STEPS FOR CARE DURING CHILDBIRTH

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

STEPS FOR CARE DURING CHILDBIRTH

(continued)

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

STEPS FOR CARE DURING CHILDBIRTH

(continued)

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

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

STEPS FOR CARE DURING CHILDBIRTH

(continued)

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

STEPS FOR PRENATAL CARE

(1)

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

STEPS FOR PRENATAL CARE

(2)

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

STEPS FOR INFECTION PREVENTION

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

After decontamination and cleaning, follow one of the steps below

(A) Boiling (high level disinfection)

(B) Autoclave (sterilization)

(C) Dry oven

(A)

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

(B)

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

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

(G)

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

HMIS Supervisory Protocol and Checklist

HMIS SUPERVISORY PROTOCOL

Service Delivery Site _____

Date _____

Name of Supervisor _____

INDEX REGISTER

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

INDEX CARDS

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

FAMILY FILE

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

137

INDIVIDUAL RECORD CARDS

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

ANTENATAL CARE REGISTER

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

FAMILY PLANNING REGISTER

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

DELIVERY REGISTER

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

16

CHILD HEALTH REGISTER

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

OUTREACH REGISTER

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

1/10

MONTHLY REPORT

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

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

Debriefing at the End of the Visit

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

1 Staff members present

2 Corrective Actions to be taken

Action _____ **Responsible**

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

SDP NEEDS ASSESSMENT

Background Information

Date

SDP Name

SDP Type

Governorate

District

Rural/urban

Director's name

When Opened

Working days

Working hours

Funds allocated by the government

Donors assistance (by whom, period either in the past or present, full description of activities assisted)

Catchment Area/Target Population

What is the catchment area served by this clinic (villages/neighborhoods served)?

- a Official Catchment Area
- b Actual Catchment Area (based on Client Register)

What is the estimated population served by this clinic?

Using the most recent census data population growth rates and age sex distribution extrapolate the following data

- a Number of married women in the reproductive age group (15-44)
- b Number of pregnant women
- c Number of children <1
- d Number of children <5

Population served within 20 km

Urban

Rural

Sketch the Catchment Area

Number of private pharmacies available in the area

Who is the clinic manager?

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

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

Does the manager have other non-managerial responsibilities?

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

Supervision

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

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

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

Describe how supervision takes place

c Describe any problems with supervision

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

If YES What was the purpose?

Overview of Services Offered

Types of services provided in the facility

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

Clinic-Based

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

Outreach

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

If Yes

What types outreach services

- General health education Recruitment Follow-Up

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

Describe the services as they are actually carried?

What are the barriers to providing outreach services?

Clinic Schedule

When are the different MCH/FP services scheduled?

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

Attendance

In general what are the most heavily attended

- a Days
- b Clinics (estimate average attendance)

Sample (most recent week)

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

Possible contributing factors

- a Market Day
- b Other _____

Finance

Are fees collected from patients?

If yes

a What are the fees?

Service	Charge
Registration	
Lab Tests	
Outpatient	
Inpatient	
Others	

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

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

What proportion of patients are given the exemption or reduction?

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

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

Month
Month
Month

e Allocation of funds received last month

Amount to Health Office

Amount to health facility

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

Records (request a copy each)

Patient Records

Are patient records kept?

If Yes

What information do they contain?

Are they individual or family records?

Are they held by the patient or by the clinic?

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

How is the information used in providing care?

Clinic Records

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

Who is responsible for

- a Entering the data
- b Tabulating the data

What is done with the information?

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

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

Logistics

Storage Facilities

Responsible person

Where are contraceptives and drugs stored?

Under what conditions?

Clean

Y/N

Organized

Y/N

Is there any security?

What type of cold change equipment is available?

What condition is it in?

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

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

Y / N

Observed temperature

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

Y / N

Is the refrigerator exclusively used for vaccines?

Y / N

Inventory System

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

a Vaccines

b Contraceptives

c Drugs/medications

d Equipment

e Consumable Supplies

d Consumable Supplies

Stock-Outs

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

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

Patient Flow

Work Stations/Organization of Tasks

Priority System

In what order are patients seen?

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

Time in Clinic (estimated)

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

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

Common Areas

Waiting Area

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

Type of patient seating

Number

Is there any health education provided while waiting?

If yes describe

Patient Registration Area

Personnel working

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

Antenatal Care

162

Working days/hours

Antenatal Care Providers

Average load Daily

Monthly (previous month)

Waiting Area

Is there a separate waiting area for antenatal care?

If yes,

Clean Y/N

Organized Y/N

Clients seating

Audiovisual (VCR and monitor)

Educational materials for videos

Educational posters in the wall

Antenatal Room

Clean

Organized

Health Posters

Health Standards Posted

Infection Control

Hand Washing Facilities

Sink

Water

Soap

Decontamination Supplies

Detergent

Chlorox

Antiseptic solution

How equipment are sterilized?

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

How is sterility maintained?

Equipment

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

Records

Antenatal card (Availability, usage storage)

Who is filling the antenatal records?

Is antenatal card completed accurately? Y / N

Prescription forms

Form for ordering lab tests

Registration (*specify data to be recorded*)

Drugs

Drugs Available

How and where are they stored?

Laboratory

Laboratory tests done in the clinic regularly

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

Services

Are there formal protocols for providing services?

Description of services (*observe and record*)

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

165

Delivery Services

Working days/hours

Providers

Average load Deliveries Daily

Monthly (previous month)

Other procedures

Space

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

Infection Control

Hand Washing Facilities

- Sink Water Soap

Decontamination Supplies

- Detergent Chlorox

Antiseptic solution

How equipment are sterilized?

- Soaked for decontamination
 Cleaned with brush and soap
 Sterilized

How is sterility maintained?

Equipment

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

Others			
--------	--	--	--

Records

Registration (*specify data to be recorded*)

Patient Record (Availability usage storage)

Who is filling out the record?

Is the record completed accurately? Y / N

Prescription forms

Form for ordering lab tests

Drugs

Drugs Available

How and where are they stored?

Laboratory

Laboratory tests done in the regularly in connection with delivery

✓	Test	Comments

Services

Are there formal protocols for providing services?

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

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

Services Provided Beside Routine Delivery

Home deliveries

Management of complicated cases

Postpartum care

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

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

Family Planning Services

Working days/hours

Antenatal Care Providers

Average load Daily

Monthly (previous month)

Waiting Area

Is there a separate waiting area for family planning?

If yes,

Clean Y/N Organized Y/N

Clients seating

Audiovisual (VCR and monitor)

Educational materials for videos

Educational posters in the wall

Examination Room

Clean Y/N Organized Y/N

Standards Posted

Contraceptive Mix

Method	No	Price	Amount Dispensed	
			Monthly	
			New	Old
Micogynon				
Neogynon				
Microlut				
IUD Copper T380A				
Neosampon				
Condoms				
Others				

Logistics

Source

Regular period of

Amount supplied

Last date of supply

Infection Control

Hand Washing Facilities

- Sink Water Soap

Decontamination Supplies

- Detergent Chlorox

Antiseptic solution

How equipment are sterilized?

- Soaked for decontamination

Cleaned with brush and soap

Sterilized

How is sterility maintained?

Equipment

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

Other			
-------	--	--	--

Records

Registration (*specify data to be recorded*)

Patient Record (Availability usage storage)

Who is filling out the record?

Is the record completed accurately? Y / N

Prescription forms

Form for ordering lab tests

Laboratory

Laboratory tests done in the regularly in connection with family planning

✓	Test	Comments

Services

Are there formal protocols for providing services?

Description of services *(If possible observe)*

Is privacy assured for the client during exam and counseling?

Provision of counseling

Are there demonstration models? *(Which ones)*

Medical examination

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

Y /N

Patient Flow Chart for a New Contraceptive User

Immunization Services

Working days/hours

Providers

Average load Daily

Monthly (previous month)

Waiting Area

Is there a separate waiting area for immunization services?

If yes,

Clean Y/N

Organized Y/N

Clients seating

Availability of health education materials

Are immunization standards posted on the wall

Infection Control

Hand Washing Facilities

Sink

Water

Soap

Decontamination Supplies

Detergent

Chlorox

Antiseptic solution

How equipment are sterilized?

Soaked for decontamination

Cleaned with brush and soap

Sterilized

How is sterility maintained?

Equipment

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

Vaccines

Type	No	Condition	Comments (utilization)
BCG			

Poliomyelitis			
Measles			
DPT			
TT			
DT			
Diluent for BCG& measles			

Logistics

Source of supply

Regular period of supply

Amount supplied

Last date of supply

Infection Control

Hand Washing Facilities

- Sink Water Soap

Decontamination Supplies

- Detergent Chlorox

Antiseptic solution

How equipment are sterilized?

- Soaked for decontamination
 Cleaned with brush and soap
 Sterilized

How is sterility maintained?

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

Services

Are there formal protocols for providing services?

Other Child Health Services

Working days/hours

Providers

Average load Daily

Monthly (previous month)

Waiting Area

Is there a separate waiting area for child health services?

If yes,

Clean Y/N Organized Y/N

Chents seating

Educational posters in the wall

Child Health Consultation/Examining Room

Clean Y/N Organized Y/N

Health education materials

Health standards posted

Services

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

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

Laboratory Services

Is there a lab on site? Y / N

If Yes, specify the tests which are done

Is there blood-banking facilities? Y / N

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

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

Emergency Services

Other Services

Operating Room

Conference Room

Dressing Room

Clinical Skill Observed

Quality Assurance

Quality Assurance Mechanisms

Is the manager aware of the concept of quality assurance?

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

Staff Perceptions

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

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

Client Perceptions

Are the clients satisfied with the services at the clinic?

What could be done to make the services better?

Client Interview:

Why did you come to this clinic today?

How far away you are living from the clinic?

Did you get the service you want?

How long did you spent time to get the service?

How much money did you spent in the clinic?

Did the staff treated you well?

Are you happy with the services in this clinic?

How the clinic could be improved?

Community Participation

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

If Yes

What is the nature of the community involvement?

If a formal advisory board

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

- b How were the members chosen?

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

- d What were the issues discussed?

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

HEALTH NEED ASSESSMENT
AT THE GOVERNORATE LEVEL

Date

Governorate

Health Office General Director

Donors working in the governorate? Specify areas

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

What is the policy of fees charging in this governorate?

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

12/1

- Who is responsible? Names and Qualification

- Facilities available?

Health personnel available

-Is there any training facilities in the governorate?

Health facilities

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

--	--	--	--	--	--	--	--

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

- Is there a referral system between these health facilities?

- Is there any kind of coordination between these facilities?

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

How community is involved in the improvement of health services?

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

If Yes, have a copy

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

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

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

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

.

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

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

How the drug supply assured to health facility?

How contraceptive supply assured to health facility?

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

How supervision system is achieved? The purposes for supervision

What are the difficulties encountered in the health services?