3rd QUARTERLY REPORT

(October 5, 1978 - January 4, 1979)

INTRODUCTION:

This report spans several important phases in the preparation for project implemantation. Means and methodology for evaluation of project inputs, outputs and outcomes were defined and worked out in some detail; training programs for all levels of the health team as well as training sequance and manuals, incorporating the new responsibilities of each health worker were prepared. Bridging these two, new forms andrecords were developed following review of the existing health center and health unit record system; a survey into the status of the drug and commodity supply and transportation repair facilities was initiated and, finally, the last field visit for the purpose of orientation to and familiarization with the project districts and problem diagnosis was made to Assiut governorate.

Interpretation of achieved project milestones:

Our last field visit to Assiut provided important clues to some of our earlier queries. Thus in one village, where, because of religous practic, dual registration of vital events is maintained, the ratio neonatal to postneonatal mortality, which in all health centers and units hitherto examined ranged from 1:5 to 1:25 was reversed, namely 1.5:1. Contrary to previously examined health posts, where most births were registered as having occurred on the day of delivery, reporting of births in the two health centers and two health units examined in Assiut followed a "normal" curve with the median lying around 4 days. Additionally, tetanus neonatoram, a condition notably absent from the list of causes of child deaths in all previously examined health posts turned out to be not only recognized as such but also mentioned as the single most important cause of neonatal deaths by the majority of the interviewed health personnel.

These findings lend strong support to our earlier voiced suspicions about underreporting of deaths in the first seven days of life. Implementation of our outreach program should further help in the verification and validification of this impression for other districts as well.

Closer scruting of the health center/unit's personnel administrative activities also tended to support our earlier impression of an unyieldy and cumbersome system.

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The environmental sanitarian alone is responsible for filling 31 individual forms or summary ledgers; MCH, outpatient and inpatient care require more that 35 forms or ledgers, the doctor is burde with a complicated drug ordering and monitoring system involving multiple forms and copies of each. In the units, the lab. assistants look after the pay, holiday revolving accounts in addition to maintaining the store's ledger, travel allowance record, personnel summary record(required for transfers), and, finally, their laboratory records.

By contrast, health service supportive systems i.e. drug availability, cold chain, seemed to be by and large adequate.

Thus it seems that strengthening of rural health services will not only require extensive reorientation of service delivery, but revision of the entire health care system: administration, service delivery, training, supportive services and community involvement.

This not only slows preparation of the training plan but makes implementation of the complete range of services on the proposed implementation dates improbable. Instead, while specific changes in the delivery of services relating to child care may be implemented on the foreseen dates, the recording, supervisory and in service-training systems as well as the overall administrative apparatus will need to be phased in sequentially and in pace with their being developed. This gradual build up towards "full strength" services is further necessitated by the fact that on the foreseen implementation dates we will have attained only 3 to 4 of the 8 prerequesites considered necessary (Drugs, Equipment, vehicles, standing orders, revised forms and records, trained personnel , an informed and participating community and central and peripheral personnel in place).

On reexamination of an earlier worked out CPM chart, according to which implementation of the majority of activities was seen feasible by March 1, 1979 the following problems were found to have slowed expected progress.

1) Ordering of Equipment was delayed by 6 weeks. Thus a considerable number of required items will not be available by the desired date

2) Contrary to expectation, the Chief of Party's time input into most phases of development of the preimplementation phase was 100% rather than an estimated 25-50% requiring sequential rather than paralled phasing of work

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3) Working with external consultants considerably reduced the little time available.

4) Development and translation of records, summary ledgers and of the training manuals took and still is taking considerable effort and time.

CONCLUSION:

While I firmly believe in the feasibility of strengthening rural health service delivery along our proposed plan, firm adherence to a fixed time frame will become increasingly different especially when it is realized that in the development of this time frame a rather different approach to the solution of existing problems and constraints was envisaged. This, of course, is not surprising considering that diagnosis of the problem and identification of constraints has shifted considerably as more detailed information became available. While our previous tasks i.e. problem diagnosis, finding suitable interventions and examining alternatives, developing the implementation plan and training programs appropriate for this plan were relatively easy, we now face the much more difficult task of implementing 'our' proposals. This involves convincing the provider and consumer alike of the need for and appropriateness of the suggested changes, it involves training the health care providers, mainly the doctors and nurses, and the mothers in the newly required responsibilities and skills, it requires reorganization of the existing health service administration and of gradual build up of supportive systems.
In closing, I believe that a careful review of project goals, activities and targets needs to be performed now by all those involved and levels of input, output and required resources be carefully reassessed before we can continue.

1-25-79

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M.O.H. COMMENTS

On The Quarterly Report (October 5,1978 - January 4,1979)

1. Under-reporting of deaths in the first 7 days of life has been discussed before. Regulations stipulate reporting of births during the first 7 days of life. This could be the cause of under-reporting of deaths in the first 7 days of life notably for biths not attended by the staff, particularly in villages far from the health center/unit. Hence this may be observed in units serving more than one village.

2. The areas of strengthening rural health services i.e. service delivery, adminstration, supervision, training, supportive services and motivation of staff and community; had been addressed in the Project Paper.

3. As the project director said in the 25th of January meeting, implementation is more difficult than planning. The areas of environmental health, health education and community involvement are still to be more developed by short-term consultants. Project director has agreed in that meeting to start implementing the plan as scheduled and on a step-wise basis, to reach "full strength" in 6-8 months. The participation of the local and peripheral staff in the national campaign for vaccination against poliomyelitis, would delay implementation in the first district (Sinbillawin) to late March 1979 instead of first week of the month.

4. M.O.H. is looking forward to receive the financial portion of the quarterly report in the due time.

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