

TASC 2/JSI ANNUAL REPORT

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Submitted by

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Summary

During this second year of TASC 2, JSI managed seven Task Orders, three of which have been continuing from Task I period and four which were awarded during TASC 2 period. The Task Orders that have been continuing since the TASC I period are:

1. Russia - Maternal and Child Health Initiative
2. Ukraine - Maternal and Infant Health Project
3. South Africa - Logistics Management Technical Assistance

However, the Task Order in South Africa ended on April 30, 2005.

The Task Orders awarded during the TASC 2 period include:

1. Global - Preventing the Medical Transmission of HIV-Reducing Unsafe and Unnecessary Injections in Selected Countries of Africa and the Caribbean
2. Djibouti - Expanded Coverage of Essential Health Services in Djibouti
3. Albania – Albania Family Planning Activity.
4. Ukraine - TASCII Ukraine MIHP

The activities under these Task Orders are progressing as planned.

The following table provides the details of the Task Orders that JSI managed during this second year of TASC 2.

Task Orders awarded to JSI, since March 2002

Task Order #	Country	Approved Budget	Obligation to Date	Remaining Obligations	Completion Date
Task Orders continuing from TASC I					
806	South Africa	\$5,597,890	\$5,597,890	0	4/30/2005
811	Dominican Republic	\$908,800	\$908,800	0	6/30/2004
812	Ukraine	\$4,992,549	\$4,992,549	0	9/26/2006
813	Russia	\$9,949,023	\$9,932,503	\$16520	9/7/2006
Task Orders awarded under TASC II					
800	Djibouti	\$9,195,958	\$9,195,958	0	4/26/2007
001	Global (MMIS)	\$56,824,216	\$4,463,880	\$52,360,336	
802	Albania	\$1,000,000	\$1,000,000	0	9/29/2006
801	Ukraine	\$999,996	\$999,996	0	9/29/2006
Total		\$89,468,432	\$37,091,576	\$52,376,856	

Albania: Albania Family Planning Project (AFPP)

The *Albania Family Planning Project (AFPP/TASC II)* was awarded at the end of September 2004 to continue USAID's family planning/reproductive health support to the Ministry of Health (MOH) in three key areas:

- achieving and maintaining contraceptive security;
- completing family planning training in the country's remaining 16 districts;
- increasing knowledge of family planning methods and promoting the use of modern contraception through a BCC program.

During the project start-up period, a cohesive project team with clearly defined roles and responsibilities was put in place, and a well-articulated Strategic Framework was designed collaboratively with stakeholders. AFPP also developed and submitted to USAID a two-year work plan along with PMP indicators to measure progress.

Although the project is being implemented intensively in sixteen (16) districts, contraceptive security and BCC activities are nationwide in scope. The FP training was conducted in six districts during this first year (Lezhe, Diber, Lushnje, Fier, Vlore, Diber) and the remaining ten districts will be covered in Year 2. Much of the AFPP/TASC II scope of work is a continuation of the family planning technical assistance provided by USAID under the previous SEATS and TASC I projects. AFPP staff participated in an external USAID assessment in September 2005, and the document prepared for the Assessment Team is attached as an Appendix to this report.

The PMP tables on the following pages summarize the project's achievements during Year 1. Contraceptive stock outs were declining by the end of the year, but remained stubbornly high, and contributed to a somewhat slower increase in Couple Years of Projection (CYP) than anticipated. However, CYP is expected to increase significantly following the initiation of the mass media campaign which began in November 2005.

Overall, the AFPP start up went smoothly and each of the three components is on track to achieve all of its PMP targets by the end of the project in September 2006.

Djibouti: Expanded Coverage of Essential Health Services Project (PECSE)

The Expanded Coverage of Essential Health Services Project (PECSE), was awarded in late April 2004. Financed by USAID for three years and implemented by John Snow, Incorporated (JSI), PECSE is the first health sector project funded by USAID in Djibouti. The project supports Djibouti health reform to expand coverage of essential health services with a focus on rural areas in order to address several of the conditions which contribute to Djibouti's high infant, child and maternal morbidity and mortality.

To achieve the objectives, the project has undertaken the following activities:

- 1) increasing the supply of essential health services by improving service facilities through rehabilitation, the provision of equipment, and the rehabilitation of water supply, as well as through expanding the range of essential services available at targeted sites;
- 2) improving the quality of services through strengthening management systems and training to improve the skills, knowledge and performance of providers; and,
- 3) enhancing local capacity to sustain health services by increasing community participation in health programs, strengthening the role of local associations, NGOs and other community groups in community mobilization and in information, education and communication activities to address health issues of importance to the community, as well as through expanding the community health aide model.

In close collaboration with the MOH, JSI has defined specific technical and geographic focus areas that the Project will support in expanding essential services and addressing each of these intermediate results.

The project operation began in May 2004 but the official launch project took place on January 23rd, 2005. The participants included numerous dignitaries including the United States Ambassador, USAID Representative, His Excellencies the Ministers of Health and of International Cooperation, and others including ambassadors, UN bodies' representatives, French Cooperation, international and local NGO representatives, members of Djiboutian civil society, MOH officials and District Hospital physicians. The official launch assembled all key partners and was the opportunity for the Secretary General of the Ministry of Health to make a presentation on the important axes of health system reform for Djibouti.

The PECSE Project has made significant gains in a number of areas during the first year of project implementation, including measurable progress towards meeting each of the main intermediate results defined by USAID and operationalized through defined indicators. PECSE met all of its project year 1 objectives, in a challenging context with numerous obstacles.

Achievements during PY 1 include:

- Some service delivery areas and water systems in targeted health facilities have been rehabilitated, and the long process of procurement of appropriate equipment and furniture to support the provision of essential services is well underway.
- PESCE's Three year Work Plan and Performance Monitoring Plan were approved.
- Essential Services package at all levels of the MOH system is defined by the Ministry of Health.

- Two radio spots on pregnancy risks signs and children diarrhoea were developed and broadcast on National Radio of Djibouti in three languages, and more are under development.
- In-service training has begun to revitalize the skills of health care providers, and has developed eleven in-service training modules this year.
- PECSE worked with the MOH to improve service management systems to sustain the quality and efficiency of health services, including supporting the development of the District Management Teams and improving national plans for Health Information Systems.
- Community mobilization and linking health facilities to community health aides and community health committees has begun in communities in all five districts. On-going discussions and a planned mobilization study tour will continue to keep this topic in the forefront.
- PECSE has introduced management innovations in the Djiboutian context including non-discriminatory practices, and discussions about HIV/AIDS workplace policy.
- Cost savings for the US government have been achieved through a variety of actions, resulting in significant savings.
- Overall health sector coordination and collaboration improved, reinforcing the MOH in its primordial role as the ultimate source of health improvements for the country.

PECSE/JSI worked hard to build trust within the MOH, and to create a long-term working relationship. While there are few qualified public health managers and technicians available to work with PECSE on a central or district level, excellent working relationships have been forged and substantial progress has been made towards all major Intermediate Results.

Russia: Maternal and Child Health Initiative (MCHI)

In September 2003, the Russian mission of the United States Agency for International Development (USAID/Russia) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract (TASC I) to implement its three-year Maternal and Child Health Initiative (MCHI). The project's objective is to ensure the adoption of internationally recognized maternal and child health (MCH) standards and practices by the targeted health facilities in Russia.

MCHI contributes to USAID/Russia's Strategic Objective, SO 3.2: *Use of Improved Health and Child Welfare Practices Increased*. Indicators directly related include: Indicator 3.2.3: *Abortion rates*, the Intermediate Result 3.2, IR1: *Access to More Effective Primary Health Care (PHC) Services Increased*, and its indicator: *Number of health facilities implementing evidence-based maternal and child health (MCH) care practices*. The expected results of the Project were modified in June 2005. The funding ceiling was increased to \$9.94 million and the scope of work expanded. The expanded expected results are outlined in the rest of this document.

In March 2005, MCHI reached its mid-point and underwent a mid-term evaluation by a team composed of a senior member from the USAID EE/EA Bureau and two senior technical experts from the JSI/Washington office. The evaluation team observed that MCHI has proved that it can make change happen. The **capacity building** at the regional level is impressive, and the potential is great for continued achievement and further expansion.

The MCHI Project has incorporated evidence-based, internationally-recognized standards of care into the Russian health care system. The project integrates previously vertical MCH, family planning, and HIV/AIDS activities and standardizes content and continuity of care.

The Project currently reaches a substantial part of the 16 MCHI target regions that together constitute more than one-sixth of Russia's population and has the **potential to scale up further** to reach a larger population. In addition to the potential for **replication** it offers an excellent potential for **sustainability**, which was built into its design. The current co-financing by the clinics and strong commitment from the management assures that the evidence-based interventions introduced by MCHI will be sustained in target facilities beyond the life of the Project and that adoption of those interventions will be rolled out or spread throughout most, if not all, of the other health facilities in the target regions.

The adoption and integration of **internationally-recognized, evidence-based standards** is occurring at an impressive pace across a broad range of political and health institutions, and is actively involving people over a vast geographic area. Inter-linking components and multi-level focus give the project and its activities strength, breadth, adaptability, and flexibility. The MCHI approach and content is, for Russia, an idea whose time has come. The MCHI **process** (participatory, interactive, kind, respectful) is a major message that Russian counterparts were longing to hear and to which they've responded. An effort has been made to model within regions the client-centered, mother-friendly, baby-friendly, youth-friendly, and family-friendly approach that the Project is striving to introduce into Russia's reproductive health services. **Continuity of care** is reportedly becoming more consistent across facilities. The regional/municipal/facility-level contributions (financially and in-kind) are far in excess of what was initially expected. Project **leveraging** is substantial. By identifying and supporting "catalyst" institutions and individuals, MCHI has helped multi-level leadership implement bold, rapid, substantive changes.



MCHI efforts to collaborate and coordinate are palpable. **Coordination** with donors and USAID-funded CAs is **close and synergistic** rather than pro-forma and perfunctory. Collaboration with Russian regional and municipal government partners has been strategic and successful. One **challenge** is the **institutional development of RSOG** as MCHI's primary Russian partner organization. Realistically, there is no other known organization that would have been a stronger choice, but it is not currently capable of continuing or expanding scale-up unaided.

The Project has been **responsive and adaptive** to changing external conditions, especially with regard to **incorporating HIV/ AIDS and PMTCT**-related activities and increasingly focusing Project attention on the Russian Far East, as well as incorporating the Vishnevskaya-Rostropovich Foundation as a subcontractor. MCHI has become a major leader in Russia for PMTCT policy development and service standards of care. The recent **PMTCT+FP Study** should provide valuable data to inform the development of strong future policy and service standards. In addition, the development of a collaborative **PMTCT-plus model** is progressing. This **synergistic** model for PMTCT-plus has the potential to revolutionize care for HIV affected families. MCHI has also worked with ARO to **integrate ARO's Early Intervention model** into multiple MCHI training materials and is considered to be a substantive, positive addition that has especially strengthened the counseling component of these courses.

While **expanding the MCHI model into the two new RFE regions**, MCHI will also focus more on developing a **youth reproductive health model** in two pilot regions, a new strategy for **strengthening family planning interventions**, and a **rural family planning pilot initiative** in two pilot regions, and on rolling out the “Couples Campaign” to **increase male participation**. To date, MCHI has done much to increase male participation in family planning and other reproductive health services. Due to factors beyond MCHI’s control, the Campaign has been delayed by six months but is expected to be launched shortly.

Influencing the Russian professional medical community has been **a great challenge**. Much work remains to be done for new MCH practices to be disseminated and accepted throughout Russia, and for federal standards to reflect evidence-based best practices. A **comprehensive Documentation and Dissemination Plan** is currently being finalized, and MCHI is already implementing various actions outlined in the draft Plan. MCHI is actively seeking to better use the Internet for dissemination; the MCHI website now under development will extend dissemination of technical materials throughout Russia, the EE/EA region, and potentially the world.

South Africa: Logistics Management Technical Assistance

This period marked a milestone for the project as ***male condom distribution surpassed the 1 billion mark*** in this final reporting period – an impressive statistic for the final reporting period of a five-year contract.

The two key Activity Areas for this reporting period were the continued dramatic increase in public sector condom distribution following the launch of Choice™ and the “live” field testing of the biometrics/smart card information system for ART in a static and community outreach palliative care setting.

Condom Distribution/Logistics Management Information Systems (LMIS) Training

A total of 131,840,000 male condoms and 144,000 female condoms were delivered during a four-month period, from January 1 to April 30, 2005, to the primary distribution sites that the NDOH is responsible for. This dramatic increase represented over one million condoms per day – a result of the substantial impact of the branded and packaging redesign of the choice™ condom. It is becoming evident that the branding and repackaging exercise has dispelled the lingering public perceptions regarding poor quality government condoms that hampered the program substantially prior to JSI’s technical assistance began in 2000 to put a quality assurance program in place and eradicate shortages and stock outs. The branding and redesign of the packaging is considered a value added activity, initiated by JSI, that has had a major impact in elevating this program’s effectiveness to the highest level.

A total of 138 participants were trained in logistics and LMIS:

- 32 participants at the Gauteng Region 9 workshop, 2nd February
- 32 participants at the Gauteng Region 9 workshop, 5th April
- 74 participants, Western Cape Province (four regions), Cape Town, 7-11 March

The STAT™ Biometrics and Smart Card System for ART

Significant progress in the development of the biometrics and smart card system for ART was made during this reporting period.

Until this point the JSI/Net1 partnership to develop the biometrics and smart card application for ART was informal, a collaborative effort built through two companies having a similar goal of developing an innovative IT solution to assist in the roll out of ART services in South Africa.

In this collaborative effort, Net1's role was to develop the front end database, provide the technology to operate the system off line, and enable the data transmission from participating ART sites on a 24 hour update basis, and make the data available to a central reporting database. JSI's role was to provide the public health environment and clinical settings to ensure the system was responsive to clinician and patient needs as well as donor and government reporting requirements, and develop the central reporting database to where NET1 would transmit the data.

Before the system could go "live" – that is begin transmission of data from sites to the reporting database, NET1 and JSI signed a licensing agreement (January 12) that specified these respective roles and responsibilities and ensured the protection of NET1's intellectual property rights relating to their Universal Electronic Payment System (UEPS), the patented technology that the new system would adapt for ART. The licensing agreement also included equipment and data transmission pricing for the sites in which JSI might eventually implement the system. There was, however, no expectation in terms of the number of sites or the timing of any future implementation as these parameters were unclear and could not be determined at that stage nor could future funding be guaranteed.

During the reporting period JSI/South Africa developed the name STAT for the biometrics/smart card system (Secure Technology Advancing Treatment). This name was deliberately chosen not to be associated with HIV/AIDS as it is envisaged that STAT will become a standard patient retained medical record in the long term and not be limited to HIV/AIDS alone. The acronym STAT refers to the overall system and the JSI reporting database.

The first "live" transmission of data occurred successfully on April 8th at the CRS/SACBC site at St. Joseph's Care Centre, Sizanani, in Bronkhorstpruit and at the Palliative Care Project in SOWETO. The data were successfully decrypted onto the JSI reporting database and standardized reports were generated. By the end of April a total 52 ART patients were enrolled on the system and included in the reports.

Transition of TASC Contract to DELIVER Contract

As the TASC contract closed out during this period and the USAID Mission in South Africa and NDOH were keen to ensure that logistics technical support continued, the Mission decided to continue funding the activity through the ongoing DELIVER contract. Thus this period involved both TASC and DELIVER funding.

To assist in the TASC close out, and facilitate a smooth transition to DELIVER, Afua Ofuso-Barko from the JSI Boston office was in country from 28 February to March 18.

LTA/JSI Staff Participation in National HIV/AIDS & STI Meetings/Conferences

- The LTA and LMIS Officer supported Northern Cape counterparts for STI week and the national even on February 12 in Uppington, Northern Cape
- STI Quarterly Meeting in Kimberly, Northern Cape, February 22-24
- The LTA and STAT Project Manager attended a workshop on HIV/AIDS Management organized by the Foundation for Professional Development and Discovery Health, February 15-17
- Malswitch Team from Malawi to JSI/South Africa to learn about the JSI STAT system and explore the feasibility of introducing STAT in Ministry of Health sites in Malawi. The Malswitch team is based in the Reserve Bank of Malawi and the team utilizes a NET1 switching device installed in country to process and track banking transactions
- NDOH Bosberaad for Annual Operational Planning, Pretoria, March 10-11
- Free State University hosted the provincial HIV/AIDS ART programme, inviting JSI to share experiences in the roll out and demonstrate ongoing efforts including STAT, Bloemfontein, March 30-31

4. Performance

All activities are on target at the end of this reporting period.

Ukraine: Maternal and Infant Health Project

1. Overview

MIHP conducted various activities during this quarter. There were 16 successful training seminars, 5 working group meetings on development of national neonatal and obstetrical protocols, and 4 follow-up visits to MIHP sites. The BCC activities focused on development of a survey to evaluate impact of IEC materials among post-partum women. Also there was one press-tour held in Donetsk maternity # 3. The MIHP Cost Impact Study was almost finalized this quarter. The PMTCT component started its training activities in Simferopol and a PMTCT coordination Meeting was held in Donetsk with participation of different HIV-serving organizations. MIHP continued to cooperate with Policy Project and UNICEF this quarter. One of the biggest successes was that the Minister of Ukraine conducted MOH Meeting in Lutsk with a tour of the Lutsk maternity.

As a result of the overall MIHP activities, Zhitomir Maternity became a center of excellence where effective perinatal technologies have been implemented. For TASC II, several new sites joined the project: 22 women's clinics in Donetsk, Donetsk maternity N 6, Zhotomir maternity and Kiev - oblast maternity N 1. By request of the Ministry of Health additional sites (Kirovodrad and Komsomolsk-city maternities) also joined MIHP. The TASC II PMTCT component was implemented in three MIHP regions: Donetsk, Simferopol and Kiev. The major success of MIHP this year was that Dr. Mykola Polischuk, the Minister of Health of Ukraine organized an extended MOH meeting in Volyn oblast on the base of Lutsk MaternityN 3 on 26 August 2005. After visiting the maternity and during a meeting at Volyn State Administration, the Minister thanked USAID for providing the opportunity to implement MIHP and made an appeal for every region of Ukraine to come close to the achievements of Lutsk maternity within 6-8 months. Please see the Year III activities summary below for details.

2. Clinical and training activities

Year III of MIHP was marked by several training activities for different health care professionals in MIHP sites. There were 9 categories of clinical trainings conducted (MNH, antenatal, Infection control, tutorial, EBM, ToT trainings etc.). In total there were 49 trainings in Year III, which covered 713 MIHP maternities' staff, 51 educators from medical universities, 22 Heads of Oblast Healthcare Departments and 13 specialists were trained to conduct follow-up visits to monitor and evaluate post-training activities. Together with the JSI-WIN Project and International experts, MIHP personnel participated in the development of an antenatal training module and the clinical staff took part in the development of the National Reproductive Health Program for 2006-2010 initiated by Policy Project. At the end of Year II, MIHP had three centers of excellence (Lutsk maternity, Donetsk maternity N 3 and Zhitomir-city maternity). Numerous delegations from other Ukrainian oblasts visited these centers in order to become acquainted with effective perinatal practices for further implementation in their institutions.

3. Protocol development component

Working in close collaboration with the Ministry of Health of Ukraine (MOH) MIHP conducted 4 working groups on protocols' development: OB/GYN, Neonatal, Pediatric and Epidemiological TAGS. In Year III there were 17 TAG meetings which resulted in 11 protocols. Protocols on preeclampsia, pre-term deliveries, abnormality in labor, post-partum hemorrhage were very timely and important protocols to improve birthing outcomes. There were also 2 MOH prikazes (orders) developed by the TAGs: Prikaz # 676 "About Improvement of Clinical Protocols on Obstetric and Gynecological Care" and Prikaz N 152 "About Improvement of Protocol on Healthy Newborn Medical Care". By the request of the MOH, MIHP supported the publication of all the developed protocols and Prikazes for further dissemination among Ukrainian Oblasts. The Main achievement of Year III was that Epidemiological Department of MOH approached MIHP and expressed its desire to revise old Prikaz N 59.

4. BCC component

BCC/IEC activities in the Year III were aimed at the development of informational materials and trainings on breastfeeding and counseling skills. The following IEC materials were developed, pre-tested and distributed among MIHP sites: (1) Posters on hand washing, HIV/PMTCT, Anti-smoking and Anti-alcohol (during pregnancy); (2) Booklets on Breastfeeding, Baby Health Card, and Postpartum Contraception. There were 4 trainings conducted on IEC counseling skills for 65 health care providers of MIHP sites, one ToT training on Breastfeeding (28 HCP trained), 2 trainings on Postpartum contraception (35 HCP trained). In cooperation with UNICEF, MIHP/BCC specialist and clinical personnel conducted 2 trainings on perinatal technologies and optimum infant feeding for national experts assessing baby-friendly hospitals (60 experts were trained).

5. PMTCT activities

The PMTCT component started in three MIHP sites in October 2004: Simferopol, Donetsk and Kiev. During Year III, MIHP/PMTCT specialists established contact with local AIDS centers, NGOs working in HIV/AIDS area including Network of People living with HIV/AIDS (NPLWH/AIDS). Needs assessments were conducted in the three mentioned oblasts. PMTCT staff took active part in adaptation of a generic PMTCT training module and development and national VCT protocol initiated by the Policy Project. During the last project year one extended training on PMTCT for ob/gyns, antenatal HCP, neonatologists, social workers from 3 MIHP PMTCT oblasts was conducted in Simferopol. MIHP PMTCT Workshop in Donetsk with participation of heads of women outpatient clinics, AIDS Center workers, deputy heads of maternities, social workers and city

authorities as well as representatives from other NGOs and Projects made it possible to establish links among different HIV/AIDS-serving organizations. A PMTCT monitoring form was developed and integrated into the existing MIHP/M&E format.

6. Equipment procurement

Necessary equipment was purchased and delivered to the MIHP sites according to the schedule in Year III. The TASC I equipment procurement plan is almost finalized with some minor items to be procured for the sites. By the end of 1st Quarter of MIHP/Year IV all the planned equipment will be provided to the Project sites.

7. M&E /Achievements

The M&E department performed routine data collection and processing for data analysis and reporting. The M&E database was reviewed and adapted to the current needs of MIHP activities. EpiInfo data analysis software helped to effectively and more accurately analyze the received data. M&E has incorporated MIHP TASC II activities into existing M&E formats. Also the MIHP cost study impact was one of the priorities this year.

8. Cooperation

During Year III MIHP collaborated with UNICEF, POLICY Project, Swiss Cooperation, CURE organization, Ministry of Health and local Health authorities. The biggest achievement was that MIHP, by request of UNICEF, trained National BFHI specialists and helped to revise criteria of BFHI. CURE organization supported press-tours in Lutsk and Donetsk maternities which resulted in dissemination of Lutsk and Donetsk maternities' achievements in 3 oblasts: Volyn, Rovno and Donetsk.

9. Challenges

Major challenges this year were difficulties in implementation of effective perinatal technologies in Kiev-oblast maternity N 1 and Lviv Oblast Maternity due to unwillingness of city and local/maternities' health management to change their attitudes and practices towards International evidence-based perinatology. According to M&E data as well as follow-up visits, there was little to no improvement in delivery and newborn care practices in the mentioned sites.

Global: Immediate Relief to Decrease Unsafe Injections Under the President's Emergency Plan for AIDS Relief: Uganda, Ethiopia, Mozambique and Nigeria, commonly known as Making Medical Injections Safer (MMIS).

With funds from the President's Emergency Plan for AIDS Relief (PEPFAR), the United States Agency for International Development (USAID) contracted John Snow Inc. (JSI) to implement *Preventing the Medical Transmission of HIV: Reducing Unsafe and Unnecessary Injections in Selected Countries of Africa and the Caribbean* in Ethiopia, Mozambique, Nigeria, and Uganda. The original 11-month USAID project began officially in early March 2004. A no-cost extension extended the project life to March 31, 2005 at which point a cost extension was awarded to continue the project activities until September 30, 2009. The project is currently being implemented in four countries: *Uganda, Ethiopia, Mozambique and Nigeria*.

In addition to these countries, JSI continues to work on a five-year cooperative agreement with the US Centers for Disease Control and Prevention (CDC) in Haiti and six countries in Africa implementing similar programs. Under a subcontract to Initiatives, JSI also implemented injection safety activities in Guyana.

In all four USAID countries, MMIS has field offices staffed with a Country Director, a logistics advisor, waste management advisor, a BCC advisor, and an administrative / finance officer (a few countries have additional part- or full-time administrative support). Each country is backstopped by a technical advisor at headquarters who serves as a Country Team Liaison (CTL) to facilitate the day-to-day management and coordination with the Country Director.

In-country teams provide technical guidance and collaborate with the Ministry of Health (MOH), USAID, CDC, the World Health Organization (WHO), the Safe Injection Global Network (SIGN), and other stakeholders in injection safety. At the international level, MMIS has established a close working relationship with the WHO Africa regional office (WHO/AFRO) and with WHO headquarters in Geneva.

Technical Approach

In the four countries supported by USAID funding, MMIS is implementing the strategy recommended by SIGN, which includes the following components:

1. ***Commodity management and procurement*** support for estimating, financing, procuring, and distributing injection equipment and waste disposal containers;
2. ***Capacity building and training*** in injection practices, supply management, waste handling, and interpersonal communications;
3. ***Behavior change and advocacy*** to reduce demand for injections;
4. Standardized system for proper sharps ***waste disposal***;
5. Strategies for working with ***private providers***¹;
6. Establish a ***policy environment*** that supports injection safety with guidelines, resources and monitoring of injection practices;
7. ***Monitoring and evaluation*** of the content and process of care, identifying quality gaps, and developing and implementing interventions ;
8. ***Travel*** to venues for sharing lessons learned.

At international and national levels in each of the four countries, the MMIS strategic approach consists of mobilizing stakeholders inside and outside the Ministry of Health to ensure that the policy and action plans developed with the contribution of our staff are coherent and sustainable. The JSI team already collaborates with many of these organizations in-country, and new partnerships continue to be developed as needed.

The following is a highlight of MMIS activities during this annual reporting period:

MMIS Participation in the 2004 Safe Injection Global Network (SIGN) Meeting

The MMIS project played a key role in the SIGN meeting held in Cape Town, South Africa by coordinating with USAID and other PEPFAR contractors on agenda topics. The MMIS project director and staff from five countries made presentations on their progress to date in implementing interventions to improve the safety of injection practices and to reduce the use of unnecessary injections. MMIS host government counterparts from Kenya, Mozambique, South Africa, Tanzania, and Uganda also made a presentation on this project's work.

¹ This work is scheduled to begin in Year 1 in Uganda and in Years 2, 3, or 4 in the other countries.

Sustainability Workshop

In October 2004, subsequent to the SIGN meeting, the MMIS project staff participated in a workshop near Johannesburg, South Africa to share information and ideas on the project to date and to work together to identify the critical elements of national safe injection sustainability strategies. The workshop discussed the technical details of injection safety initiatives; best practices and strategies for overcoming constraints in project implementation; sustainability of injection safety programs; health care waste management, logistics and supply management, advocacy, BCC, financial sustainability, and capacity building.

MMIS 2005 Annual Meeting

In September 2005, the MMIS project staff held the MMIS Annual Meeting in Dar es Salaam, Tanzania. The annual meeting was also attended by the international project partners (WHO Geneva, WHO AFRO, IASIT) and other PEPFAR projects in injection safety (Chemonics, University Research Corp., and Initiatives). Scaling up of injection safety interventions and capacity building to ensure sustainability were the major issues discussed. During the meeting, an MMIS Country Expo was presented to share experiences and lessons learned by each country program with project and partner colleagues.

Commodity Management and Procurement

Procurement assessments continue in countries that have not been assessed, and specific follow up activities are moving forward in other countries. To address needs that emerged in assessments, two regional workshops are being planned, with the objectives of strengthening the understanding of quality standards for safe injection materials, providing current sourcing information for international suppliers, and forecasting issues related specifically to injection material and safety boxes. Country-specific activities included new product registrations in Ethiopia and Nigeria. In Ethiopia, a pilot data collection exercise is underway to assess impact on cost recovery systems and also to establish the most reasonably complete set of data on products in the market place to compare with estimated needs.

In June 2005, PATH began conducting evaluations of the injection safety products introduced into MMIS countries. Using a standardized questionnaire developed by PATH, the evaluation collected specific user feedback on the use of the products. The results from this evaluation have been used to refine training materials and provide feedback to manufacturers, and to guide the procurement tender.

Waste Management Meetings

A series of meetings is underway to accelerate improvement in waste management practices in MMIS countries. An initial meeting was held in Geneva in June 2005 to clarify WHO policy on waste management, including clarifications on the acceptability of incineration as an interim treatment solution, the use of needle-removers, limitations in the practice of chemical disinfection of waste, limitations in advanced treatment systems such as autoclaves and shredders, and the importance of matching waste solutions to infrastructure settings.

A second meeting took place in October 2005 in Ethiopia for all MMIS medical waste staff, their MOH and/or Ministry of Environment counterparts, and technical experts. The goal of this meeting was to identify approaches and technologies for waste management that are best suited for African infrastructure settings.

Coordination with Other PEPFAR Partners

MMIS participated in several PEPFAR partner meetings. In October 2004, USAID convened a meeting of PEPFAR injection safety projects to coordinate their contributions to the 2004 Safe Injection Global Network (SIGN) meeting. The MMIS Project Director made a presentation on SIGN to the participants. At the December 2004 PEPFAR meeting, the MMIS Project Director and CTO debriefed the other contractors who had been unable to attend the SIGN meeting in South Africa.

Standardization of Training Materials

In response to requests from country directors and in consultation with WHO/AFRO, the MMIS project prepared a draft training manual and a facilitators' guide. In April, a two-week workshop, co-sponsored with WHO/AFRO regional office was conducted in Harare, Zimbabwe to finalize the Injection Safety Facilitators' Guide. At the end of the workshop action plans were created to strengthen Injection Safety and Infection Prevention and Control training activities to take place in the medical institutions in each country. Following the workshop, a training workshop was conducted at an African medical university for key trainers from selected MMIS project countries. The final version has been translated to French and Portuguese in order to maximize its usefulness. Currently, the document is being used and adapted by MMIS teams with the injection safety task force in selected countries.

Monitoring and Evaluation

Several new monitoring and evaluation tools were developed for use by country staff. The first tool was a needle stick injury report form, developed from materials received from PATH and similar to the tool developed by the University of Virginia. This tool was distributed to all MMIS country programs.

The second tool was a list of Norms and Standards of the MMIS project, developed from an appendix in *A Guide for Supervising Injections*, published by WHO (February 2004 version). This list guides revisions in training materials to ensure injection safety messages for health workers are clearly defined. The third tool is a test of health worker attitudes to be administered at the beginning and end of training workshops; this tool tests the degree to which the staff being trained have absorbed (and intend to follow) key aspects of injection safety knowledge and practices. Both of these tools were developed for the standardized training materials mentioned above.

A supervisory checklist tool was developed for use by MOH staff as they visit health facilities in their areas. A set of tools including a standard survey protocol, analysis plan, reporting guidelines, sample data entry program, revised data collection tools, and training support for data collectors was developed for health facility assessments to improve the quality of the assessments and to ensure that data are analyzed and reported in accordance with MMIS indicators.

Communications, Advocacy, and Knowledge Management

MMIS developed a communication strategy that includes knowledge management and global advocacy plans. Implementation activities to date include the development of the project logo and branding guidelines, development of a project brochure and fact sheet, prototypes of a project newsletter and information resources for staff, and launching of the project website.



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MINISTRY OF HEALTH

ANNUAL REPORT

October 2004 – September 2005



Albania Family Planning Project

October 2005



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

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ACRONYMS

AFPP	Albania Family Planning Project
BCC	Behavior Communication Change
CPR	Contraceptive Prevalence Rate
CS	Contraceptive Security
CSC	Contraceptive Security Commission
CYP	Couple of Year Protection
FP	Family Planning
FY	Fiscal Year
GOA	Government of Albania
HMIS	Health Management Information System
IEC	Information Education Communication
IPH	Institute of Public Health
IT	Information Technology
IUD	Intrauterine Device
JSI	John Snow, Inc.
LMIS	Logistic Management Information System
Manoff	JSI subcontractor for BCC
MCH	Mother and Child Health
MOH	Ministry of Health
MWRA	Men and Women of Reproductive Age
PHC	Primary Health Care
PHD	Public Health Directory
PMP	Performance Management Plan
POP	Progesterone-only Pills
PTT	Participatory Training Techniques
RH	Reproductive Health
RHU	Reproductive Health Unit
RT	Regular Trainers
SDP	Service Delivery Points
SEATS	Service Expansion and Technical Support
TASC	Technical Assistance & Support Contract
TIP	Trial of Improved Practices
TFR	Total Fertility Rate
UNFPA	United Nation Fund Population Aid
USAID	United States Agency for International Development
WCR	Women Consultancy Room

I. Executive Summary

The *Albania Family Planning Project (AFPP/TASC II)* was awarded at the end of September 2004 to continue USAID's family planning/reproductive health support to the Ministry of Health (MOH) in three key areas:

- achieving and maintaining contraceptive security;
- completing family planning training in the country's remaining 16 districts;
- increasing knowledge of family planning methods and promoting the use of modern contraception through a BCC program.

During the project start-up period, a cohesive project team with clearly defined roles and responsibilities was put in place, and a well-articulated Strategic Framework designed collaboratively with stakeholders. AFPP also developed and submitted to USAID a two-year work plan and PMP indicators to measure progress.

Although the project is being implemented intensively in sixteen (16) districts, contraceptive security and BCC activities are nationwide in scope. The FP training was conducted in six districts during this first year (Lezhe, Diber, Lushnje, Fier, Vlore, Diber) and the remaining ten districts will be covered in Year 2. Much of the AFPP/TASC II scope of work is a continuation of the family planning technical assistance provided by USAID under the previous SEATS and TASC I projects. AFPP staff participated in an external USAID assessment in September 2005, and the document prepared for the Assessment Team is attached as an Appendix to this report.

The PMP tables on the following pages summarize the project's achievements during Year 1. Contraceptive stock outs were declining by the end of the year, but remained stubbornly high, and contributed to a somewhat slower increase in Couple Years of Projection (CYP) than anticipated. However, CYP is expected to increase significantly when the mass media campaign begins in November 2005.

Overall, the AFPP start up went smoothly and each of the three components is on track to achieve all its PMP targets by the end of the project in September 2006.

PERFORMANCE MANAGEMENT PLAN (PMP): REPORT FOR YEAR 1

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Expected & Actual Achievements for the 1 st year (Sept 2004–Sept 2005)		Target FY 2006
						Expected	Actual	
% of service delivery points providing family planning services	# of SDPs with commodities, trained provider(s), IEC materials/ total # of SDPs SDP's = 446 MOH facilities (Maternities, WCRs, HCs) Unit: %	LMIS Reports; project reports Quarterly	16 Project Districts	LMIS Officer	0 % (2004 LMIS)	50 %	53.9 % (96 /178)	90 %
			National		68 % (2004 LMIS)	84 %	82% (366/446)	99 %
Couple years of protection (CYP) *	Total number of contraceptives distributed by type (method) in a given period with weights applied to different methods. 1 CYP = 15 Packets Oral Pills 1 CYP = 4 Depo Injections 3.5 CYP = 1 IUD 1 CYP = 120 Condoms Unit: #	LMIS Reports Quarterly	16 Project Districts	LMIS Officer	774 per quarter (2004 LMIS)	1000	854	1600
			National		3,750 per quarter (2004 LMIS)	4000	3,754	5000

*When calculated annually means average quarterly CYP

IR 1: Health Resources Efficiently Managed

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Expected & Actual Achievements for the 1 st year (Sept 2004 – Sept 2005)		Target FY 2006
						Expected	Actual	
Sub IR1.2: Health Information Systems Improved								
% of service delivery points stocked out of condoms, POP, injectables and low dose contraceptives in 16 target districts	# of SDPs reporting zero stock of specific commodities/ # of SDPs reporting Unit: %	Routine LMIS Reports Quarterly	Project 16 districts	LMIS Officer				
			*Condoms		28 %	20	28.7 %	10 %
			*POP		64 %	20	59.9%	10 %
			*Low dose		22 %	20	17.3%	10 %
			*Injectables		14 %	20	15.4%	10 %
IR2.2: Skills of PHC Providers Enhanced								
% of SDPs in 16 target districts with staff trained using national FP curriculum	# of SDPs in target districts with at least one staff person trained using national FP curriculum/ total # SDPs in intervention districts SDP = MOH facilities (maternities, WCRs, health centers) Unit: %	Training Records; Quarterly	By type of SDP:	Training Officer				
			Maternity		0 %	50 %	37.5 % (6/16)	90 %
			WCR		0 %	50 %	90.9 % (10/11)	90 %
			Health Center		0 %	50 %	53 % (80/151)	90 %
			By cadre:					
Doctors	0 %	50 %	58 % (103 / 178)	90 %				
Nurses/ midwives	0 %	50 %	57% (203/357)	90 %				

IR 3: Use of PHC Services Increased								
Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Expected & Actual Achievements for the 1 st year (Sept 2004 – Sept 2005)		Target FY 2006
						Expected	Actual	
IR 3.1 Access to PHC Services Increased								
Total # of family planning visits in 16 target districts	Total clients visits to SDPs for first FP visits, re-visits, and counseling Unit: #	LMIS Reports; Quarterly	First visits	LMIS Officer	750 per quarter	945	921	1500
			Re-visits		1339 per quarter	1700	1490	2680
			Counseling only		686 per quarter (2004 LMIS)	900	1271	1370
% MWRA attending SDPs, who have been exposed to at least one campaign material and can state at least one message	# of MWRA attending SDPs, who state that they have been exposed to at least one campaign material and can state at least one message/ # of MWRA interviewed. Unit: % Campaign materials = TV spots or programs, events, pamphlets/ brochures). MWRA attending SDPs that provide MCH services are MWRA attending target facilities for maternal or routine child health care	Exit interview at SDPs; during campaign; end of project		BCC Officer	0%	8 %	0% ²	15 %

IR3.3: Community Participation in Health Promotion Activities Increased

² No data collected for this indicator in Year 1 because the TV spots begin only in Nov 2005. The 15% target for Year 2 remains unchanged.

Indicator	Indicator Definition and Unit of Measure	Data Source/ Frequency	Disaggregation	Person Responsible	Baseline (Year)	Expected & Actual achievements for the 1 st year (Sept 2004 – Sept 2005)		Target FY 2006
						Expected	Actual	
% of villages which have FP service provided by at least one community midwife in 16 districts	# of villages which have FP service provided by at least one community midwife in 16 districts / total # of village in the 16 districts Unit: %	Training Records; Quarterly	16 Project Districts	Training Officer	0	10 %	9.64 % (128/1328)	18 %

II. BRIEF OVERVIEW OF THE PROJECT

The Albanian Family Planning Project (AFPP) operates within a national Primary Health Care (PHC) framework established by the Ministry of Health to ensure universal access to primary care in Albania.

AFPP Counterpart	Ministry of Health
Prime Contractor	John Snow, Inc.
Subcontractor	The Manoff Group (for BCC)

AFPP Goal Work within the national PHC framework to expand access to quality family planning services in sixteen districts, and to increase awareness of modern family planning methods and availability of contraceptives nationwide.

AFPP Components

1. Contraceptive Security – assist the Ministry of Health achieve and maintain contraceptive security.
2. Family Planning Training -- complete FP training in the country's remaining 16 (of 36) districts
3. Behavior Change Communication -- increase knowledge of FP and promote the use of modern family planning methods.

COMPONENT 1: Contraceptive Security

Strategy: Use the existing National Contraceptive Security Commission for maintaining adequate contraceptive stocks in the country, and coordinating the contributions of the public, social marketing and commercial sectors to contraceptive security in Albania. Support the MOH Logistics Management Information System (LMIS) to ensure an uninterrupted supply of contraceptives to approximately 300 MOH service delivery points that provide FP services.

Expected Overall Result: Contraceptive security in Albania, i.e., the guaranteed long-term supply of quality contraceptives for every Albanian who wants them.

Key Indicators for Component 1

- Contraceptive Security Commission meets regularly under the leadership of the MOH vice Minister, with representatives from the social marketing and commercial sectors.
- Timely and accurate LMIS data is generated by the MOH and used in decision making to ensure contraceptive security in Albania.

Strategies for Component 1

1. Ensure a continuous supply of contraceptives at health facilities nationwide, with special focus on availability in the sixteen target districts.
2. Strengthen the Contraceptive Security Commission by forming a small working group within the Commission to serve as a Secretariat.
3. Use the Bucharest RH Conference (April 2005) to 're-start' the Contraceptive Security Commission and provide a contraceptive security action agenda for AFPP.

4. Assist the MOH to streamline LMIS to make it more sustainable while providing all the core data required to maintain contraceptive security in Albania.
5. Integrate LMIS training into the FP training; include LMIS in the topics that the Master Trainers are qualified to teach.
6. Assist the MOH to synchronize the current LMIS with the emerging HMIS.
7. Leverage UNFPA resources to support contraceptive security in Albania, especially in contraceptive forecasting and LMIS (computers, printing forms, technical assistance.)

COMPONENT 2: Family Planning Training

Strategy: Form teams of local trainers and master trainers (MOH staff) who train providers in 16 target districts (170 service delivery points) in quality family planning services, including modern methods of contraception, contraceptive logistics management, counseling and community out-reach. Build upon the curriculum, cue cards, and trainers previously developed in Albania with JSI collaboration.

Expected Overall Result: By training FP providers in these remaining 16 districts, Albania will achieve nationwide FP service coverage by mid-2006.

Key Indicators for Component 2

- A minimum of one provider trained in family planning in 90% of 170 potential FP service delivery points (Maternities, Women's Consultation Rooms, Health Centers) in 16 target districts.
- Increase in the number of FP service delivery points in Albania from 300 to 430 by 2006.
- Couple Years of Protection (CYP) in the target districts doubles during the life of the project.

Strategies for Component 2

1. Begin FP training in the most populous of the 16 target districts for a greater impact early in the project.
2. Develop a National Family Planning curriculum & Trainer's Guide based on current international FP guidelines, effective counseling techniques, and informed choice.
3. Develop an indigenous, sustainable FP training capacity in Albania by forming a small cadre of Master Trainers within the MOH able to organize and implement trainings for district-level FP trainers throughout Albania.
4. Use local training teams composed of MOH staff to deliver FP training courses, thus building local training capacity and contributing to the long-term sustainability of FP training.
5. Use FP training to integrate the other two project components by including in all trainings 1) LMIS to ensure availability of contraceptives, and 2) BCC materials to create awareness and demand for family planning.
6. Include some community midwives in training sessions to increase community out-reach with FP information and services, and improve the linkage between community midwives and local health centers for support, supervision and LMIS reporting.
7. Coordinate FP trainings with ProShendetit to create synergy and maximize the use of resources.
8. Conduct follow-up visits to a sample of trainees to reinforce FP training through on-the-job support, provide the basis for supportive supervision by local officials, and assess training effectiveness.
9. Conduct exit interviews with a sample of clients to help assess quality of FP counseling.

COMPONENT 3: Behavior Change Communication

Strategy: Use mass media, print materials and community mobilization to increase awareness of the availability of family planning methods and services, to motivate people to seek these services, and to use safe, reliable family planning methods to achieve their goals for timing and limiting pregnancies. Create awareness and demand for FP services in the sixteen target districts, but also nationwide. Phase BCC activities into the sixteen districts in a synchronized way to create demand once the training component has assured that trained personnel are in place and that the contraceptive security component has assured a consistent supply of contraceptives.

Expected Overall Results: Increased social acceptability of using effective contraceptive methods and increased demand for and use of FP counseling/ methods.0

Key Indicators for Component 3

- Couple Years of Protection (CYP) in the target districts doubles during the life of the project.
- Number of family planning visits in the target districts doubles during the life of the project.

Strategies for Component 3

1. Use social research-based methodologies and results of other studies to determine audiences, behaviors to promote (e.g., appropriate media and BCC messages.)
2. Identify and address barriers to/supports for changing key behaviors necessary to achieve increased use of modern methods.
3. Use mass media to broadcast FP messages and the location of FP services; re-enforce mass media messages with a variety of FP training and print materials (flip charts, brochures.)
4. Develop spots aimed at male and female married Albanians, segmented by rural and urban audiences
5. Insert a 'family planning message' or discussion into at least one popular TV program.
6. Get family planning information to Albanians nationally through a call-in show which features prominent, respected Albanian family planning experts (e.g., from the MOH)
7. Address potential barriers to increased contraceptive use in the community and increase community midwives technical awareness by providing FP awareness seminars at monthly district meetings of community midwives; these will be synchronized to precede the appearance of the FP actors and actresses in the district.
8. Contribute to community mobilization to support family planning by collaborating closely with the ProShendetit Project in developing BCC materials, insuring the inclusion of community research findings in AFPP training, and developing a sustainable face-to-face communication pilot campaign in selected areas.
9. Promote the national FP logo in BCC campaigns and materials.

III. PROGRESS MADE IN YEAR 1

With AFPP assistance, the Ministry of Health (MOH) expanded family planning (FP) services to forty-seven (47) new service delivery points during Year 1 of the project.

Table.1 Increase in Family Planning Service Delivery Points During Year 1

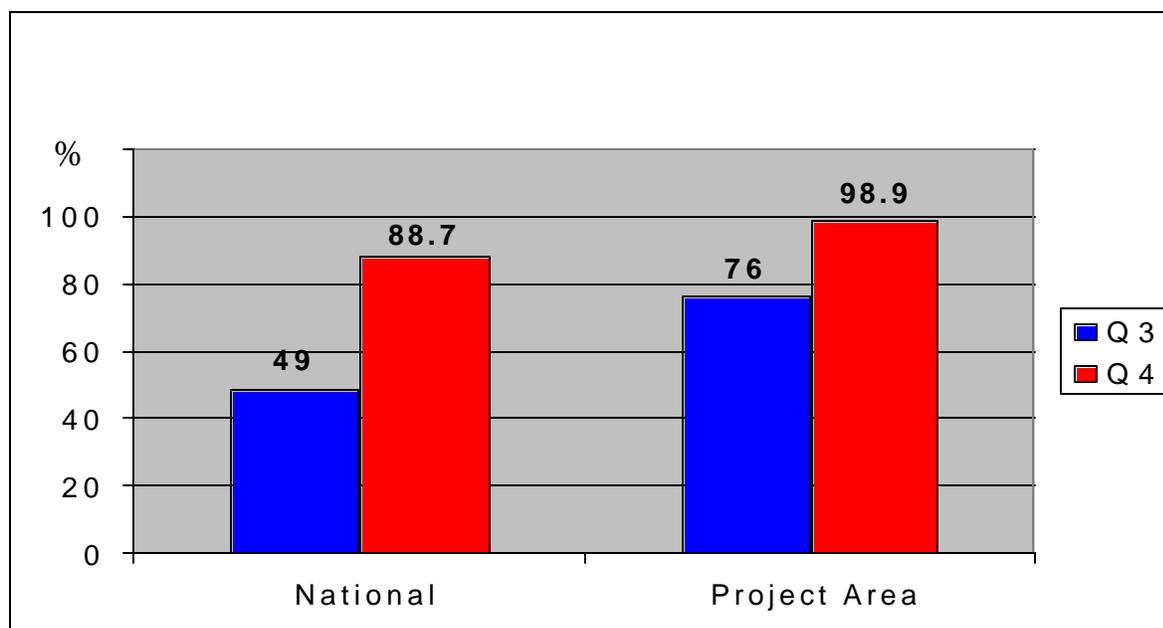
Target Districts Year 1	# of Service Delivery Points Providing FP Services in 2004 (baseline)	# of Service Delivery Points Providing FP Services in September 2005	Net Gain
Fier	8	19	11
Vlore	16	17	1
Lushnje	10	17	7
Diber	4	16	12
Lezhe	4	11	7
Puke	1	10	9
TOTAL	43	90	47

Source: LMIS

A. CONTRACEPTIVE SECURITY AND LMIS

The LMIS reporting rate increased significantly during the year. Complete, accurate and timely LMIS data is the foundation of contraceptive security.

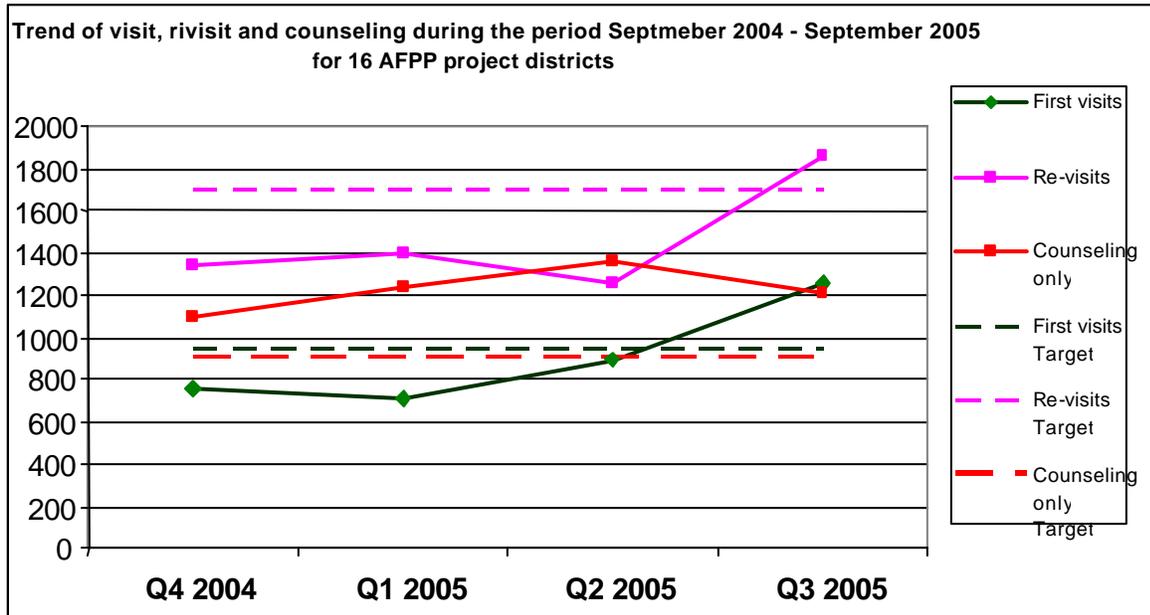
Graph 1: Percent of MOH Family Planning Service Delivery Points Reporting LMIS



Source: LMIS

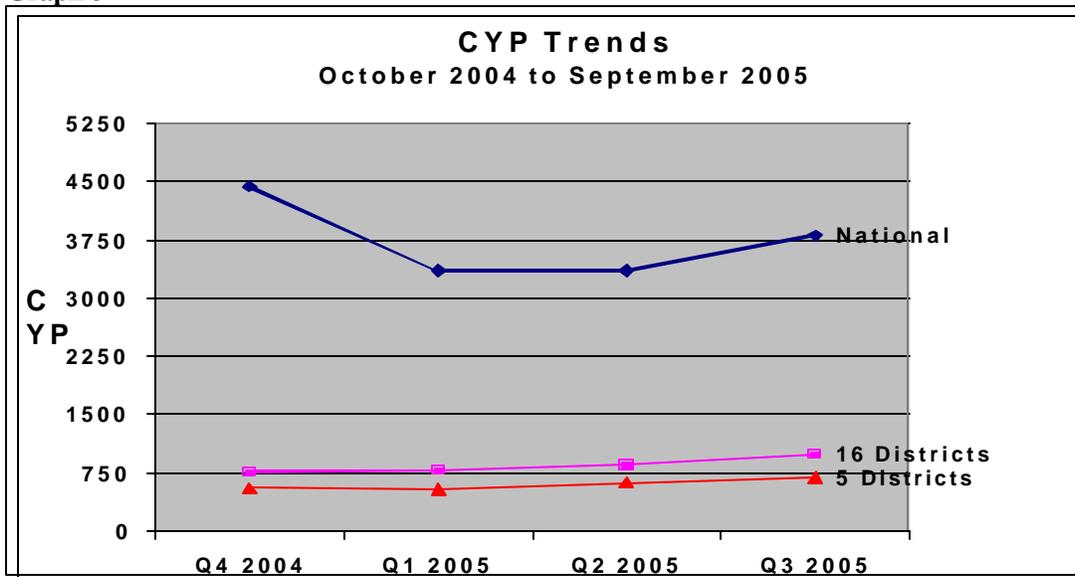
Use of FP Services. First visits, re-visits and counseling in the AFPP focus districts increased during Year 1, and exceeded the targets established at the beginning of the project. One of the causes for the slight decline in counseling during the last quarter was that in the large Fier District, the WCR was undergoing renovations that interfered with FP services.

Graph 2



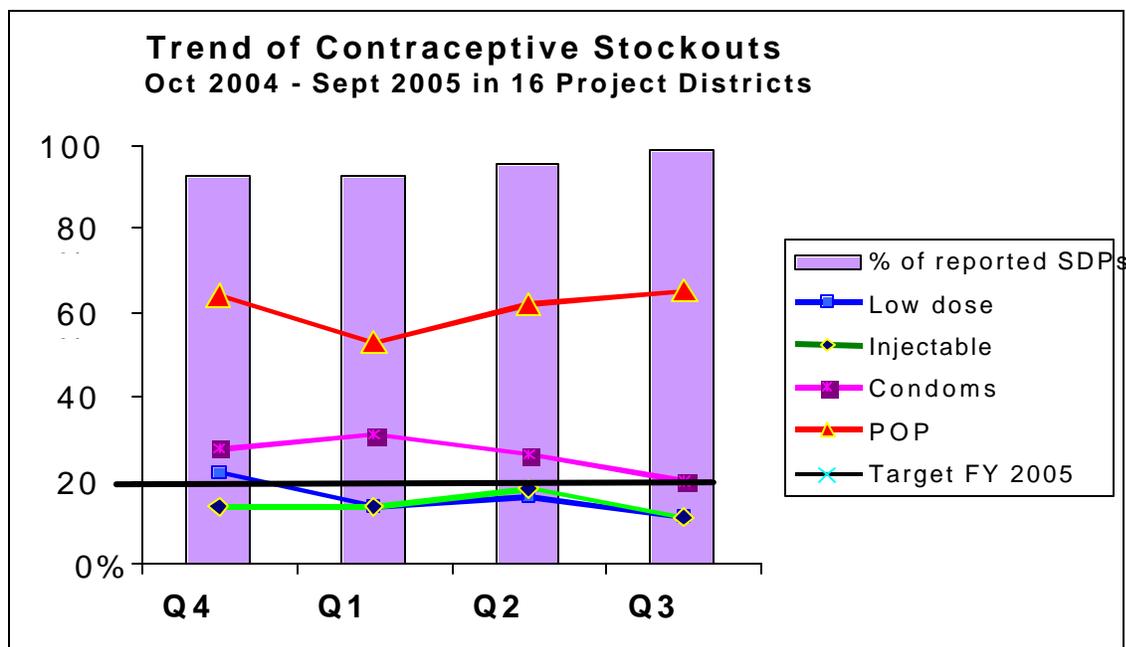
Couple Years of Protection. CYP reversed a decline in Qtr 4 of 2004 and then increased steadily for the remainder of the year. CYP is calculated using LMIS data, so the increased LMIS reporting rates contributed to the upward CYP trend.

Graph 3



Contraceptive Stock Outs. Stock outs, a chronic problem in Albania, declined in the project area during Year 1. High stock outs continue for the progesterone-only oral contraceptive (POP), which has been ordered by UNFPA and should arrive in the country by the end of 2005.

Graph 4



Bucharest Commodity Security Conference, May 2005. USAID's Bureau for Europe and Eurasia sponsored a Reproductive Health Commodity Security Conference in Bucharest, Romania, with representatives from Albania, Armenia, Azerbaijan, Georgia, Romania, Russia and Ukraine. AFPP used the Conference to focus on the current status of contraceptive security in Albania, and specifically on progress-to-date in implementing the *Albania National Contraceptive Security Strategy* adopted in 2003.

Contraceptive Security Report 2005. A draft *Contraceptive Security Report 2005* updating the National Contraceptive Security Strategy 2003 was prepared using LMIS data and information collected by AFPP staff from the public, private and social marketing sectors. Field visits were done to identify supply problems and improve the reporting system. In many SDPs, stock outs were found, and AFPP facilitated an urgent re-supply of contraceptives with our partners MoH and UNFPA.

LMIS Shifted from MOH to Institute of Public Health. Near the end of Year 1, the MoH shifted LMIS operations from the Reproductive Health Unit to the Institute of Public Health. LMIS is more likely to be sustainable at IPH because the Institute has more IT capability and also currently manages the vaccine supply system for Albania. This shift enhances the long-term institutionalization and sustainability of LMIS. The MOH Reproductive Health Unit retains responsibility and authority for MoH contraceptives but LMIS operations now fall under IPH. LMIS data will continue to be analyzed and used by the RHU to maintain contraceptive availability at all government health facilities, and all policy decisions re LMIS will continue to be made by the RHU.

AFPP started family planning training in April 2005 according to the agreed rollout plan. The FP training was well planned based on a clear strategy and in collaboration with other stakeholders operating in the project area. AFPP began by training service providers in the five largest of the 16 districts. One of these districts (Lezha) overlapped with ProShëndetit and another (Diber) overlapped with the Albanian Child Survival Project implemented by the American Red Cross. Both projects have a strong community element, and AFPP collaborated with them to enhance the family planning results in those districts. The other three focus districts -- Fieri, Vlora and Lushnja – were selected to carry out the FP training this year because of their relatively large populations.

Family Planning Training Indicators for Year 1. The project made steady progress during Year 1, and is on track to reach all of the training targets by the end of the project. The National FP Curriculum was developed by AFPP and officially adopted by the MOH as the national curriculum to be used for all FP training in Albania.

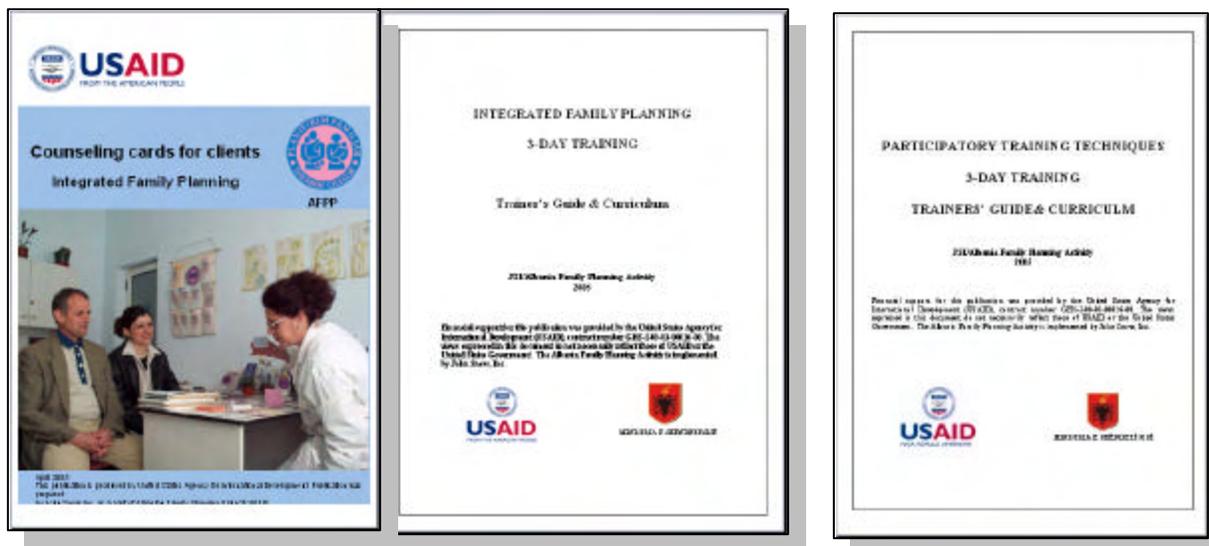
Indicators	September 2005
% of SDPs in 16 target districts with staff trained using national FP curriculum	53.9% (96/178)
% of Maternities in 16 target districts with staff trained using national FP curriculum	37.5% (6/16)
% of WCR in 16 target districts with staff trained using national FP curriculum	90.9% (10/11)
% of Health Centers in 16 target districts with staff trained using national FP curriculum	53.0 % (80/151)
% of Doctors in 16 districts trained with FP national curricula (GP+Ob-Gyn.)	57.9% (103/178)
% of Nurse/Midwives in 16 districts trained with FP national curricula	57% (203/356)

Training Cadre Expanded. AFPP expanded the cadre of regular FP trainers established under previous USAID-funded projects in Albania by creating a core group of five ‘Master Trainers’ capable of designing, planning, implementing and evaluating FP training programs. This is the first time Master Trainers has been developed within the MOH, and they will contribute significantly to the long-term sustainability of FP training in Albania.

Collaboration with ProShendetit. AFPP worked with ProShendetit to develop a FP counseling flip chart and client pamphlets that are to be distributed during training sessions.

Collaboration with MOH. One of the most important indicators of AFPP success is the high level of government support and ownership of project-supported training activities. All trainers are MOH employees, and the local MOH health directorates organized the trainings in their respective districts. At the national level, the MOH has a leading role in trainer selection and coordination of training activities in the field.

Training Tools Produced During Year 1. AFPP thoroughly documented the FP training program so that the MOH is able to continue FP training when the project is completed. Three key training documents are shown below. Copies may be obtained from the MOH or from USAID.

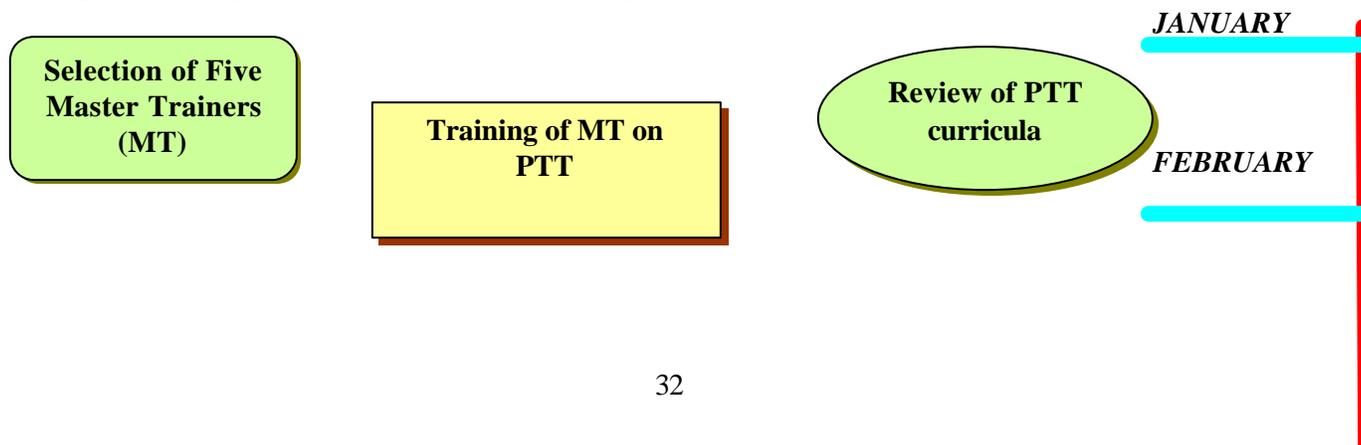


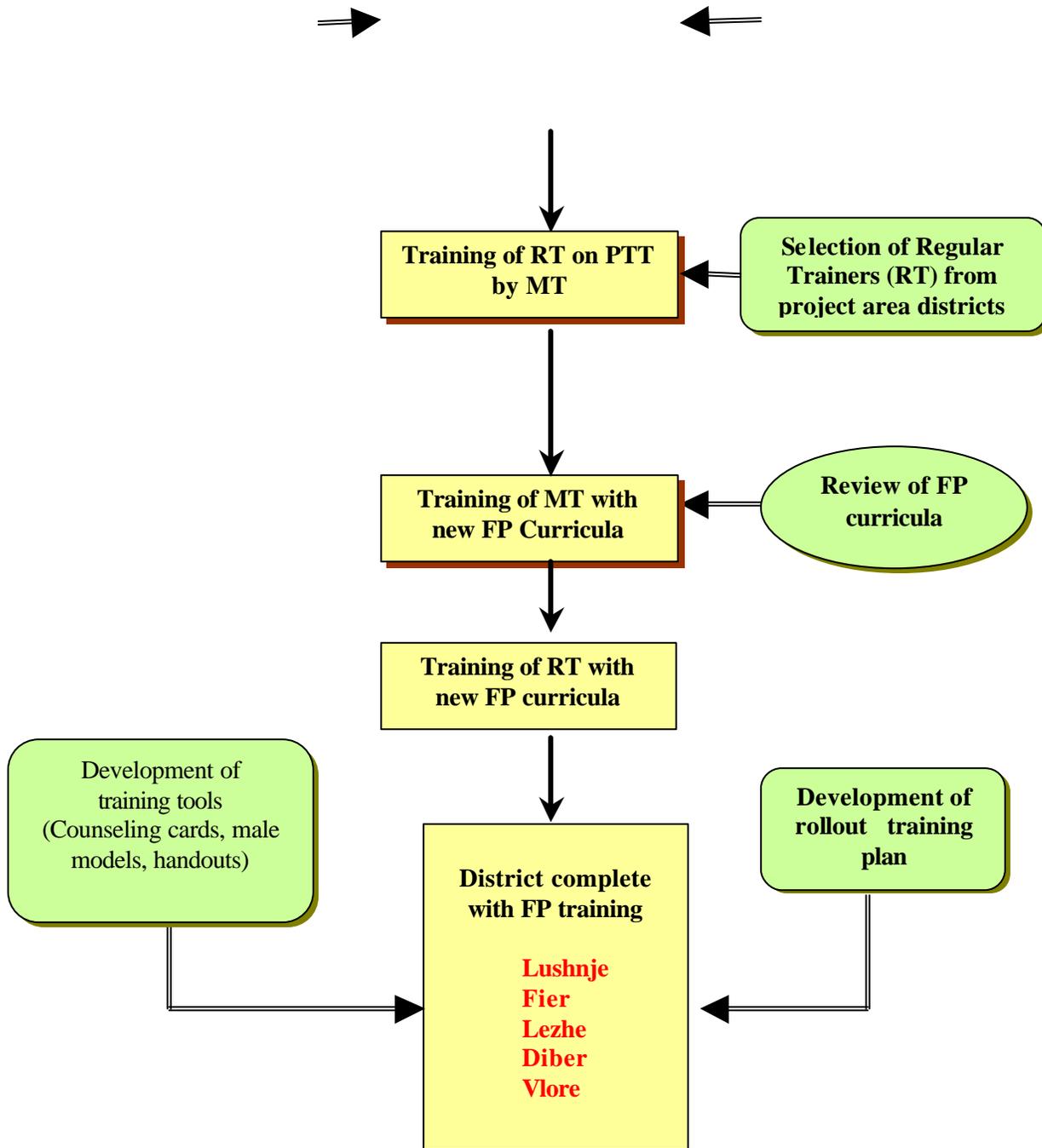
Training Follow Up. During September 2005, AFPP returned to five districts where training had been conducted to follow up the trainees, i.e., to reinforce the training (technical, counseling, LMIS), monitor the progress and effectiveness of AFPP interventions, and identify any problems that needed correcting. To guide the follow up, and to ensure consistency, a standardized "Integrated M&E Follow Up Checklist" was developed and used. Resource and time constraints made it possible to follow up trainees working in only a sample of service delivery points.

Table. 2 Number of SDPs Selected for Training Follow-Up

	Diber	Fier	Lezhe	Lushnje	Vlore	Total
# of SDPs where staff were trained	16	23	12	19	16	86
# of SDPs followed up	5	8	4	6	5	28

Fig. 2 Training Component Timeline, January –September 2005





C. BEHAVIOR CHANGE COMMUNICATION

The main BCC achievements during Year 1 included determining the most effective messages for promoting the use of modern family planning methods and maximizing clients' choice, and the development of two TV spots that will begin airing in November 2005. Unlike previous IEC

interventions, AFPP will focus equally on husbands and wives since research results suggest that husbands tend to initiate discussions of family planning and often control the decision making in selecting the method to be used.

BCC Qualitative Study. A total of 60 married couples were interviewed in three districts regarding their behaviors related to family planning. The study focused on family planning and abortion behaviors in their gender, marital, and cultural contexts. The study elicited meanings and emotions attached to fertility, gender/marriage/reproduction, as well as family planning and sexuality in marriage. The behaviors found in this qualitative research study were used to develop a menu for behavioral trials aimed at defining feasible family planning behaviors for Albanian couples.

TIPs (Trials of Improved Practices). Intensive interviews were conducted with six couples in Fier district (half of these couples subsequently adopted and used a modern contraceptive method.) Researchers negotiated the “improved” behaviors with the couple during the first two visits. All couples were eager to change their behaviors, and several couples did not wait until the next sequenced, negotiated behavior, but went directly from learning about and discussing family planning (the first negotiated behavior) to going for counseling and a method. Based on the findings of the study and the TIPs, the project’s BCC strategy was developed and is now being implemented.

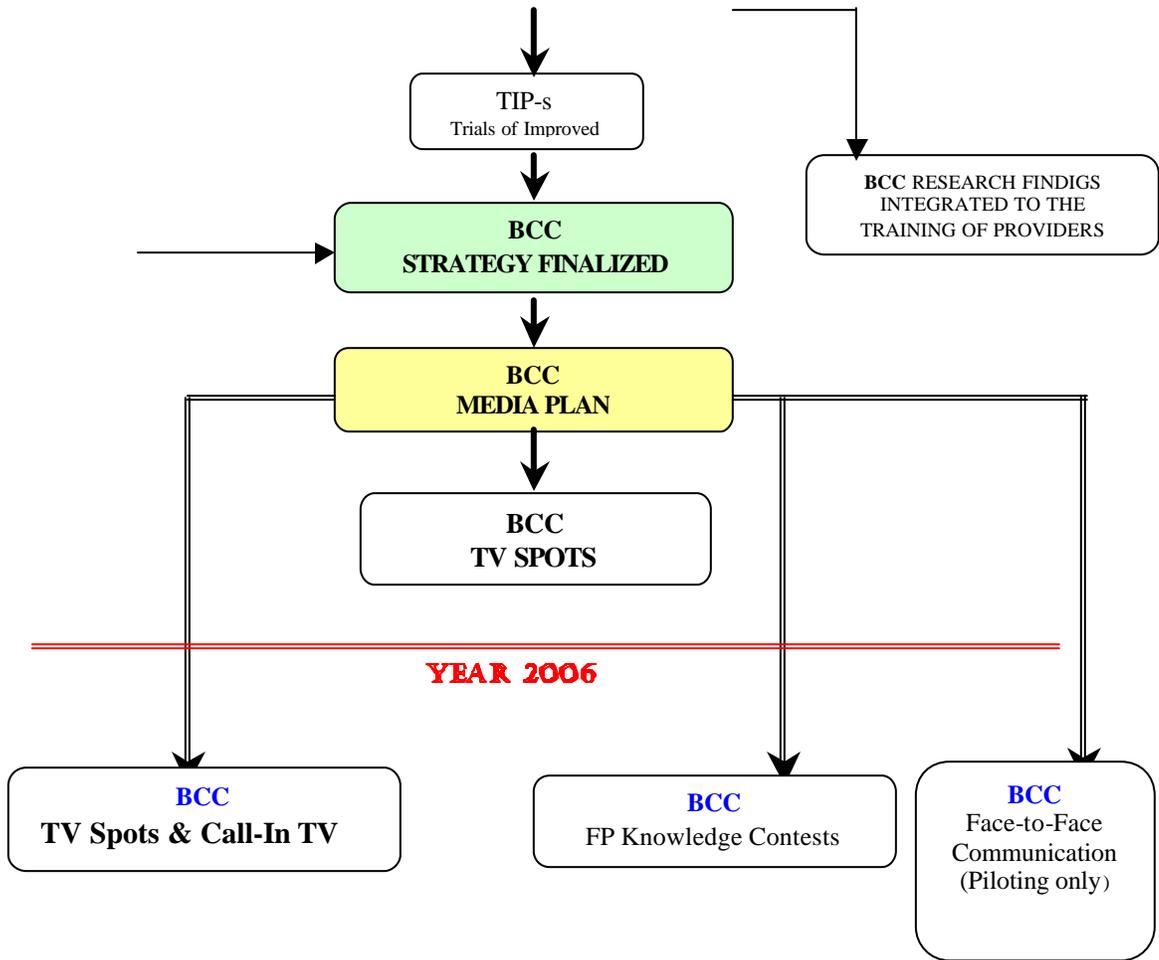
BCC Strategy. Based on the results of the literature review, qualitative research, TIPs, discussions with other health and family planning projects, and the MOH, AFPP developed a draft behavior change strategy and vetted it at a strategy development workshop. A wide array of partners was invited, including the MOH, USAID, multilateral organizations, NGOs, and other family planning projects. The strategy, presented and discussed at the workshop, was modified based on suggestions of workshop participants. (p. 16)

Media Plan. TV was found to be the most effective channel to inform people about modern family planning methods and to foster behavior change. Therefore, two short TV spots, targeted separately to urban and rural couples, were developed and will begin airing on national television in November 2005. The AFPP media plan is summarized below:

- **TV spots**
 - Urban Couple
 - Rural Couple
 - Satisfied users
- **TV Programs**
 - Call-in show with FP experts
 - FP knowledge contest
- **Face-to-face communication (pilot only)**

Fig 3. BCC Component Timeline, January to September 2005





IV. CHALLENGES ENCOUNTERED DURING YEAR 1

- Family planning visits and CYP did not increase rapidly during the first six months of the project due to an increase in contraceptive stock outs at SDPs nationwide during that period, and poor LMIS reporting. AFPP worked diligently to assist the MOH to address both problems. LMIS reporting is now very high; stock outs are reduced but remain a challenge.
- The National Contraceptive Security Commission (CSC), the centerpiece of Albania's contraceptive security strategy, did not meet during Year 1. National elections delayed the appointment of a new Vice Minister (who chairs the CSC), and the MOH decided to wait until the new Vice Minister was in place before calling a CSC meeting. An active and effective CSC remains the key to contraceptive security in Albania, and AFPP will focus on strengthening the CSC during the final year of the project.
- Contraceptive stock outs in MOH facilities continued to be a serious problem with the potential to slow (or even reverse) the rising Contraceptive Prevalence Rate. Stock outs have multiple causes -- an inactive Contraceptive Security Commission, lack of LMIS reporting, and the MOH's dependence on UNFPA for contraceptive storage and distribution. Contraceptive availability is the key indicator of contraceptive security in Albania; therefore, AFPP highest priority is to assist the MOH in reducing stock outs. AFPP specific goals for Year 2 are to revitalize the CSC, provide LMIS refresher training for district-level operators, and update the long-term contraceptive forecast. AFPP will also begin facilitating weekly meetings between UNFPA and the MOH to review procurement and distribution.
- Limited resources preclude AFPP from being able to follow up and evaluate the skill levels of FP providers trained under former projects (20 districts.) The MOH also lacks the resources for such follow up. The MOH supervisory system needs to become more effective so that FP providers are followed up and given on-the-job FP refresher training.
- All FP projects in Albania operated blind until the first RH Survey results were published in 2004. The challenge is to revamp FP interventions to address problems highlighted in this survey. For AFPP, this means putting more emphasis on BCC to increase knowledge of modern contraception among Albanian couples.
- Understaffing and regular changes of key persons within in the MOH severely limit opportunities for capacity building. AFPP itself is understaffed for the project's broad scope of work and short two-year timeframe.
- Development of IEC print materials for clients (e.g., pamphlets on FP methods) has been delayed beyond the target completion date of June 2005. AFPP is collaborating with ProShendetit to develop and distribute these materials, but is reliant on ProShendetit for the actual printing of these materials.
- Lack of an explicit policy component within AFPP's scope of work has limited the project's ability to facilitate/influence key decisions required to expand family planning services in Albania.

V. EXPECTED PROGRESS DURING YEAR 2 (*October 2005-September 2006*)

1. Address the contraceptive funding shortfall in Albania; prepare a up-to-date forecast of the contraceptive commodities required by the government and social marketing programs over the next five years, and assist in obtaining financial commitments to cover these supply needs.
2. Re-vitalize the National Contraceptive Security Commission. Mobilize stakeholder participation in the Commission, i.e., representatives from government, donor and international organizations, social marketing and the commercial sector. The NCSC needs to better articulate its mission and authority, and mutually agree on problem identification and problem solving procedures.
3. Determine the cause(s) of chronic contraceptive stock outs at MOH service delivery points, and take action to assist the MOH correct these problems.
4. Determine the type and level of donor assistance required over the next five years to maintain contraceptive security in Albania, and communicate these assistance needs to the MOH and potential donors.
5. Mobilize increased government funding for reproductive health, thus reducing the current dependency on donors for the procurement, storage and distribution of contraceptives, for RH training, and for contraceptive logistics management. Strive to engage donors in ways that ensure short and medium term availability of contraceptives while simultaneously ensuring long-term contraceptive independence.
6. Increase demand for FP services through a mass media campaign that informs Albanians about the advantages of modern FP methods, and provides accurate information for decision-making and for obtaining quality FP services.
7. Integrate BCC survey findings into FP training in order to reinforce BCC messages among FP providers.
8. Conduct follow-up and supportive supervisory visits to at least 33% of trained service providers to reinforce training and obtain data regarding the quality of FP services.
9. Complete training of providers in the remaining 10 intervention districts.
10. Increase the level and reliability of LMIS reporting through training at district level, and developing LMIS trouble-shooting and data analysis capability at the central level.

VI. Financial Reports

Contract No.:GHS-I-00-03-00026-00
 Albania Family Planning Activity
 John Snow, Inc.

Project Line Items	Total Contract Budget	Total Project Expenditures July 01, 2005 - Sept 30, 2005	Total Project Expenditures September 30, 2004 - September 30, 2005	Balance Remaining
Salaries				
Indirect Cost/Overhead				
Travel, Transportation, Per Diem				
Equipment, Material, and Supplies				
Other Direct Costs				
Program Costs				
Subcontracts				
Total Cost				
Fee				
Total Cost Plus Fixed Fee				

Quarterly Level of Effort Report 2

Contract No.:GHS-I-00-03-00026-00 Albania Family Planning Activity John Snow, Inc. Quarterly Level of Effort Report 4				
Functional Category	Total Contract Person Months Ordered	Current Period (Quarter) Expenditures July-Sept, 2005	Total Person Months Expended (As of Sept 30, 2005)	Balance Remaining (As of Sept 30, 2005)
Total Person Months	16	0.55	6.31	9.69

APPENDIX

Report Prepared for USAID External Assessment Team

Questions for JSI from the USAID Assessment Team
September 2005

Brief History of USAID Support for Reproductive Health in Albania from JSI's Perspective

USAID has a long history in FP in Albania with JSI being the prime contractor for the entire period. JSI/Albania budgets averaged \$500,000-\$600,000 per year from 1999-2006 (excluding the “gap year.”)

<u>Project</u>	<u>Dates</u>	<u>Budget</u>
SEATS	1996-2000	??
TASC I	9/99-9/03	\$2,493,000
“Gap Year”	10/03-9/04	-
TASC II	10/04-9/06	\$1,000,000

SEATS 1996-2000

SEATS established the basic three-pronged framework (training, LMIS/contraceptive security, IEC/BCC) for USAID’s technical assistance to FP. SEATS initially concentrated on Tirana and Dures and then expanded into two contiguous areas, Kruja and Kavaje. The SEATS period had two long staff evacuations due to civil unrest, and the security situation in the country prevented JSI from expanding geographically as originally planned. Work was just beginning in the north (Shkoder) and the south (Elbasan) when the project ended. SEATS designed a FP logo and successfully promoted it through a national media campaign. SEATS worked with the private sector (pharmacies) and NGOs to expand FP access. SEATS and TASC I overlapped in 1999-2000 during a time when half a million Kosovar Albanian refugees had crossed Albania’s borders; as requested, JSI submitted possible scenarios under which the newly awarded TASC contract might modify its SOW to address the immediate, pressing needs of the Kosovar refugees.

TASC I 1999-2003

USAID awarded TASC I as a three-year “Technical Assistance to Improve Access to Quality Reproductive Health Services for Albanian Women” project. The project was later extended by one year until Sept 2003.

TASC I goals:

- To enhance Albanians’ ability to make informed choices that allow them to achieve their reproductive intentions;
- To improve the knowledge and skills of health professionals to provide quality reproductive health services;

- To increase the number and quality of service delivery sites providing reproductive health services.

TASC I continued the work begun by SEATS. The project developed IEC materials, published a reproductive health newsletter, organized a first-ever major workshop for the MOH and the Albanian Parliament (“Reproductive Health: Beginning the New Millennium”), established a nationwide LMIS and National Contraceptive Security Strategy, and completed FP training in 10 districts. In May 2002, the original TASC I contract was modified to extend the completion date by one year (to September 2003), to revise the SOW to emphasize reproductive health services at the primary care level, as mandated by USAID/Albania’s revised health strategic objective, and to expand coverage to 18 districts. A later modification increased this number to 20 districts. New curricula were developed, trainers were trained and courses in antenatal care/exclusive breastfeeding and prevention of STI/HIV/AIDS and well as FP were conducted in 20 of the 36 districts.

It is important to understand that TASC I was originally designed to expand FP geographically to cover 10 districts and also to deepen activities substantially by moving into long term and permanent methods with real clinical training. However, USAID's Rita Hudson arrived at this time and did not support this plan. She refused to let JSI bring in FP experts in those areas, as well as in quality and M&E. USAID was "rethinking its entire portfolio." The general thrust in then-named Europe and Newly Independent States Bureau was towards health reform and primary care. In truth, Albania is more of a developing country in some ways than a transition country, but the Bureau was looking for homogeneity and wanted Albania’s health portfolio to be more like that in other Bureau countries. Therefore, Albania got its first health reform project (PHR*plus*) and TASC I was re-directed to integrate antenatal care/exclusive breastfeeding and the prevention of STI/ HIV/AIDS into its ongoing basic FP work. TASC I also provided training to the two PHR*plus* districts so that ultimately a total of 20 districts were covered.

TASC II 2004-2006

TASC II was awarded in Sept 2004 to continue RH support to the MOH in three key areas:

1. Assist the Ministry of Health to achieve and maintain contraceptive security.
2. Complete FP training in the remaining 16 (of 36) districts
3. Increase knowledge of FP and promote the use of modern family planning methods with a BCC program.

In spite of the one-year gap, TASC II was a follow on to TASC I with reduced resources (during the final two years of TASC I, budgets were approximately \$1m per year; TASC II was \$500,000 per year.)

A detailed description of TASC II can be found at the end of this document.

General Questions Guiding the Assessment Team’s Appraisal

1. *Is USAID’s health strategy right for the Mission and the right for Albania?*
 - a. *Is it relevant to USAID/Washington’s, the Mission’s, and country/local government’s strategies/priorities?*

In a small country such as Albania, a donor tends to over-reach because it seems feasible to be relevant to all government health priorities. In Albania, the problem is that the government itself has

had shifting priorities, which has incrementally nudged USAID toward a “broad and shallow” health portfolio.

b. Is it consistent with the means/resources available?

With regard to FP, USAID resources have been sufficient only for a “shallow” program focused on condoms and pills (resupply methods) when what Albania requires is a “deep” program focused on a much broader contraceptive method mix, including long-term and permanent methods, and the clinical-based training and IEC/BCC work to support both the supply and demand sides.

c. Is the strategy technically sound and coherent?

The Mission strategy of working simultaneously on reform and service delivery is sound, but finding the right balance is a challenge. The current strategy may be skewed toward reform with not enough focus on day-to-day health service delivery.

Are the two main health activities (Proshendetit and AFPP) using their resources optimally to reach agreed upon goals?

Given the limited resources, JSI is relying upon (and investing in) local Albanian staff to move the project forward. This is an optimal use of resources from our viewpoint. A “deeper” program would require additional resources and expatriate technical assistance.

2. Are the health activities having the right impact?

Reproductive Health: The overarching question for USAID: After 10 years of support for RH services in Albania, why did the 2002 RH Survey find a CPR for modern methods of only 8% among married women? (if tubal ligations are removed - which were likely performed for medical indications rather than to limit childbearing -- the CPR for modern methods is only 4%.)

Table 3: Current Contraceptive Use

Extracted from RHS Table 7

Method Used	Married Women 15-44	Married Men 15-49
Any Method	75 %	77 %
Any Modern Method	8	3
*Tubal Ligation/Vasectomy	4	0.1
*Condom	2	2
*Pills	1	0.3
*IUD	0.5	0.3
*Injectables	0.4	0.2

*Emergency Contraception	0	0
*Spermicides	0	0.2
Any Traditional Method	67	74
*Withdrawal	67	72
*Periodic Abstinence	0	2

The good news is that preliminary data from the August 2005 ProShendetit survey in Korce, Lezha and Shkodra show that CRP among married women in those three prefectures is now 15% for modern methods. Although not statistically comparable with the 2002 RH Survey, CPR seems likely to have increased rapidly in these prefectures between 2002 and 2005 during the time of JSI-supported interventions. USAID is clearly having an impact on CPR.

Low CPR in Albania is due to the fact that the vast majority of Albanians already contracept using withdrawal and the occasional condom, backed up by legal abortion. There is basically a <1% non-user rate among married couples. Given that withdrawal has about an 80% efficacy rate among long term users, in some ways this “system” works pretty well for Albania (TFR 2.6), especially since withdrawal is free. However, a case can be made for modern methods, even if they do require “commodities,” may cost money, may have unwanted side effects, and may require interfacing with the health care system. **The bottom line is that Albanians should have choice**, and they currently **lack the information** (probably more than the services) to make an informed choice. They deserve to know there are other ways of contraception that are not coitally related, that provide more reliable protection, with less inconvenience, and that are for the most part safe.

Other probable reasons for the low CRP for modern methods are:

1. Expansion of FP services and the training of FP providers has been a slow, gradual process – as recently as 2001 only 10 of 36 districts had benefited from support from USAID, and there is still not nationwide coverage (although the remaining 16 districts will be covered by the end of the current AFFP in 2006).
2. Inconsistent and unreliable supply of contraceptive commodities during much of the past 10 years has been a major constraint. Even in 2005, the MOH continues to struggle with stock outs.
3. The choice and availability of methods such as the IUD is limited.
4. No reliable FP data upon which to base interventions has been available – FP projects literally operated blind in Albania until the first RH Survey results were published in 2004.
5. The funding for major IEC/BCC mass media campaigns to provide FP information and to address major misunderstandings and misperceptions about modern contraceptives has been very limited.
6. Residual effects of the pro-natalist policies of the former communist regime, and the adverse effects of major disruptions and civil upheavals during the late 1990’s.
7. Regular changes in key government appointed officials, resulting in lack of continuity in FP programmatic priorities and leadership.

8. Chronic understaffing in the MOH Reproductive Health Unit that severely limits opportunities for capacity building and for oversight and supportive supervision of FP services at the district and facility levels.
9. Minimal data (until AFPP's BCC research in 2005) on Albanians' attitudes and preferences regarding FP, and the significant role men play in decision making regarding contraception.
10. Providers such as nurses and midwives (especially community midwives) have been under-utilized for providing FP information/counseling and services.
11. Government budgets and donor funding has been insufficient to have a significant impact on increasing/improving demand, access, quality and utilization of FP programs and services.

In summary, FP goals in Albania have been high -- reduce reliance on abortion, significantly increase CPR for modern methods, reduce unmet need -- but the resources very limited. This combination of ambitious goals and limited resources has resulted in a series of FP programs that focused largely on non-clinical based training of providers, little refresher training beyond the initial FP training, limited follow-up and supervisory support for FP providers, an over-reliance on re-supply methods with heavy reliance on government provision of free commodities, sporadic mass media campaigns, and FP interventions based on insufficient data.

3. Assuming no increase in funding, would you recommend any changes in strategic focus, priorities, or activity resource allocations in the near and medium term?

The results of the recently published RH Survey 2002 not only make a strong case for continued USAID support for family planning in Albania, but also suggest shifting some USAID health resources to BCC (e.g. mass media campaigns, print materials, effective counseling for individuals and couples, research). The most important RHS finding is that most **Albanians lack the most basic knowledge of modern contraceptive methods**. The RHS asked respondents if they had ever heard of X method or Y method. Respondents were not asked to list the contraceptive methods with which they were familiar, so the RHS measured recognition, not recall. Even with this prompting, the results reveal a huge knowledge gap.³

Percent of Women 15-44 and Men 15-49 Who Have Heard of Specific Methods of Contraception

(Extracted from RHS Tables 5a and 5b)

Specific Method	% of Women who have heard of method	% of Men who have heard of method
Modern Methods		
Condoms	81	89
Pills	68	32
Tubal Ligation	65	14
Injectables	34	6
IUD	23	8

³ The RHS contains statements like "almost all the women (96%) were aware of one method, with 90% aware of at least one modern method and 84% aware of a traditional method (Table 5a)" and "awareness of any method of contraception was also almost universal among men (98%) (Table 5b). These seemingly reassuring statements are misleading and contradict the data in the tables.

Emergency Contraception	11	10
Vasectomy	6	4
Spermicides	5	4
Traditional Methods		
Withdrawal	82	85
Periodic Abstinence	24	21

These are amazingly low knowledge levels for a population that is 99% literate; furthermore, the gender difference is striking. Even though the August 2005 ProShendetit survey in Korce, Lezha and Shkodra showed higher knowledge of contraceptive methods than the 2002 national RH Survey, knowledge levels are still extremely low in Albania. USAID should address this knowledge gap by significantly enhancing and extending the current BCC program, especially the mass media campaign. The RH Survey found that most women (94%) and men (98%) watch at least one hour of television daily (only 43% of women and 54% of men listen to the radio for at least one hour daily.) Therefore, television is the preferred media for reaching large numbers of Albanians with information about modern contraception. The AFPP qualitative study showed that women frequently learned about modern contraceptive methods from other women: relatives, friends, and neighbors. Therefore, supplementing mass media with face-to-face communication is important for reaching women. In contrast, married men did not generally discuss family planning with anyone other than their wives, so mass media alone would be an appropriate way to reach men. No donor besides USAID is prepared to support such a BCC program, and the MOH lacks the technical expertise and resources to mount such a campaign on its own.

Detailed Questions from the USAID Team for JSI/AFPP

- A.3. *What results have been achieved in the first year of work?
Were any targets missed, and if so why?*

COMPONENT 1 Results: Contraceptive Security

LMIS. LMIS reporting increased in the AFPP target districts to a level significantly above the national reporting rate. LMIS data is the foundation for a district maintaining contraceptive availability.

% of FP service delivery points reporting LMIS data in Apr-Jun 2005 quarter	In sixteen (16) project districts	76 %
	In all MOH FP SDPs	60 %

Contraceptive Security Commission. AFPP aims to facilitate the re-vitalization of this Commission were delayed because of personnel changes within the MOH. Once a MOH Vice Minister is named (September/ October 2005), AFPP will facilitate a meeting of the Commission. (The Vice Minister chairs the Commission and we want to use the first meeting to make the new Vice Minister aware of contraceptive security issues.)

Contraceptive Stock Outs. The data below show that stock outs are a chronic problem for the MOH. The stock out situation for the progesterone only pill (POP) is especially serious (the MOH did not make a timely request to UNFPA to procure POP.) The stock out issue is an important agenda item for the Contraceptive Security Commission, but in the meantime, AFPP will assist the MOH to take a number of practical steps to reduce stock outs – for example, LMIS officers from all

36 districts are being called to Tirana for a refresher training in October; AFPP will begin facilitating weekly meetings between UNFPA and the MOH RH Unit to discuss procurement and distribution; AFPP will intervene directly to assist the MOH to increase the national LMIS reporting rate; AFPP will begin regular follow up with UNFPA on the distribution schedule for contraceptives.

Stockouts in 16 AFPP Districts							Target 2005	Target 2006
	Q1 2004	Q2 2004	Q3 2004	Q4 2004	Q1 2005	Q2 2005		
Low dose	14%	12%	10%	22%	14%	19%	20%	10%
Injectable	17%	8%	12%	14%	14%	20%	20%	10%
Condoms	23%	22%	15%	28%	31%	26%	20%	10%
POP	26%	41%	52%	64%	53%	59%	20%	10%

Indicator	Desegregation	Baseline (Year)	Last Quarter (Jan-March 2005)	Current Quarter (Apr-June 2005)	Expected & Actual Achievements for the 1st year (Sept 2004 – Sept 2005)		Target FY 2006
					Expected	Actual	
% of service delivery points stocked out of condoms, POP, injectables and low dose contraceptives in 16 target districts	Project 16 districts						
	Condoms	28 %	31 %	26 %	20		10 %
	POP	64 %	53 %	59 %	20		10 %
	Low dose	22 %	14 %	19 %	20		10 %
	Injectables	14 %	14 %	20 %	20		10 %

COMPONENT 2 Results: Family Planning Training

Family planning training was completed in the first five of the sixteen target districts during the first year -- Lezha, Diber, Lushnje, Fier, Vlore. A total of 282 MOH staff at 86 facilities were trained in family planning, including LMIS. Of those 282, 44 were community midwives, which are the first time that FP training has been provided to community-level providers in Albania, thus marking a milestone in beginning of the expansion of FP to the community level.

Total MOH Staff Trained, Through June 2005

Districts	Providers	Total
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	Doctors	Nurse Midwife	Other	
Diber	12	35	2	47
Fier	48	42	0	90
Lezhe	9	30	2	39
Lushnje	13	37	1	50
Vlora	13	37	1	50
TOTAL	95	181	6	282

Specific PMP indicators for this training component:

Indicator	Disaggregation	Baseline (Year)	Last Quarter (Jan- March 2005)	Current Quarter (Apr-June 2005)	Expected & Actual Achievements for the 1 st year (Sept 2004–Sept 2005)		Target FY 2006
					Expected	Actual	
% of service delivery points providing family planning services	16 Project Districts	0 % (2004 LMIS)	0	46 % (86/187)	50 %		90 %
	National	68 % (2004 LMIS)	68%	77% (332/433)	84 %		99 %
% of SDPs in 16 target districts with staff trained using national FP curriculum	By type of SDP:						
	Maternity	0 %	0 %	31 % (5/16)	50 %		90 %
	WCR	0 %	0 %	45 % (9/20)	50 %		90 %
	Health Center	0 %	0 %	48 % (72/151)	50 %		90 %
	By cadre:						
	Doctors	0 %	0 %	51 % (95 / 187)	50 %		90 %
Nurses/ midwives	0 %	0 %	49 % (181/374)	50 %		90 %	

COMPONENT 3 Results: Behavior Change Communication

BCC research was conducted in three districts – Fier, Dibër and Devoll – from March 15 to April 14. Specially trained interviewers contacted 60 currently married men and women (each having at least one living child.) The sample was drawn randomly in rural areas and opportunistically in urban areas. These three districts were selected because they represent the geographical center, north and south of Albania. In one district, the project conducted Trials of Improved Practices (TIPs) with married couples to test what behaviors are feasible for Albanian husbands and wives to practice that will lead to their use of modern contraceptives. Based on this research, a BCC strategy and BCC media plan was developed, and TV spots are being prepared that are aimed at urban and rural couples.

During the first year, family planning visits and CYP are below targets, and the MOH is especially concerned about a significant decline in national CYP in the April-June 2005 period. The problem is 1) an increase in contraceptive stock outs at SDPs nationwide; and 2) poor LMIS reporting during the quarter, which means that CYP is under-reported. AFPP is working to assist the MOH to address both problems, but unlike in 2002-2003, JSI is not willing to step forward and temporarily assume LMIS and/or contraceptive distribution functions.

Indicator	Disaggregation	Baseline (Year)	Last Quarter (Jan-March 2005)	Current Quarter (Apr-June 2005)	Expected & Actual Achievements for the 1 st year (Sept 2004–Sept 2005)		Target FY 2006
					Expected	Actual	
Total # of family planning visits in 16 target districts	First visits	750 per quarter	680	727	945		1500
	Re-visits	1339 per quarter	1348	1072	1700		2680
	Counseling only	686 per quarter (2004 LMIS)	984	1409	900		1370
Couple years of protection (CYP) *	16 Project Districts	774 per quarter (2004 LMIS)	774	631	1000		1600
	National	3,750 per quarter (2004 LMIS)	3336	1925	4000		5000
IR3.3: Community participation in health promotion activities increased							
% of villages which have FP service provided by at least one community midwife in 16 districts	16 Project Districts	0	0	9 %	10 %		18 %

*When calculated annually means average quarterly CYP

B. 1,3 How has the GOA participated in and benefit from your work?

Contraceptive Security: The MOH benefits from having a sound USAID-supported Logistic Management Information System (LMIS) for contraceptives that allows for the effective management of MOH contraceptive commodities. The MOH benefits from a multi-sector Contraceptive Security Commission that includes stakeholders from the public and commercial sectors, social marketing, local NGO, international organizations and donors. MOH policymakers benefited from attending a regional CS conference in Bucharest that linked them to CS efforts in the region. The MOH benefits from AFPP's facilitating the maintenance of contraceptive availability, especially in the 16 focus districts, and the expansion of LMIS to the new SDPs.

Training: MOH has benefited from expanded FP services to 400+ SDPs and the training of hundreds of MOH staff in FP. An MOH cadre of 19 FP trainers and 5 master trainers created by JSI/AFPP, has conducted the FP training, and the MOH has always felt ownership of the training activities. MOH participated fully in curricula development and adopted the FP curriculum as their national curriculum. The MOH had a leading role in trainer selection and coordination of training activities in the field. MOH district authorities organize and manage all FP training activities -- they select participants, training venues, etc. Follow-up tools have been developed as a basis for supportive supervision, and master trainers are learning how to design, evaluate and update a training program for capacity building.

BCC: The MOH contributed staff to join our BCC research teams and directed MOH district offices to assist in BCC research activities. The research results are being shared with the MOH and represent the first documentation of many family planning behaviors and associated attitudes and behaviors.

C. 2 *Is the project design right? Are there gaps that needed to be addressed in the future?*

Gaps to be addressed in the future:

- Consistent and committed oversight of the FP program by the National Contraceptive Security Commission, especially with regard to having a sound strategy moving toward market segmentation and increased method mix (less reliance on re-supply methods), a functional LMIS, procurement of commodities thru a mix of government and donor contributions with a gradual decrease of the latter, strategic coordination of the public, social marketing, and commercial sectors, and proactive support for the other components of a successful FP program (provider training and supportive supervision, demand creation/BCC.)
- An expanded BCC program with on-going mass media campaigns appropriate for both rural and urban audiences, reliable supply of up-to-date print materials, hot lines and call in programs, periodic surveys to make sure messages are meeting the need for information to make informed choices and decisions.
- Training that includes a clinical component, especially for long-term and permanent methods. Training should be both pre-service and at regular intervals for in-service providers (possibly exploring innovative ways to provide updates such as web sites, distance learning, computer modules, etc)
- Provide timely follow-up after training and on-going supportive supervision at the district and facility levels.

- Increased community outreach, through increased utilization of community midwives as providers of FP services and information/counseling and utilizing existing NGO networks.
- Promote feedback from clients at SDPs (e.g. suggestion boxes, exit interviews, participation on quality improvement teams) to improve both quality in fact and quality in perception.

D. 2 What level of effort goes into the 3 main components (CSC, training, awareness campaign)? Is the right balance? Where do you get the biggest bang for buck?

AFPP Total Budget 2004-2006 Allocated by Technical Components*

	Contraceptive Security	Behavior Change Communication	Training	TOTAL
SALARIES**				
INDIRECT COSTS / OVERHEAD				
TRAVEL, TRANSPORTATION AND PERDIEM				
EQUIPMENT, MATERIALS AND SUPPLIES				
OTHER DIRECT COSTS				
PROGRAM COSTS				
SUBCONTRACT (Manoff Group)				
TOTAL costs				
TOTAL in %				
FEE				
Total				

AFPP Level of Effort (person months)

	Contraceptive Security	BCC	Training	TOTAL
JSI US / Expat	5.3	2.8	7.8	16.0
Manoff Subcontract	0	37.8	0	37.8
Cooperating Nationals	29.1	22.5	37.5	89.0
Total	34.4	63.1	45.3	142.8
Total in %	24%	44%	32%	100%

*Admin support costs allocated equally to the three technical components

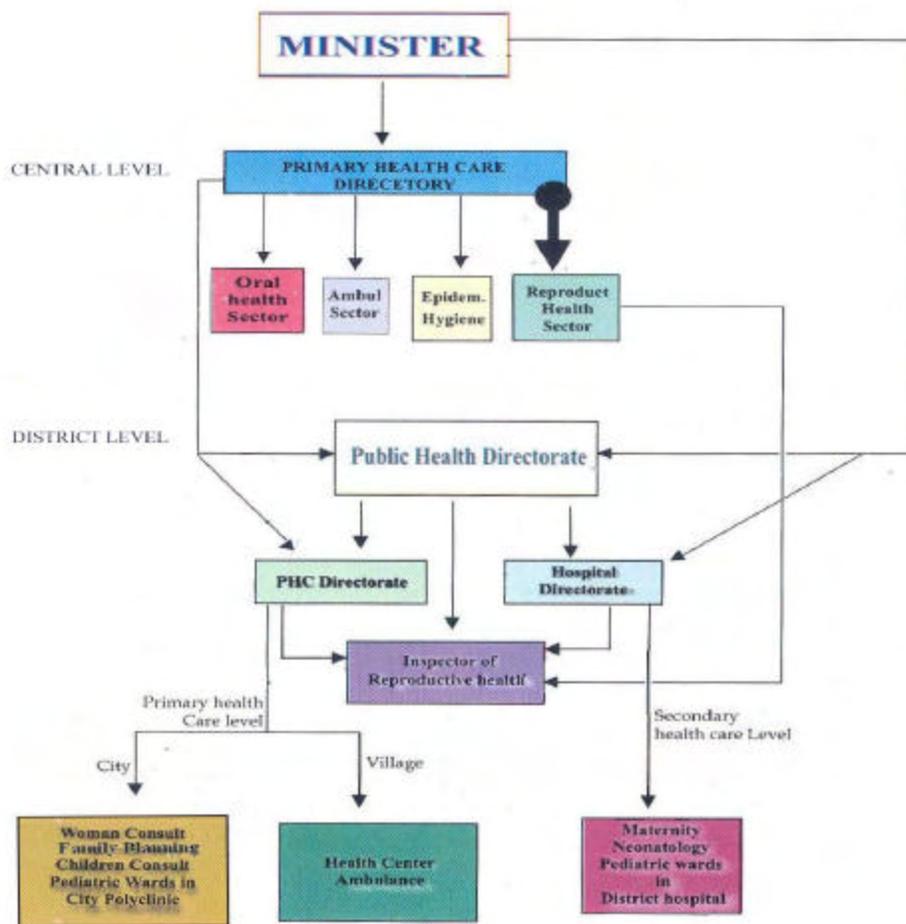
**Project Director is allocated 50% Contraceptive Security; (50%/3) to each component and Finance/LMIS Officer is allocated 40% Contraceptive Security; (60%/3) to each component

The current budget allocations to Contraceptive Security (26%), BCC (38%) and Training (36%) are based on technical and field implementation requirements. JSI uses no budget allocation formula for these components, but the current allocation seems appropriate given the current SOW. Level of effort is higher for BCC because the rigorous BCC methodology requires more intense external technical assistance.

E. 1,3 How well is FP/RH integrated into PHC?

The MOH Organogram below shows that FP/RH is well integrated into the government structure. The central level has included the Reproductive Health Unit under PHC Department, which further is connected with Public Health Directorate at the district level. SDPs that offer FP services are: Women’s Consultancy Rooms, Health Centers and Maternities.

There is little reliable data to evaluate whether FP is well integrated into PHC in actual practice at the facility level. There is likely to be considerable differences between individual SDPs and individual providers as to whether all opportunities to provide FP information/counseling and services (or referral for services) are being utilized. The integration of FP into antenatal, STI/HIV and exclusive breastfeeding curricula was developed by JSI toward the end of TASC I,



Organogram of Reproductive Health in Albania

but there were limited resources for adequate **follow up** to the providers trained in the 20 districts. JSI collaborated with Abt to integrate FP into the pilot PHC Project in Berat.

F. 3 *What has been your experience working with Contraceptive Security Commission? Is it becoming more effective?*

The CSC was established with fanfare and success just at the end of TASC I (2003.) It was the first forum in Albania where government, social marketing and the commercial sector talked to each other, and collectively talked to donors and international organizations, about contraceptive security issues. Frankly, many of these issues raised were uncomfortable for the MOH – how long did the government intend to rely on UNFPA for all its commodities? Were not MOH ‘free’ commodities not an obstacle to long term contraceptive security by hindering the growth of the social marketing and commercial sectors? Was not the MOH’s proper role to focus on long-term and permanent methods and leave the condoms and pills to social marketing and the commercial sectors? The CSC held some tense meetings in 2003.

TASC I served as the de facto Secretariat for the Commission. The CSC has not met since the project ended in 2003 (the new ProShendetit project’s RH activities did not include contraceptive security.) The MOH chose not to call meetings to avoid the sensitive policy issues that would have been raised. Nevertheless, these contraceptive security policy issues must eventually be addressed, so a forum like the CSC is needed in Albania. USAID is in a position to support the CSC as part of the Mission’s broader health policy reform agenda. A revitalized CSC would be able to address the major FP/RH policy issues in Albania – method mix, market segmentation, public/private partnership, contraceptive availability, service quality, etc.

The revival of the CSC is the centerpiece of AFPP current contract SOW for contraceptive security, and JSI still intends to facilitate CSC revitalization. However, given the delay in appointing a new Vice Minister (the CSC chair), JSI intends to identify and assist the MOH deal with a few key contraceptive security issues outside the CSC framework (especially the LMIS reporting and contraceptive stock out issues.) This change of approach results from AFPP’s short timeframe. The CSC remains the best long term solution to contraceptive security in Albania, and JSI shall make every effort to enhance the role and credibility of the CSC in the final year of the project.

G. 3 *What progress has been made in completing FP training in all districts? Are previously trained providers maintaining their knowledge/still using the training?*

Summary of FP Training by District and by Number of SDPs

Nr	SEATS/TASC Project		AFPP	
	District	Nr of SDPs	District	Nr of SDPs
1	Tirane	37	Diber	16
2	Durres	11	Fier	23
3	Kavaje	11	Lezhe	12
4	Kruje	8	Lushnje	19
5	Elbasan	27	Vlore	16
6	Shkoder	18	# of SDPs trained up July 2005	86
7	Librazhd	11	Delvina	5
8	Peqin	7	Devoll	6
9	Gramsh	11	Has	5
10	Pogradec	8	Kolonja	9
11	Kurbin	5	Kukes	16
12	Malesi e M	5	Mirdite	9
13	Korce	19	Permet	10

14	Mallakaster	9	Puke	11
15	Gjirokaster	10	Skrapar	11
16	Sarande	8	Tepelene	11
17	Bulqize	8	Tropoje	9
18	Mat	13	To be trained	101
19	Berat	15		
20	Kucove	3		
	TOTAL	244		

Limited resources have precluded being able to evaluate the current practice level of providers trained in the 20 districts of the former projects. The MOH does not have a regular supervisory system or database that can provide reliable information. A very indirect measurement would be the LMIS data indicating the number of clients served, commodities distributed and CYP. As discussed earlier, supportive supervision and provision of updates/refreshers are essential to maintaining quality of FP services. In August 2003, 102 trained providers were evaluated in 10 of the 20 intervention districts. The results were as follows:

Comparison of Average Test Scores for 102 Family Planning Providers from 10 Intervention Districts (Note: Highest possible score = 20)	
Pre-training test score average	12.6
Post-training test score average	17.3
Follow-up test score average (6-9 months after training)	16.1

During follow-up, 102 providers were evaluated through observation, interview, testing and chart audit. The following data represents selected findings during follow-up.

Area of Evaluation	Number of Providers Meeting Evaluation Criteria
Stated correct advice for counseling on dual protection	92/102
Stated correct advice for counseling on normal side effects associated with oral contraceptive pills	94/102
Stated correct advice for counseling on normal side effects of the IUD	93/102
Frequency that providers provide or offer FP IEC pamphlets to clients	97/102
Frequency that providers counsel clients on whether their FP method offers protection from STI/HIV	Always: 78/102
Demonstrated correct condom use	91/102

H. 2,3 *Are you working on getting men more involved in family planning?
Any success ?*

Getting men more involved in family planning is a priority of AFPP, especially the BCC component. The target for the media campaign will be the married couple (half of the respondents in our BCC qualitative research were men, who helped us to better understand very important issues related to

marital relationship and family planning.) The BCC strategy is drafted for both male and female audiences, with the husband not seen as a passive participant, but his FP role is acknowledged and well defined and will be addressed in all the BCC interventions. Men will be shown in our TV spots and other TV programs as actively involved in FP. In the face-to-face BCC interventions, the target will be equally married men and women. One of the key behaviors that AFPP is promoting in its mass media and community face-to-face communication campaign is for husbands and wives to read the (USAID-supported) informational materials on modern contraceptives and discuss contraception together.

I. 5 If ProShendetit follows up on AFPP’s activities within the broader PHC effort after 2006, what advice would you give them?

The primary challenge facing family planning in Albania during the 2006-2009 period will be to assist the MOH to increase the CPR for modern methods. CPR already appears to be on the rise in Albania -- preliminary data from the August 2005 ProShendetit survey in Korce, Lezha and Shkodra indicate that CRP among married women in those three prefectures is now 15% for modern methods (the 2002 RH Survey found only 8% nationally.) Although not statistically comparable with the 2002 RH Survey, CPR seems to have increased substantially in these prefectures between 2002 and 2005. **This CRP increase in Korce, Lezha and Shkodra would seem to be directly related to the JSI-supported interventions.**⁴

Retaining JSI as the RH contractor during the 2006-2009 period, under the current close working relationship with ProShendetit, would give FP/RH a higher profile within the Mission’s health portfolio and maintain the current CYP momentum being generated by AFPP. It would also ensure continuity and consistency of technical approach, especially in the critical areas of contraceptive security and BCC, and maintain the strong technical links and lessons learned from JSI’s other RH health projects in the region (Ukraine, Russia, Georgia, Romania.)

Nevertheless, if ProShendetit were to assume responsibility for the Mission’s RH activities after 2006, they would be able to build on the momentum generated by AFPP, and also on the momentum of a rapid demographic change that is resulting in a more urban population and smaller average household size. One concern would be ProShendetit’s capacity to maintain the current FP momentum while simultaneously focusing on its exceptionally broad PHC and health reform agenda.

Year	Average Household Size	Average Urban Household Size	Average Rural Household Size	% Urban/% Rural
2001	4.2 persons	3.9 persons	4.5 persons	42 / 58
1989	4.7 persons	3.9 persons	5.3 persons	36 / 64
1979	5.6 persons	4.6 persons	6.2 persons	-

BCC. ProShendetit would find much **work needs to be done on the demand side** in 2006-2009 to support and accelerate the increase in CPR that seems already to be underway in Albania. Continuation of the AFPP-initiated mass media campaign aimed at couples would be the highest priority (the AFPP-supported media campaign will have run for only six months and ought to be

⁴ The JSI interventions in Korce and Shkodra occurred in late 2002 after the RH Survey data was collected. The JSI intervention in Lezha was in May 2005, three months before the ProShendetit survey was done. Therefore, increased CPR in these prefectures can be attributed primarily to the JSI interventions, which added a total of 49 new FP service delivery points.

extended and expanded, both from a behavior change point of view and from a USAID investment point of view. More difficult than merely continuing the mass media campaign would be its adaptation in light of the impact the campaign makes on actual behavior in 2006. Measuring this impact, and making the correct adjustments in the campaign, is already built into the AFPP technical approach.

AFPP is already looking ahead to expanding mass media interventions to TV call-in shows and a family planning knowledge contest and to initiating a complementary pilot sustainable face-to-face communication program linking couples to community midwives and health facilities for family planning information and services. With lessons learned from the pilot areas, AFPP is planning to expand this program. Based on its BCC research, AFPP is also planning for special interventions, e.g., to men.

Overall, our advice to ProShendetit re BCC is that this is **the priority RH intervention during the 2006-2009 period**, and they should maintain the BCC approach initiated in 2004, and fully utilize the research data already collected, so that the BCC program does not lose valuable time and momentum. We would suggest that ProShendetit hire one, and possibly two, field officers to support and expand the face-to-face BCC activity currently being designed and field tested by AFPP.

Contraceptive Security. Albania is likely to remain prone to contraceptive stock outs during the 2006-2009 period, which has the potential to slow (or even reverse/) the rising CPR. ProShendetit would find a substantial challenge in keeping contraceptive availability at SDPs on the MOH and UNFPA agenda. One priority would be to complete the institutionalization of the contraceptive security policy framework established with JSI/AFPP assistance (the National CS Strategy) and to arrange external technical assistance, for example from DELIVER, for specialized CS issues that will inevitably arise, e.g., long-term contraceptive forecasting, contraceptive market segmentation. The Logistics Management Information System would require ProShendetit to provide continuing support (LMIS refresher training for district-level operators, LMIS software support, LMIS troubleshooting for MOH, plus perhaps an LMIS re-design.) Perhaps most importantly, to ensure contraceptive security, ProShendetit would be required to provide technical assistance in the design and implementation of a contraceptive procurement, warehousing and distribution system for the MOH (these logistics functions are currently performed by UNFPA on behalf of the MOH, but this unusual arrangement will have to change during the 2006-2009 period, with the MOH establishing its own logistics system for contraceptives.)

Overall, our advice to ProShendetit re contraceptive security is that it requires major follow up and support, keeping an eye on the day-to-day availability of contraceptives at 400+ service delivery points and simultaneously nudging the MOH toward 'contraceptive independence' in 2010, which is the stated goal of the MOH in the National CS Strategy.

Family Planning Training. FP training will have been completed in all 36 districts by September 2006, but training follow up and support will need to continue if the MOH is gain the full value of this major investment. The MOH will require assistance in developing the current supervision and support system for FP staff (AFPP will have introduced supervisory checklists for MOH supervisors by 2006.) Because of frequent staff transfers, hiring of new staff, and changing FP technology, FP refresher training will be required in 2007-2008, especially if CPR increases rapidly, as seems likely, and staff find themselves seeing more and more well-informed FP clients who demand a higher level of service and a wider range of contraceptives. Also, ProShendetit would want to nurture the cadre of approximately 24 FP trainers/master trainers created by JSI/AFPP within the MOH by using them

to do FP trainings, and perhaps other types of training, and most importantly, assist the MOH to utilize this valuable in-house training resource. For long-term sustainability, ProShendetit would want to ensure that up-to-date family planning be included in pre-service training for all clinicians in Albania (something that SEATS attempted unsuccessfully due to lack of resources.)

Overall, our advice to ProShendetit re FP training is that it requires intense, timely and possibly repeated follow up to reinforce new skills, knowledge and attitudes. The provider is the ultimate critical link between demand creation and the provision of commodities through counseling (informed choice). We would suggest that ProShendetit consider hiring a field officer to focus on training follow up.

Other FP/RH Challenges and Opportunities for ProShendetit in 2006-2009

1. Almost ? of the urban population is concentrated in seven cities (20% in Tirana alone,) making it relatively easy to reach the urban population with family planning information/services. The greater challenge is to reach the rural population, which is geographically dispersed and economically poor, knows less about FP choices, has less access to alternative sources of contraceptives (social marketing and commercial products) and generally has a greater unmet need for FP.
2. Approximately 96% of women and 97% of men had heard of HIV/AIDS, but the RH Survey notes that “Albanians are disproportionately aware of HIV/AIDS in comparison to its incidence in the country and are a great deal more aware than some other countries in Eastern Europe. The close proximity and access to Greek and Italian media may be one source of this information.” The Greek and Italian media might be investigated for a potential BCC role.

Brief Summary of the Albanian Family Planning Project (TASC II)

The Albanian Family Planning Project (AFPP) operates within a national Primary Health Care (PHC) framework established by the Ministry of Health to ensure universal access to primary care in Albania. The AFPP counterpart agency is the Ministry of Health, with active collaboration with ProShendetit on BCC and training, and with UNFPA and NESMARK on contraceptive security.

Prime Contractor: John Snow, Inc.

Subcontractor: The Manoff Group (for BCC)

AFPP Goal: Expand access to quality family planning services in sixteen districts, and increase awareness of modern family planning methods and availability of contraceptives nationwide.

Component 1, Contraceptive Security, assists the MOH to achieve and maintain a high level of contraceptive security by operationalizing the *National Contraceptive Security Strategy 2003*. A key objective is to re-vitalize the existing National Contraceptive Security Commission to act as a FP policy and coordinating body for the government, social marketing and commercial sectors. AFPP also supports the MOH Logistics Management Information System (LMIS) to provide the stock data required to ensure an uninterrupted supply of contraceptives to over 400 government FP service delivery points. ***Expected Overall Result of Component 1:*** Contraceptive security in Albania, i.e., the guaranteed long-term supply of quality contraceptives for every Albanian who wants to use them.

Component 2, Family Planning Training, assists the MOH train FP providers in government service delivery points (Maternities, Women’s Consultation Rooms, Health Centers) in 16 target districts. AFPP trains and supports local training teams composed of MOH staff who deliver the FP training courses, thus building local training capacity and contributing to the long-term sustainability of FP training. Recently, a small group of Master Trainers within the MOH was formed to organize and support the existing cadre of FP trainers. AFPP also includes some community midwives in FP training sessions, which is the first step in extending FP access to the community level. **Expected Overall Result of Component 2:** Trained FP providers in the remaining 16 districts, thus achieving nationwide FP service coverage.

Component 3, Behavior Change Communication, uses a rigorous social research-based methodology to increase awareness of family planning methods and services and to motivate people to seek these services. The BCC program promotes informed choice in selecting safe, reliable family planning methods to achieve Albanians’ goals for timing and limiting pregnancies. The nationwide BCC mass media campaign is focused on Albanian married couples and uses both an emotional and knowledge-based appeal. In addition, AFPP is implementing a face-to-face communication pilot campaign that builds on women’s usual means of learning about most contraceptives and that complements the mass media campaign. **Expected Overall Results:** Increased social acceptability of using modern contraceptive methods and increased demand for and use of FP counseling/methods.

- *To make sure we focus on the most important statistics, could you compile a half page or so of family planning/reproductive health indicators for inclusion in our report?*

Albania Demographic and FP/RH Indicators

Indicators	2001	Source
Total Population	3,087,159	INSTAT
Percent of Population Urban/Rural	42% / 58%	INSTAT
Infant Mortality	15.1 / 1000 live birth	MoH (2002)
Maternal Mortality	12.7 / 100,000	MoH (2002)
Total Fertility Rate (TFR) (Women Age 15-44)	2.6	RH Survey
CPR Modern Methods (all women)	5.6%	RH Survey
CPR Modern Methods (married women)	8.0 %	RH Survey
Traditional Methods (total married women)	44.8 %	RH Survey

Indicators	2001	Source
Unmet Need for Contraception	45.7 %	RH Survey
Mean duration of breast feeding (exclusive)	2.8 months	RH Survey
HIV Prevalence	<1	INSTAT
Average Age at First Marriage	Woman 21.9 Men 26.5	RHS
Median age at delivery of first child	23.4	RHS 2002

Expanded Coverage of Essential Health Services in Djibouti

Annual Report

Project Year 1: May 2004- April 2005

Submitted by:

**Dr. Stanislas Paul Nebie
Chief of Party**

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



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

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ACRONYMS

BCC	Behavior Change Communication
CA	Cooperating Agency
CHC	Community Health Center
CME	Continuing Medical Education
COP	Chief of Party
CS	Child Survival
DEPCI	Direction of Studies, Planning, and International Cooperation
DMO	District Management Officer
DMT	District Management Team
EOC	Emergency Obstetrical Care
EPI	Expanded Program on Immunization
FP	Family Planning
HGP	Pelletier General Hospital
HIS	Health Information System
HP	Health Post
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IST	In-service Training
JSI	John Snow Inc.
MCH	Maternal and Child Health
MHC	Medical Hospital Center
MOE	Ministry of Education
MOFA	Ministry of Foreign Affairs
MOH	Ministry of Health
NCTHP	National Center for Training Health Professionals
NGO	Non-governmental organization
PECSE	Projet d'Extension de la Couverture des Soins de Santé Essentiels (Expanded Coverage of Essential Health Services)
PMP	Performance Monitoring Plan
QA	Quality Assurance
QI	Quality Improvement
RH	Reproductive Health
RMT	Regional Management Team
TA	Technical Assistance
UGP	Project Management Unit of the Ministry of Health
UNFD	National Union of Djiboutian Women
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The Expanded Coverage of Essential Health Services Project, or PECSE, was awarded in late April 2004. Financed by USAID for three years and implemented by John Snow, Incorporated (JSI), PECSE is the first health sector project funded by USAID in Djibouti. The vision of the project is to support Djibouti health reform, and to expand coverage of essential health services with a focus on rural areas. The Project Special Objective is to achieve “Expanded Coverage of Essential Health Services” in order to address several of the conditions which contribute to Djibouti’s high infant, child and maternal morbidity and mortality. The contract stipulates the following anticipated results for the three-year implementation period:

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

To expand coverage of essential health services, USAID has funded the Expanded Coverage of Essential Services Project to assist the MOH in:

- 1) increasing the supply of essential health services by improving service facilities through rehabilitation, the provision of equipment, and the rehabilitation of water supply, as well as through expanding the range of essential services available at targeted sites;
- 4) improving the quality of services through strengthening management systems and training to improve the skills, knowledge and performance of providers; and
- 5) enhancing local capacity to sustain health services by increasing community participation in health programs, strengthening the role of local associations, NGOs and other community groups in community mobilization and in information, education and communication activities to address health issues of importance to the community, as well as through expanding the community health aide model.

USAID refined these goals into Intermediate Results (IR) for the Project. These are: Increased Supply of Essential Health Services (IR 1); Improved Quality of Services (IR 2); and Enhanced Local Capacity to Sustain Health (IR 3). In close collaboration with the MOH, JSI has defined specific technical and geographic focus areas that the Project will support in expanding essential services and addressing each of these intermediate results.

In May 2004, the project began start-up activities. After equipping the JSI office in Heron and the office provided to JSI by the Ministry of Health (MOH), first the administrative team and then the technical team were hired and oriented by the Chief of Party and other JSI staff. In spite of delays in

hiring caused by difficulties in identifying competent persons for many of the positions, the technical and administrative staff is now complete.

PECSE/JSI worked hard to build trust within the MOH, and to create a long-term working relationship. While there are few qualified public health managers and technicians available to work with PECSE on a central or district level, excellent working relationships have been forged and substantial progress has been made towards all major Intermediate Results.

The official launch of the project took place at the Sheraton Hotel on January 23rd, 2005. Numerous participants attended including the United States Ambassador, USAID Representative, His Excellencies the Ministers of Health and of International Cooperation, and others including ambassadors, UN bodies' representatives, French Cooperation, international and local NGO representatives, members of Djiboutian civil society, MOH officials and District Hospital physicians. The official launch assembled all key partners and was the opportunity for the Secretary General of the Ministry of Health to make a presentation on the important axes of health system reform for Djibouti.

The PECSE Project has made significant gains in a number of areas during the first year of project implementation, including measurable progress towards meeting each of the main intermediate results defined by USAID and operationalized through defined indicators. PECSE met all its project year 1 objectives, in a challenging context with numerous obstacles.

Achievements during PY 1 include:

- Some service delivery areas and water systems in targeted health facilities have been rehabilitated, and the long process of procurement of appropriate equipment and furniture to support the provision of essential services is well underway.
- PESCE's Three year Work Plan and Performance Monitoring Plan are approved and in use.
- Essential Services package at all levels of the MOH system is defined by the Ministry of Health.
- Two radio spots on pregnancy risks signs and children diarrhoea were developed and broadcast on National Radio of Djibouti in three languages, and more are under development.
- In-service training has begun to revitalize the skills of health care providers, and has developed eleven in-service training modules this year.
- PECSE worked with the MOH to improve service management systems to sustain the quality and efficiency of health services, including supporting the development of the District Management Teams and improving national plans for Health Information Systems.
- Community mobilization and linking health facilities to community health aides and community health committees has begun in communities in all five districts. On-going discussions and a planned mobilization study tour will continue to keep this topic in the forefront.
- PECSE has introduced management innovations in the Djiboutian context including non-discriminatory practices, and discussions about HIV/AIDS workplace policy.
- Cost savings for the US government has been achieved through a variety of actions, resulting in significant savings.
- Overall health sector coordination and collaboration improved, reinforcing the MOH in its primordial role as the ultimate source of health improvements for the country.

INTRODUCTION

John Snow Incorporated (JSI) was awarded the TASC II contract for health sector work in Djibouti, “Expanded Coverage of Essential Health Services”, in late April 2004. The Project, known as PECSE, its acronym in French, is a three-year contract with very ambitious objectives.

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

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

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

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

Each of these IRs are being measured by project benchmarks, which have been finalized and included in the Performance Monitoring Plan (PMP). The PMP was developed jointly with the MOH, and approved by both the MOH and USAID.

This report covers progress made during the first project year (PY 1), May 2004- April 2005, and addresses progress made against each IR and benchmark.

In addition, this report summarizes management issues and cost-savings efforts.

CONTEXT

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

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

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

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

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

The total fertility rate is high at 4.2, and the maternal mortality rate is among the highest in the world (estimated at 740 per 100,000 live births). The life expectancy of 49 years at birth is one of the

lowest in the world. Vaccination coverage rates for all antigens have not been consistently reported in recent years, with the last complete data in 2000 reported at 33% for BCG, 45% for both DPT3 and OPV3, 50% for measles, and 15% for TT2. Acute respiratory infections and tuberculosis, diarrheal diseases, and malaria are the principal reasons for medical consultations. Poor sanitation and hygiene, coupled with poverty and malnutrition, render the health situation more difficult.

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

I. Partnership with the Ministry of Health

Upon arrival in Djibouti in May 2004, JSI staff was briefed on the advantages and challenges of working closely with the Ministry of Health (MOH). Unlike in many countries, the MOH did not have many outside funding partners, and had developed close working relationships with those that it had: UNICEF, WHO, WFP, French Cooperation. Many active donors were multilateral donors from within the United Nations family. Few bilateral donors were present in the health sector, although the French government had provided both long-term technical advisors and funding to the health system since the country's independence primarily in Djiboutville. Other bilateral aide comes from Japan, China, and Saudi Arabia. The MOH contracts with Cuba to provide physicians to staff mobile clinics. In addition, non-governmental organizations (NGOs) from Spain, the USA and other countries provide direct services or advising in the health sector. The few NGOs, both international and local, that play a role in the health sector are modest in size.

The PECSE contract was the first USAID bilateral contract in the health sector in Djibouti. In real terms, this meant that the MOH didn't understand the nature and content of a USAID health project managed by a contracting agency like JSI and needed continuous assistance during the first project year in understanding a number of things, including the following:

- USAID rules and regulations including limitations on what could be funded or procured;
- Differences between USAID and multilateral funding;
- Financial management and the non-role of the MOH in handling PECSE funds;
- Content of the USAID bilateral accords with the Djiboutian government;
- Emphasis on joint planning and implementation by JSI;
- Equal opportunity hiring practices and procedures;
- Non-discrimination in all project areas (ethnic group, gender, geographic origin, etc).

As the first year ended, many of the issues had been explained and clarified multiple times to different staff at the MOH, and the role and responsibilities of the MOH, USAID and JSI as a USAID contractor had become clearer. Working relationships were clear and strong professional ties between JSI staff and the MOH had developed. The JSI Chief of Party (COP) and key MOH staff worked together regularly, producing plans and documents, planning improvements and working together to meet PECSE objectives.

One area of the PECSE contract that requires special attention is human resource development with the MOH. Djibouti does not have a medical school but does have a facility for training auxiliary health professionals. However, there was a serious lack of trained personnel in the five districts, and many health posts were staffed by untrained health aides. Many of the trained health providers- nurses, midwives, nurses aides- were unwilling to work in the districts where they had no family. Fortunately, the MOH instituted a series of policy changes that would help to recruit students from districts who would then take up positions in their home regions when they were trained; while PECSE is unlikely to benefit much from these changes, within 5 years the change should be evident. While the MOH had expressed plans to move some trained personnel to the field, by the end of PECSE's first project year, this had not yet taken place.

In the meantime, PECSE conducted an assessment of the National Center for Training Health Professional (NCTHP) and worked closely with it's Director and with the French advisor assigned to the NCTHP. The Center had few trained staff, and only two assigned to in-service training for the

employees of the MOH. For many of the district-level health workers, there had been no in-service training for 15-20 years, and the NCTHP needed assistance in beginning the process. PECSE has worked closely with NCTHP staff to design and implement the first several in-service training courses. The severely limited human resources at the NCTHP were hit hard when the French government withdrew the training advisor from the center, leaving a huge gap that PECSE cannot fill. Since then, PECSE has been waiting for the Center to provide a description of any short-term technical assistance needs in pre-service training that could be filled by PECSE consultants. PECSE continues to work with available staff on training materials design and workshop implementation.

At the district level, PECSE staff met with each District Medical Officer and visited each health post. Plans for renovations and equipping, staff training and discussions of other needs took place during these initial visits. By mid-year, PECSE and the District Medical Officers had planned and implemented the first rounds of health worker training for health post staff, and completed the training of trainers for the medical officers. Working relationships between PECSE and health workers in the districts were strong. Unfortunately, more than half of the District Medical Officers were reassigned to other posts during the year, so PECSE had to start over each time with introductions and joint planning for the district.

Besides the myriad actions laid out of PECSE in its Work Plan, PECSE was also flexible and responsive to MOH needs. During Project Year 1, PECSE supported several maternal and child health activities of the MOH, including working with WHO and UNICEF for the National Immunization Campaign in December 2004, International AIDS Day, and the organisation of the large regional conference on the fight against Female Genital Mutilation which took place in the spring of 2005. JSI worked closely with the MOH on additional immunization campaigns after polio epidemics broke out in several neighbouring countries in 2005.

In summary, PECSE and the MOH have developed very satisfactory working relationships on several levels and throughout the country, leading to significant joint activities including planning, human resource development, renovation oversight and problem-solving. This is a real partnership, and is appreciated by both the MOH and JSI.

II. Technical Progress: Achievements and Innovations

To expand coverage of essential health services, the PECSE Project is to assist the MOH in:

- 1) increasing the supply of essential health services by improving service facilities through rehabilitation, the provision of equipment, and the rehabilitation of water supply, as well as through expanding the range of essential services available at targeted sites;
- 2) improving the quality of services through strengthening management systems and training to improve the skills, knowledge and performance of providers; and
- 3) enhancing local capacity to sustain health services by increasing community participation in health programs, strengthening the role of local associations, NGOs and other community groups in community mobilization and in information, education and communication activities to address health issues of importance to the community, as well as through expanding the community health aide model.

USAID refined these goals into Intermediate Results (IR) for the Project. These are : Increased Supply of Essential Health Services (IR 1) ; Improved Quality of Services (IR 2) ; and Enhanced Local Capacity to Sustain Health (IR 3). In close collaboration with the MOH, JSI has defined specific technical and geographic focus areas that the Project will support in expanding essential services and addressing each of these intermediate results, which will be discussed below.

Planning

One of the very first PECSE project activities was to work with the Ministry of Health (Unite de Gestion des Projets — UGP), to develop a three-year Work Plan. The Work Plan was developed to reflect the Project's statement of work and the five year work plan of the MOH as well as to take into account the work of other stakeholders. The process involved holding a series of workshops and joint field visits by the members of the MOH and JSI team. (USAID's Senior Health Advisor had not yet relocated to Djibouti and was therefore not able to participate in the work planning process.)

The Work Plan draft was developed during May 2004, approved by both the Ministry of Health and USAID, and continues to be one of two primary guiding documents for the implementation of PECSE. A Performance Monitoring Plan (PMP) was developed with the MOH to track project as well as MOH performance, with on-going technical assistance from MEASURE/Evaluation. Progress against the indicators from the PMP is reviewed below.

Essential Services Package

JSI also worked closely with the WHO and MOH to finalize a minimum package of essential services, especially for the district hospitals and rural health posts; this package was validated in a workshop of health experts. A plan has been developed to ensure an effective delivery of the essential services minimum package and to provide training to the service providers and managers, much of it with assistance from PECSE.

Within the newly defined structure of the essential services package, it became clear that PECSE could not respond to all the MOH's needs. USAID's Regional Senior Health Advisor worked with PECSE staff to define eight key areas of intervention for PECSE:

- Recognition of danger signs for pregnant women and prevention activities against malaria, anaemia and tetanus;
- Child growth monitoring and breast feeding;
- IMCI (integrated Management of Childhood Illnesses) focusing on diarrhoea control, ARI, and immunization;
- Treatment of common diseases, such as malaria;
- IEC and Health Education;
- Prevention of HIV/AIDS through counselling and STI treatment;
- School health (prevention of diseases);
- Community based services.

In order to provide high-quality technical support to the MOH, an excellent staff is required. PECSE began the year with the highly talented Chief of Party on staff, and proceeded to begin a long and ultimately fruitful search for qualified technical personnel. The technical team is now composed of a Monitoring and Evaluation Specialist, Training Specialist and Community Mobilisation Specialist. The high calibre and dedication of the technical staff have made many of the achievements possible in spite of challenging working conditions, and a Presidential election.

Besides the technical assistance from staff, JSI bolstered the team with expert outside assistance in multiple areas. Banking and legal services, financial management and planning all received support during the first quarter. Health information systems received multiple visits from an international expert. As mentioned above, JSI provided technical assistance for the assessment of the National Center for Training Health professionals and for assistance in finalizing training materials and conducting workshops. JSI's subcontractor The Manoff Group also provided technical assistance to PECSE and the MOH on social mobilization and the research and development of the first set of radio spots.

Four Strategic Objectives

USAID defined four "strategic objectives" or SOs; progress was made in each of the four key areas of technical work.

Strategic Objective 1: % of targeted health posts which provide at least one of the interventions supported by PECSE

For Project Year 1, the target was 12% of health posts which provide at least one intervention, with 0% as the base line. After the training of health providers in Ali-Sabieh, the 6 health posts in the district provide at least one intervention per site supported by the project. The 12% target was met.

Strategic Objective 2: % of health providers trained in PECSE implementation areas

The target for project year 1 was 38%, with the working assumption that no health provider received in-service training recently. PECSE met the target of 38%.

Strategic Objective 3: DPT 3 coverage of children under the age of 24 months.

The target was 20%, which is the basic rate in rural zones. The project interventions have not allowed an increase above 20%, and significant increases will not be possible until UNICEF-supplied cold chain improvements and vaccinations and PECSE-funded renovations are completed in more areas; improvements will then be seen in the following year's statistics. (For DTP-3 coverage to increase, it takes at least a full year of improved service delivery to increase the number of children receiving the three vaccinations before they reach 24 months of age.)

Strategic Objective 4: Utilization rate of health services.

The base line data of this indicator has been estimated to 10%; since technical interventions have just started, there is only have anecdotal data about an increase in service use in renovated facilities and/or in sites with staff that is now partially trained.

PROGRESS TOWARDS INTERMEDIATE RESULTS

Each of these IRs is measured by PECSE Project benchmarks, finalized and included in the Performance Monitoring Plan (PMP) in the appendices.

I) Progress Towards IR 1: Increased Supply of Essential Health Services

Task 1.1 Essential Health Services Package Development:

In the first and the second quarters, the project provided technical support to the MOH to define the minimum health package in collaboration with a WHO. The three-year workplan of the project was also approved by the MOH. The mission of Cornelia Davis of USAID/REDSO enabled clarification with the MOH of the essential health service packages that will be supported by the PECSE project. These activities are:

- Recognition of danger signs for pregnant women and prevention activities against malaria, anaemia and tetanus
- Child growth monitoring and breast feeding
- IMCI (integrated Management of Childhood Illnesses) focusing on diarrhoea control, ARI, immunization
- Treatment of common diseases, such as malaria;
- IEC and Health Education
- Prevention of HIV/AIDS through counselling and STI treatment
- School health (prevention of diseases)
- Community based services

This package of essential health services was presented to district health teams and specific training related to some of these eight areas has been completed.

1.1.1. *A national workshop to validate the minimum package of activities was successfully completed.*

The package of activities for health posts was validated by the MOH and their main partners during Quarter 2, with assistance from PECSE staff and the JSI Vice-President for the International Division.

1.1.2: % of health facilities targeted by the project which provide at least one of the interventions supported by PECSE

See Strategic Objective 1, above. PECSE met its target of 12%.

Task 1.2 Human Resource Development

Following the first technical assistance conducted during the 2nd quarter, additional technical support needs were identified to assist the MOH in improving the ability of health post and district staff to provide selected primary care services. During Quarter 4, an outside expert drawn from one of JSI's projects in the region was seconded temporarily to Djibouti to reinforce the MOH's ability to develop training modules and to train their own trainers. The training of trainers (TOT) modules are in Annex 1. The TOT was successfully carried out, including health providers from all five PECSE districts and with excellent participation from the National Training Center. The first in-service training modules for providers in health posts were developed, field tested and used to train providers in Ali Sabieh during Quarter 4.

Planning for the roll-out of this training, and development of additional modules with the MOH and the National Training Center, was completed during Quarter 4 also.

1.2.1: % of training centre trainers (CFPS) trained.

The target of the quarter was 50% of the CFPS trainers trained, but all of them have been trained. Target of 100% has been achieved.

1.2.2: Number of training modules developed

The target for Quarter 4 was ten modules developed. In total, PECSE worked closely with NTC staff to adapt eleven modules covering the following subjects:

- Principles for the Training of Trainers
- Supportive Supervision
- Elements of IMCI: immunization or EPI
- Elements of IMCI: control of diarrhea disease or CDD
- Elements of IMCI: acute respiratory infections or ARI
- Family Planning
- Infection prevention
- Breastfeeding
- Child growth monitoring
- Prevention and identification of risks during pregnancy
- TB care

1.2.3: % of trainers and supervisors followed up by district

The Quarter 4 target was to train 25% of trainers and supervisors, which at the current time is 17 MOH staff. Seventeen trainers have been trained from the districts. The training team was made up of the JSI consultant, the PECSE Training Officer, the in-service training officer of the CFPS (National Training Center) and Director of Prevention and Public Hygiene of the MOH.

In addition, six of the seventeen have already been supervised, which makes the total rate of 29% of target MOH staff trained and/or supervised. (PECSE is pleased with progress to date, since before these activities there were no district level trainers and most sites report only visits to deliver supplies, vaccines or food aide, with no regular supervision planned or carried out.)

1.2.4: % of trained health providers in the targeted health facilities

The Quarter 4 target was 38% of health providers in target facilities trained.

Ten health providers were trained from April 25-27, 2005. The seventeen MOH staff also trained as trainers in certain technical areas are also providers, therefore giving a total of 60 providers trained. The overall result is that 45% of providers in targeted health facilities have been trained in some PECSE interventions.

1.2.5: % of supervised health posts by district

This indicator did not have a first year target. Currently, the training for health providers is on-going. Members of newly formed district management teams will be trained in supportive supervision before conducting their supervision visits in the field. This activity is planned for Quarter 5.

Task 1.3 Targeted health facilities refurbished

Local construction companies have rehabilitated the first three sites, and the sites have been rededicated. Additional improvements in environmental control and site hygiene, including the addition of simple cement incinerators, will be completed soon. Collaboration with the MOH team on renovations was excellent, and site-level supervision carried out by a PECSE consultant. Technical planning for the next group of eight clinics to be renovated was almost completed during Quarter 5. In addition, collaboration with the US Army may lead to the US Army renovating one priority PECSE site during the next two quarters.

1.3.1: % of rehabilitated health facilities by PECSE and its partners, taking into consideration USAID guidance on the solid waste management system

The annual target of 12% was met.

The first three rehabilitated sites have been officially reopened during the fourth quarter. Eight women have already given birth in the Goubetto Health Post, which has never had a maternity service before. The MOH sent two trained nurses for two rehabilitated health posts this quarter. The challenge will be to assist them in staying at their post and improving the quality of services under current conditions.

During Quarter 4, USAID regulation and document review and detailed discussions allowed the identification of a number of environmental modifications to improve site hygiene. One of these,

selection of solid waste disposal mechanisms, included the study and selection of models of incinerators with the MOH. The solid waste management system details for each site will be developed during the Quarter 5. These improvements will take place simultaneously with the rehabilitation, and providers trained to manage use once they are completed.

1.3.2: % of equipped health facilities:

Procurement of equipment and supplies for health posts is in process; limitations in local suppliers have slowed part of the process. PESCE/JSI discussed options with the Contracting Officer from REDSO during his visit to Djibouti-ville at the end of project year 1.

Progress Towards IR 2: Improved Quality of Services

Task 2.1.1 Norms and standards

2.1.1: Number of documents on the norms, standards and guidelines available

Norms have been defined in the developed modules, including:

- infection prevention and disinfection of medical equipment
- medical waste management
- child growth monitoring
- antenatal care

PECSE will work with the MOH to continue the process of the development of norms and standards. These norms will be prepared into separate documents and will be made available at health posts to all staff. The Project Year 1 target was 0%.

2.1.2: % of health facilities that have norms, standards and guidelines available

The documents will be developed in Project Year II.

Task 2.2 Health information system reinforced

2.2.1: Rate of Completeness

In the first year of the project, contacts are in progress for the reinforcement of the Djibouti health information system, with the project team who have just developed a model of a consultation book, monthly activity report and the model of the patients health files, The system will be functional by the second year.

2.2.2: Promptness rate

The system will be functional by the second year. The first year target was 0%.

2.2.3: % of health providers trained in data management

This training is plan for the second year of the project; the Quarter 4 target was 0%.

Task 2.3: Identification of pregnancy risks and prevention against malaria, anemia and tetanus.

2.3.1: Antenatal care coverage

The project year 1 target was 35%. 35% coverage represents an estimation of the base line; PECSE anticipates increased coverage in the second project year.

2.3.2: Malaria prophylaxis in pregnancy (coverage)

Project year 1 target of 28% represents the base line coverage of malaria prevention. PECSE anticipates increases in the following years per the PMP.

2.3.3: Iron supplementation in pregnant women (coverage)

The Project Year 1 target of 28% represents the base line coverage of iron supplementation of pregnant women and will only increase in the following years.

2.3.4: % Deliveries in health facilities

The project year 1 target of 40% is the baseline. According to the “Djiboutian Survey on Family Health” (PAPFAM 2002) the base line for this indicator is 40%. It likely did not increase during the first project year, given that the delivery rooms are mostly not renovated and those that are do not all have trained staff available.

Task 2.4: Child growth monitoring

Task 2.4.1: % of under 5 children seen in preventive consultation

The project year 1 target of 20% is the base line according to PAPFAM (see above).

2.4.2: % of under 5 children having received a supplementation in Vit A

The project year 1 target of 20% is the base line according to PAPFAM (see above).

Task 2.5: Fight against diarrhea and vaccination in the framework of IMCI

2.5.1: DTC3 coverage (see SO 3)

2.5.2: % of under 5 children diarrhea cases treated according to the MOH protocols

The Project Year target of 5% is the base line, and did not increase this quarter.

Task 2.6: Behavior Change Communication

2.6.1: % of health facilities conducting at least one session of IEC per month

This activity planned for the second project year.

2.6.2: Number of IEC themes treated in the health facilities

The project year target of 20% is the base line according to PAPFAM (see above).

Task 2.7: STI and HIV prevention by counseling

2.7.1: % of patients seen for STI who received HIV test counseling

The training and support required for this activity will take place in project year 2; PECSE anticipates collaboration with FHI's new HIV/AIDS activities.

2.7.2: % of trained health providers in STI/HIV counseling

This training is planned for the second project year.

Task 2.8 Quality Assurance

2.8.1: % of health providers trained in infection prevention

Ten health providers have been trained in infection prevention out of a total of sixty to be trained, which makes 17% completed this quarter. The others will be trained during the second year of the project.

2.8.2: Quality indicators for the Quality Prize recipient health facilities have been defined and are known by providers

This activity is planned for the second year.

2.8.3: % of rewarded health posts: Planned for the second year.

This activity is planned for the second year.

Progress Towards IR 3: Enhanced Local Capacity to Sustain Health Services

Task 3.1 District Health Management Team Reinforced

3.1.1: List of administrative tasks developed

During Quarter 4, management functions for the District Health Management Team (DHMT) were jointly identified.

3.1.2: % members of district team trained in management

Activity planned for the second project year.

Task 3.2 MOH Capacity reinforced

3.2.1: Number of partners meetings held

The Quarter 4 target was one. PECSE supported three partner meetings during Quarter 4, surpassing its target threefold. PECSE also assisted three departments of MOH in basic function improvements.

3.2.2: Number of international and national activities supported by PECSE

During the fourth quarter, PECSE supported with the other partners in Djibouti the World Health Day (20 – 27 April in Djibouti) and International Women's Day (March 8). The quarterly target was one event supported by PECSE.

Task 3.3: Effective Social Mobilization

3.3.1: The report of research on the behavioral studies exists

Documentary research on the behaviour of health providers has been conducted and the results are available. In addition, a consultant from Manoff Group completed qualitative research on pregnancy risks and their perception in rural areas and urban zones of Djibouti for the preparation of radio programmes. The survey of all the three communities (Afars, Somalis and Arabs) in Djibouti was completed as planned. The consultant worked in close collaboration with the Education for Health Department of the MOH throughout the entire process.

3.3.2: BCC and Mobilization Strategy is available

The draft strategy has been discussed twice with the MOH and the document exists. On-going discussions with the MOH and other partners continue around this theme.

3.3.3: Number of radio spots developed in the first year

Two radio spots were produced in the third quarter, using the survey data. CRIPEN developed the radio spots with PECSE assistance, producing one on danger signs during pregnancy and another on diarrhoea in children. After a quick pre-test by the MOH team, negotiations took place with the RTD (Radio and Television of Djibouti) which transmitted the spots in three languages for two weeks.

3.3.4: Number of radio spots broadcast by end of PY 1

Two spots have been broadcast during the first year of the project; the target was achieved.

3.3.5: % of primary schools conducting Education for Health in the villages with health facility.

Activity planned for the second year.

Task 3.4 Improved Community Participation

3.4.1: % of health committees put in place

The project year target of 19% was achieved. Five committees have been put into place or reinforced in the five model sites. PECSE anticipates a total of twenty-six sites will have committees, and the current coverage is 19% as planned.

3.4.2: % of supervised health committees

All five health committees have been supervised during this quarter and the reports exist detailing results of the visits.

3.4.3: % of villages having a health facility with at least one field worker trained.

This activity is planned for the second year of the project.

Monitoring and Evaluation

The PECSE Performance Monitoring Plan (PMP) is the monitoring and evaluation plan for the PECSE Project. It was developed during the second and third quarters with the Ministry of Health, was finalized in the fourth quarter in partnership with the MOH. The PMP has been approved by USAID/Djibouti, by the senior technical advisor from REDSO/USAID and by the Ministry of Health.

PECSE has also provided support to improving the MOH's Health Information System (HIS). Generally, the MOH department known as DEPCI is recognized as the structure responsible for HIS management, such as data collection, dissemination, recording and analysis. This includes not only routine HIS data from the health facilities, but also non-routine data collection methods such as periodic surveys. This department is also responsible for the management of the computer system for the HIS, not only for the hardware, but also for the appropriate software. The software and systems support starts from the definition of equipment and software norms, up to the technical support and maintenance of the computer system at the central and peripheral level. Like much of the MOH, the DEPCI is not currently staffed sufficiently to perform these functions at the central and district level. Neither routine data nor surveys are consistently completed.

It was recommended y PECSE to the DEPCI to put in place in the coming months a Health Information System National Committee; potential members are:

- DEPCI representative
- Representatives from other departments of the MOH
- Representatives of health providers (Directors of MCH, Director of Peltier General Hospital...)
- HIS consultants
- Representatives of health sector partners (WHO, UNICEF, USAID, etc)
- PECSE representative.

The mandate of this committee will be:

- Coordinate the identification of information needs at all levels (especially at the District/Regional level)

- Reach decisions by consensus on the organisational norms and procedures of the HIS (e.g. dissemination rules or report procedures)
- HIS monitoring and evaluation
- Coordination / Supervision of all restructuring of the HIS

STI/HIV/AIDS

PECSE has met with USAID and FHI officials based in Nairobi on several occasions, as they plan for activities along the trucking corridors that pass through Djibouti to the port. USAID/REDSO is developing interventions against HIV/AIDS on the Djibouti – Ethiopia corridor, and may be interested in using the presence of the project for some support of these activities. PECSE is anticipating receipt of additional details from the technical partner, FHI, as soon as they are available. At the end of project year 1, PECSE has been informed that two sites along trucking corridors have been chosen for FHI activities and that a detailed plan is being developed.

As one of the eight areas of key concern for PECSE, STI and HIV/AIDS are part of the service delivery package to be offered at each MOH site. PECSE is becoming increasingly concerned as to the complete lack of training, equipment and medicines to face STIs and HIV in the districts. While the MOH is responsible for supplying essential drugs to the health posts and district pharmacies, reasonable supply of STI treatment drugs have not been provided to any district site.

Social Mobilization and Community Health

PECSE found that the MOH had little inherent interest in community mobilization for health, and was rather more interested in finding ways to finance paid community health workers. In addition, the health education efforts of the small health education team working in Djiboutiville rarely impacted on the districts, and tended only to focus on whatever scarce outside funding supported. Little to no mass media, community education, school education or networks take place and the MOH did not see this area as a priority.

Under these circumstances, development of a community mobilization strategy was a daunting task and required many months of dialogue and discussion throughout the MOH. A fragile consensus was reached, and PECSE decided that a study tour for a few key government and local officials could turn the tide in favor of community education and mobilization. The study tour, to Ethiopia and Madagascar, is planned for early in project year two.

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

A framework in five communities has been constructed and community health workers selected to work with the MOH through the health post in their vicinity. On-going work with these communities will help to define reasonable models before expanding mobilization efforts throughout the districts.

III. Coordination with USAID and other Donors

Regular meetings and routine sharing of information and issues has reinforced on-going positive coordination with USAID. PECSE continues to enjoy excellent technical and administrative support

from USAID in Djibouti and USAID/REDSO in Nairobi. In 2005, USAID's long-term Senior Health Advisor arrived in Djibouti and soon became PECSE's CTO, adding to available support and coordination with the MOH.

USAID asked JSI to help the MOH to establish a donor coordination mechanism, despite MOH resistance. Due to USAID and the PECSE COP, the health partners' meetings became a reality. The JSI COP is in charge of the secretariat of the partner coordination group. The first meeting resulted in a frank discussion between the MOH and the donors about the issues of human resources, and mechanisms for partner coordination. Three meetings in total were held during project year 1 with PECSE project support and two technical adhoc groups have been created; one on the Millennium Objectives and the other on the health human resources development. Overall, donor and partner enthusiasm for the coordination meetings has been high.

JSI has also coordinated efforts with the USAID-funded EQUIPE I/AIDE project in the education sector. JSI and the EQUIPE I/AIDE project coordinate in improving health messages in school curricula and in developing new ways to integrate specialized messages into primary school classrooms. Currently, draft posters and a work book for elementary school students have been developed and will be printed during project year two.

The PECSE Project works closely with other donors in the health sector, sharing information and coordinating efforts whenever possible. USAID funds UNICEF for both routine immunization and polio campaigns, and PECSE has planned all its interventions in these areas in accordance with MOH and UNICEF plans to avoid overlap and improve services as rapidly as possible. PECSE also coordinates with WHO, World Food Program (on food distribution), the US Army (on renovations and assessments), and other groups as possible.

IV. Cost Control and Costs Savings

The PECSE Project uses all available means to provide good value to the US Government and quality services to the population of Djibouti. Part of JSI's management philosophy, applied to PECSE, is to both control costs and to seek ways to reduce costs whenever possible. During the first project year of PECSE, a number of actions have been taken to contain costs:

1. **Leveraging:** Whenever possible, PECSE shares funding for activities with the MOH and other donors or projects. For example, cost-sharing for IMCI activities was done with UNICEF. National Immunization Days and World AIDS Day activities were funded by multiple partners including PECSE.
2. **Negotiating:** PECSE's Director for Administration and Finance worked closely with the project's local bank to lower costs in a number of areas including wire fees, exchange rates and banking charges.
3. **Identifying Best Local Value:** When finalizing arrangements for the purchase of project vehicles, PECSE went outside of the usual suppliers to find additional options, saving the project funds and obtaining a better model at a lower price.
4. **Using Local Government Resources:** Although the PECSE contract stipulated use of outside experts for engineering and architectural work on clinic rehabilitations, PECSE identified qualified experts within the MOH to do some of the work, reducing costs, increasing MOH ownership of the activities and increasing internal expertise within the MOH.

5. Identifying Appropriate JSI Resources: Whenever possible, PECSE uses experts internal to JSI to provide needed technical support. Some of these experts come from other USAID-funded projects, such as MEASURE/Evaluation and ImmunizationBASICS, thus using US government resources whenever possible. PECSE has also utilized experts from other JSI projects overseas, who have first hand knowledge of similar conditions. In both these cases, costs are usually lower than hiring independent consultants and results have been excellent to date.
6. Working with the MOH to Access Government of Djibouti resources: PECSE has used its partnership with the MOH to gain access to other governmental resources in Djibouti in cases where this is beneficial. Notably, this led to better access and lower costs for air time used for health messages during project year 1.

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

V. Summary Statement

The PECSE Project has made significant gains in a number of areas during the first year of project implementation, including measurable progress towards meeting each of the main intermediate results defined by USAID and operationalized through defined indicators. PECSE met all its project year 1 objectives, in a challenging context with numerous obstacles.

Some service delivery areas and water systems in targeted health facilities have been rehabilitated, and the long process of procurement of appropriate equipment and furniture to support the provision of essential services is well underway. In-service training has begun to revitalize the skills of health care providers. PECSE works with the MOH to improve service management systems to sustain the quality and efficiency of health services, including supporting the development of the District Management Teams.

Community mobilization and linking health facilities to community health aides and community health committees has begun in communities in all five districts. On-going discussions and a planned mobilization study tour will continue to keep this topic in the forefront. In the long-term, PECSE aims to support community engagement in managing and mobilizing health activities with the MOH.

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

TASC ANNUAL REPORT

**MATERNAL AND CHILD HEALTH INITIATIVE (MCHI)
PROJECT - RUSSIA
HRN-I-00-98-00032-00 Delivery Order No. 813**

**IMPLEMENTED BY
JOHN SNOW, INCORPORATED**



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SEPTEMBER 2005

I. Executive Summary

In September 2003, the Russian mission of the United States Agency for International Development (USAID/Russia) awarded a task order (TO) to John Snow, Inc. (JSI) under the Maternal and Child Health Technical Assistance and Support Contract (TASC I) to implement its three-year Maternal and Child Health Initiative (MCHI). The project's stated objective is to ensure the adoption of internationally recognized maternal and child health (MCH) standards and practices by the targeted health facilities in Russia.

MCHI contributes to USAID/Russia's Strategic Objective, SO 3.2: *Use of Improved Health and Child Welfare Practices Increased*. Indicators directly related include: Indicator 3.2.3: *Abortion rates*, the Intermediate Result 3.2, IR1: *Access to More Effective Primary Health Care (PHC) Services Increased*, and its indicator: *Number of health facilities implementing evidence-based maternal and child health (MCH) care practices*. The expected results of the Project were again modified in June 2005. The funding ceiling was increased to \$9.94 million and the scope of work expanded. The expanded expected results are outlined in the rest of this document.

In March 2005, MCHI reached its mid-point and underwent a mid-term evaluation by a team composed of a senior member from the USAID EE/EA Bureau and two senior technical experts from the JSI/Washington office. The evaluation team found that MCHI is a project that is definitely working—change can happen. The **capacity building** at the regional level is impressive, and the potential is great for continued achievement and further expansion.

The design and implementation process of the MCHI Project is an **excellent model** for similar work in other countries and for the incorporation of evidence-based, internationally-recognized standards of care into the Russian health care system. MCHI has the **potential to scale up further** than it has. The Project already reaches a substantial part of the 16 MCHI target regions that together constitute more than one-sixth of Russia's total population. Both **replicability** and **sustainability** are key MCHI successes. The selection process for intervention regions has worked extremely well and is a major contributor to the Project's robustness. The competitive and co-financing elements were motivating and innovative. Choosing facilities that are interrelated sets of MCH clinics, family planning centers, and HIV/AIDS centers has helped to horizontalize previously vertical institutions and to standardize content and continuity of care.

It is highly likely that the evidence-based interventions introduced by MCHI will be sustained in target facilities beyond the life of the Project and that adoption of those interventions will be rolled out or spread throughout most, if not all, of the other health facilities in the target regions. It is unlikely that MCHI interventions will spread to neighboring regions without organized intervention and support of some sort after the Project ends in 2006.

The adoption and integration of **internationally-recognized, evidence-based standards** is occurring at an impressive pace across a broad range of political and health institutions, and is actively involving people over a vast geographic area. Inter-linking components and multi-level focus give the project and its activities strength, breadth, adaptability, and flexibility. The MCHI approach and content is, for Russia, an idea whose time has come. The MCHI **process** (participatory, interactive, kind, respectful) is a major message that Russian counterparts were longing to hear and to which they've responded. An effort has been made to model with regions the client-centered, mother-friendly, baby-friendly, youth-friendly, and family-friendly approach that the Project is striving to introduce into Russia's reproductive health services. **Continuity of care** is reportedly becoming

more consistent across facilities. The regional/municipal/facility-level contributions (financially and in-kind) are far in excess of what was initially expected. Project **leveraging** is substantial. By identifying and supporting “catalyst” institutions and individuals, MCHI has helped multi-level leadership implement bold, rapid, substantive changes.



MCHI efforts to collaborate and coordinate are palpable. **Coordination** with donors and USAID-funded CAs is **close and synergistic** rather than pro-forma and perfunctory.

Collaboration with Russian regional and municipal government partners has been strategic and successful. One **challenge** is the **institutional development of RSOG** as MCHI’s primary Russian partner organization. Realistically, there is no other known organization that would have been a stronger choice, but it is not currently capable of continuing or expanding scale-up unaided.

The Project has been **responsive and adaptive** to changing external conditions, especially with regard to **incorporating HIV/ AIDS and PMTCT**-related activities and increasingly focusing Project attention on the Russian Far East, as well as incorporating the Vishnevskaya-Rostropovich Foundation as a subcontractor. MCHI has become a major leader in Russia for PMTCT policy development and service standards of care. The recent **PMTCT+FP Study** should provide valuable data to inform the development of strong future policy and service standards. In addition, the development of a collaborative **PMTCT-plus model** is progressing. This **synergistic** model for PMTCT-plus has the potential to revolutionize care for HIV affected families. MCHI has also worked with ARO to **integrate ARO’s Early Intervention model** into multiple MCHI training materials and is considered to be a substantive, positive addition that has especially strengthened the counseling component of these courses.

While **expanding the MCHI model into the two new RFE regions**, MCHI will also focus more on developing a **youth reproductive health model** in two pilot regions, a new strategy for **strengthening family planning interventions**, and a **rural family planning pilot initiative** in two pilot regions, and on rolling out the “Couples Campaign” to **increase male participation**. To date, MCHI has done much to increase male participation in family planning and other reproductive health services. Due to factors beyond MCHI’s control, the Campaign has been delayed by six months but is expected to be launched shortly.

Influencing the Russian professional medical community has been **a great challenge**. Much work remains to be done for new MCH practices to be disseminated and accepted throughout Russia, and for federal standards to reflect evidence-based best practices. A **comprehensive Documentation and Dissemination Plan** is currently being finalized, and MCHI is already implementing various actions outlined in the draft Plan. MCHI is actively seeking to better use the Internet for dissemination; the MCHI website now under development will extend dissemination of technical materials throughout Russia, the EE/EA region, and potentially the world.

II. Selected MCHI Highlights & Constraints

A. *Russian Partner Organization*

The Result: A Russian organization with a strong MCH mandate empowered and strengthened to partner with MCHI in implementing the replication model.

- The JSI Eastern Europe and Eurasia (EE/EA) Regional Conference was held in Moscow (October 2004) in conjunction with the annual RSOG “Mother and Child” Congress
- MCHI conducted a strategic planning/capacity building workshop for national and regional RSOG representatives (May 2005)
- RSOG participates in the Regional Coordinating teams responsible for overseeing Project implementation, the MCHI interregional Working group (IWG). Members have been trained as trainers for capacity building.
- MCHI contributes articles to the RSOG Journal.
- Providing the level and extent of capacity-building that RSOG would need to allow them to continue MCHI-type interventions is beyond the resources (time, human, financial) of MCHI, nor could RSOG absorb such intense capacity-building efforts, even if available, at this time. In Russia, the specialist associations have yet to have a major role in decision-making.

B. *Adoption of Internationally-Recognized, Evidence-Based Standards*

The Result: Internationally recognized standards and USAID-promoted MCH and HIV/AIDS prevention practices adopted by targeted health facilities in at least fourteen regions of the Russian Federation, in addition to the two WIN Project’s pilot regions. (Note: two additional regions in the RFE were added as of modification #5 in June 2005 for a total of 16 intervention regions, including 4 in the RFE).

- Successful selection criteria was used for the selection of the Project’s initial 12 intervention regions (not including WIN regions) was applied to selecting the final two new regions in the RFE.
- MCHI signed agreements with the new Regional Health Care Administrations and Regional Coordinators were selected who then formed Regional Coordinating Teams. Baseline facility surveys will be conducted in the new regions and Region-specific implementation plans will be developed based on a needs assessment in the new regions.
- Training has been completed in most several technical areas of the comprehensive replication package (e.g. family planning/reproductive health/HIV/AIDS prevention, Family Centered Maternity Care/ PMTCT, breastfeeding/Baby-Friendly Initiative/HIV/AIDS prevention; newborn care and breastfeeding/PMTCT; neonatal resuscitation; infection/ HIV control in maternities; antenatal/PMTCT; youth friendly services/HIV prevention) in the fourteen Project regions.
- MCHI has expanded their cadre of trainers to meet MCHI’s expanded training needs.
- Follow-up visits to regions began in December 2004. Follow-up visits demonstrated that most pilot facilities have plans on project implementation and training courses and that working groups have been meeting on a regular basis. In maternities, most delivery rooms

“I was very nervous when I went to Perm (for FCMC training) ...it is very hard to change rules and practices. The Perm trainers were excellent, and I got a lot of support from the City Health Department to implement the changes. I now go to every MCHI training and meeting that I can, and would like to see the Regional maternity and others included in MCHI...we need to increase the spread of this kind of service!” Chief Ob-Gyn, Vologda

were reconstructed into individual delivery rooms that are well-decorated and women/family friendly. The number of delivery with partners increased. The percent of women receiving spazmolitics decreased, and WHO partogram is used by staff. Nevertheless, some old practices of delivery and neonatal care still remain in some facilities. While Orenburg facilities have made a tremendous move ahead in changing practices, Kaluga sites have improved slowly and have requested more assistance from the project.

- Monitoring data from the sites has demonstrated:
 - Increased family support during labor & delivery at maternity hospitals from 0 to 35%
 - Increased exclusive breastfeeding up to 6 months from 17% to 47%
 - Increased individual delivery room instead of common delivery halls from 0% to 100% in most maternity hospitals
 - Overall use of evidence-based practices increased from 0 to 60%, and ineffective or harmful practices decreased from 82% to 22%
- The mid-term evaluation team found during visits to three regions that support and enthusiasm at multiple levels for the changes and innovations introduced by MCHI were broad, deep, and infectious. The regions visited were forward-thinking and vibrant and each had contributed substantially (financially and in-kind) to support the MCHI interventions. At all levels, the public authorities and the health providers expressed pride in what they had accomplished; they felt they had chosen their implementing sites well and saw MCHI as showcasing new approaches and appropriate technologies. Family planning and breastfeeding were not new concepts, but many aspects of FCMC and PMTCT were truly revolutionary. Many acknowledged that the pace of implementation has been very brisk, but they seemed to thrive on it.
- More than the physical changes in their facilities and more than their deepened knowledge of evidence-based practices, many in the regions stressed the changes in their ways of thinking—their “mentality”—as the most powerful outcome of being involved with the MCHI Project. The process and content of MCHI seems to have been exceptionally timely for Russia. Many saw the Project as fostering a renewed support and respect for the Russian family, values that they felt had suffered in recent times but that were core to the Russian spirit. Many also spoke of the Project as a “transformation,” having completely changed the way they related to their patients and clients, as well as the way health professionals related to each other. They spoke of being less “authoritative” and more “humane.” They spoke of a strong sense of partnership. The RCs and RCT members also spoke of a camaraderie that had started at the Perm Launch Conference and that only grew stronger with each opportunity to interact with other regions and learn of their experiences.
- New mothers reported being very happy, especially those who had a previous delivery experience for comparison. Rooming-in was essentially universal. Midwives, especially, described feeling empowered and finding new purpose in their work.
- The federally-mandated obligatory free health services include basic childbirth services, but not all the “extras.” Some FCMC interventions (private delivery room, partnership delivery, rooming-in) were already available to some degree in many of the regions but were only available to a few and at an extra cost; the impact of MCHI has been to make these services much more the standard and to make them more universally available to all families. One facility reported earning 2 million rubles from such extra services the year before, funds which was used to make further renovations and buy additional equipment.

Before MCHI, our maternity houses were like prisons. Women feared being there.” Vologda maternity house Ob-Gyn

- PMTCT was not included in the original Contract, but from the start of the Project, MCHI and USAID/Russia agreed that HIV/AIDS and PMTCT should be integrated into MCHI activities. In the new contract modification, this focus has been formalized.
- Monitoring and evaluation training, including the methodology for conducting facility-based surveys, was conducted in 2 Far East regions and the 4 new regions.
- There is still a need to bring federal precazy (regulation) into line with the new practices. Many non-Project sites are eager to adopt Project approaches but are concerned about being in violation of federal mandates without the “protection” of being a designated-MCHI facility.
- The regional/municipal/facility-level contributions (financially and in-kind) are far in excess of what was initially expected.

C. *Youth*

The Result: A comprehensive reproductive health program for youth developed and implemented in at least two MCHI regions

- MCHI created an Inter-regional Working Group on Youth Reproductive Health (WGY) in early in 2005.
- WGY members visited Barnaul in May 2005 to get familiar with Barnaul Municipality experience in youth programs
- A consultant will assist the TWG to develop a Reproductive Health Replication Package for youth later in 2005.
- Data on current youth activities are being collected from three regions; these regions will become pilot sites for the introduction of the Youth Package.

D. *Male Involvement*

The Result: Access to reproductive health services and information for men increased in the targeted regions

- MCHI has developed appropriate strategies and interventions to increase male participation in family planning counseling and other reproductive health services. These include interventions in training, communications, monitoring, and follow-up visits that support male involvement.
- Considerable attention has been given to increasing active male participation and support at multiple junctures. Male participation, including that of youth, has increased at MCHI sites in FCMC, breastfeeding support, family planning, post-abortion care, and counseling. Gender integration is more than adequate.
- In collaboration with the Healthy Russia 2020 Project, a “Couples Campaign” was designed to promote creating habits of responsible behavior for improvement of reproductive health of men and women in regions of Russia.
- Delays of at least six months in the multi-media campaign addressing male involvement are beyond the reasonable control of MCHI as the technical design of the actions is the primary responsibility of a partner organization. This may or may not have an impact on MCHI’s final results regarding men’s increased access to both reproductive health services and information as the delay has decreased the time of impact between the campaign and the final MCHI surveys that will measure male participation in three types of services.

- The campaign has progressed, with the media spots and , print materials have been developed, tested, finalized, and sent to be printed,.
- Adult male and youth have benefited from improved physical and emotional access to reproductive health care. FCMC, with its emphasis on partnership deliveries and the active involvement of partners during labor, has led to very positive experiences being reported by men, female partners and the providers.

Antenatal care centers in maternity hospitals and women's consultation clinics, breastfeeding support rooms in pediatric polyclinics, post-partum and post-abortion care service areas, and youth consultation rooms are all reporting increased numbers of men accompanying their female partners for both services and counseling. Providers report low to no attendance in prenatal classes. Men still feel uncomfortable attending Mother's School (the traditionally named rooms for prenatal classes) in many places. No wonder!

E. Medical School Involvement

The Result: Introduction of newly developed protocols and internationally recognized standards into basic medical school educational materials initiated

- The introduction of internationally-recognized, evidence-based standards for selected maternal child health interventions into the pre-service and post-graduate curricula of training institutions for physicians, nurses and midwives has been initiated in at least 11 of the 14 MCHI regions, plus a major state medical academy in Moscow.
- In March 2005, MCHI conducted a six-day orientation workshop designed explicitly for medical university and academy representatives. Each representative developed a strategy and plan for further integrating the Project's approaches and materials into pre-service and post-graduate curricula.

F. Family Planning Services

The Results: 1) Use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions; 2) Family planning services with a special focus on post-partum and post-abortion clients strengthened in all MCHI regions; 3) Family planning capacity strengthened in the regions and at the national level; 4) Integration of family planning into primary healthcare services piloted in selected rural areas in at least two regions with high abortion rates; 5) Family planning integrated into counseling services for HIV-positive women; 6) Family planning and prevention of mother-to-child-transmission of HIV (PMTCT) capacity strengthened at HIV centers.

- Cadre of family planning trainers expanded
- Leveraged assistance from a local pharmaceutical company (conference and training support, distribution of print materials, shared data, etc).
- The federally-mandated free package of obligatory services includes maternity care and abortions but not family planning services. Some regions do cover family planning services out of their own funds, including the provision of free contraceptives to high-risk groups. Method mix is very limited (oral contraceptives, IUDs, condoms and emergency contraception). Age and parity restrictions limit access to female sterilization. Provider barriers are extreme. The quality of counseling reflects many of these problems. Only ob-gyns can provide contraceptive methods; other physicians and other health care providers can only counsel.

- Despite family planning training of providers since the onset of the project and evidence of increased family planning counseling, progress results has not been very evident disappointing to date. As mentioned above, the barriers and challenges are great.
- Early in year three, a local and an international consultant will assist MCHI to develop a family planning strategy to improve integration of family planning into the broader MCH interventions and trainings, and to develop a rural family planning model for implementation in two regions. A family planning coordinator will be hired to oversee family planning activities for the Project.

G. Hepatitis B Vaccinations in Russian Far East

The Result: Hepatitis B vaccination program for adolescents implemented in partnership with Vishnevskaya-Rostropovich Foundation (VRF) in the Far East.

- A subcontract between JSI and VRF was signed in November 2004, extending VRF's existing hepatitis B vaccination program to Primorsky Krai where the MCHI Project already worked.
- Vaccines and cold chain equipment have been procured.
- Health workers within the existing school system have been trained.
- Immunization activities began in March 2005 and will involve three cohorts. The federal government launched coverage of hepatitis B immunizations for all 13-year-olds nationwide. Consequently, VRF added 11th-graders as its new cohort.
- Parents and school children receive leaflets and schools receive posters about the Hepatitis B campaign and its benefits.

H. Integration of ARO Early Intervention Model

The Result: Early Intervention model developed by USAID-funded Assistance to Russian Orphans Program (ARO) integrated in MCHI models.

Note: The Assistance to Russian Orphans' Early Intervention model is designed to foster a positive emotional/ psychological environment during pregnancy and childbirth and to further promote maternal/ child bonding. Although designed specifically to counter abandonment, it is applicable to all pregnancies and births and is very congruent with the MCHI model. Staff feels its holistic, humanistic approach highlights respect for the newborn and emphasizes the need to be "newborn-friendly" as well as "women-friendly." Its approach is viewed as being very supportive to families with babies having disabilities.

- Beginning with the FCMC training in Irkutsk, the EII model was incorporated into the FCMC schedule of trainings. ARO's Early Intervention model is being integrated into multiple MCHI training materials and is considered to be a substantive, positive addition that has especially strengthened the counseling component of these courses.
- In March 2005, the revised antenatal care curriculum (revision included incorporating EII materials) was field-tested.
- New materials from ARO on bonding have been prepared as handouts for upcoming training courses.

I. Development of Collaborative PMTCT-plus Model; Abortion Rates and Contraceptive Prevalence Rates

The Results: A collaborative model on PMTCT developed and implemented together with ARO in one of the pilot regions, for example in Irkutsk. The abortion rate reduced in the targeted regions; and use of modern contraceptives as a mean to prevent unwanted pregnancies increased in the targeted regions.

- Irkutsk collaboration is in progress.
- MCHI's respected status among many Institutes and individuals in the medical community has helped ARO gain access to the medical sphere, thereby enabling critical links between the medical and social services to begin in some areas. This synergistic model for PMTCT-plus has the potential to revolutionize care for HIV-affected families.

J. PMTCT and Other Additional Project Activities

a. PMTCT

Increasingly, as WIN was ending and MCHI was beginning, Russia's attention and the attention of USAID/Russia turned to Russia's worsening HIV/ AIDS situation. Although PMTCT was not included in the original Contract (except for being mentioned in an appendix describing UNICEF's work in Russia) from the very start of the MCHI Project, MCHI and USAID/Russia agreed that HIV/AIDS and PMTCT would receive major attention within the MCHI project. .

Training Materials/Evidence-Based Practices

The first step was to begin integrating HIV/ AIDS and PMTCT information into the MCHI training materials. MCHI immediately began collecting relevant materials dealing with current Russian statistics, risk assessment approaches, counseling and treatment issues, infection control standards, PMTCT guidelines, etc., for review, adaptation, and incorporation. Handouts for MCHI consultants and trainers were developed.

Consequently, the December 2003 MCHI Three-Year Workplan gives considerable attention to HIV/ AIDS prevention generally and PMTCT specifically. At the February 2004 MCHI Launch Conference, PMTCT was included as one of the core integrated MCHI internationally-recognized evidence-based practices. At the same time, PMTCT was added to the existing breastfeeding curriculum. In March 2004, MCHI staff participated in USAID/ Russia's two-day workshop on the mission's new HIV/ AIDS strategy. As agreed to with "Healthy Russia 2020," new PMTCT materials were collaboratively developed with Healthy Russia 2020, including cue cards, brochures for clients, and leaflets for providers.

MCHI also sought from the beginning to involve itself with the major Russian individuals and institutions dealing with PMTCT, such as the Federal Scientific Center for the Prevention of MTCT/ HIV; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's Department for HIV/ AIDS Control; the Federal Center for HIV+ Pregnant Women and Children, the Federal Pediatric AIDS Clinic; and the Future without AIDS Foundation.

Russia currently does not have a confidential voluntary counseling and testing (VCT) system. Widespread involuntary testing occurs including of pregnant women. Reportedly, a federal precar

mandates HIV testing of all pregnant women at various stages of pregnancy. Children born to HIV+ mothers are registered and tested at regular intervals until the age of 18 months, at which time they are removed from the registry if all tests are negative. Unfortunately, these children are generally institutionalized during most if not all of this time. Another donor is reportedly supporting efforts to reduce the length of time these children are surveyed before being removed from the registry if they continue to test negative.

In the visited regions, it appeared that MCHI is helping to create the needed linkages between the HIV/ AIDS Centers and the maternity houses/ women's consultation clinics/ pediatric polyclinics that will enable them to work together more efficiently to provide care to HIV+ pregnant women and their infants. When MCHI asked regional health leaders about major problems regarding PMTCT implementation during the September 2004 training in Irkutsk, one of the issues raised was that typically the HIV/AIDS Centers were "too far" in terms of service accessibility to many women's consultation clinics and maternity houses.

It was beyond the scope of this assessment to comment on the specific content of the care provided. However, it was certainly the case that nearly everyone recognized PMTCT as a matter of growing concern to Russia generally and to their region specifically and nearly everyone indicated a need for further work in this area.

PMTCT Guidelines

In September 2004, a two-day "PMTCT in MCHI Regions" workshop was held in Irkutsk for all MCHI Regional Coordinators and representatives from their HIV/ AIDS Centers. Other participants included the head of the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare's Department for HIV/ AIDS Control and representatives from USAID/ Russia, AIHA's Ukraine PMTCT Project and the Elizabeth Glazier Foundation. Reportedly, the MCHI regional teams at that meeting indicated a very strong need for clinical/ organizational guidelines to improve the quality of PMTCT services. There was also consensus that the Quality Assurance Project (QAP) website could be used to share experiences and materials.

An MCHI working group on PMTCT guidelines was formed that in November 2004 began collaboration with the MOHSD's Institute for Management and Communication for Health. By February 2005, draft guidelines were ready for wider review.

This first draft of the PMTCT Guidelines was distributed to the MCHI regions by early March and, in mid-March, MCHI hosted a PMTCT Guidelines Workshop in St. Petersburg. Participants again included all MCHI Regional Coordinators and the heads of their HIV/ AIDS Centers; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare; USAID/ Russia; and, in addition to MOHSD's Institute for Management and Communication for Health, the head of MOHSD's Center for Assisting Pregnant Women and Children with HIV and the deputy head of MOHSD's Mother and Child Health Department. Revisions are being made and the finalized PMTCT Guidelines are will soon be delivered to MOHSD. As part of this process, AIHA is translating and adapting the WHO PMTCT curriculum which MCHI will then consider incorporating into the PMTCT guidelines. The intent is to post the guidelines and curriculum on the MCHI website (see Section VII: Documentation and Dissemination).

PMTCT Coordination

As HIV/AIDS generally and PMTCT specifically have developed as areas of major concern and increasing activity, the need to collaborative and coordinate has also grown. To meet this need, the MOHSD had created a Coordinating Council on PMTCT whose membership includes representatives from institutions like the Joint United Nations Programme on HIV/ AIDS (UNAIDS), UNFPA, WHO, and USAID as well as representatives from some of the USAID-funded health projects, including MCHI.

In late 2004, MCHI did a small survey of the maternity care received by HIV+ women in Perm City Hospital #21. When the results were analyzed and presented to the MOHSD Coordinating Council, the consensus was that there was a great need for more information regarding PMTCT practices and the family planning services and options available to HIV+ women.

At the same time, USAID/ Russia also recognized the need for greater coordination among the USAID-funded health projects who often worked with the same counterparts in the same sites. In addition to a closer coordination of activities so as to avoid duplication and achieve synergy, there was also the need to ensure the consistency of key messages in materials and training courses. Equally important was the desire that all the USAID-funded groups be able to contribute to policy discussions in a timely way and that activities and achievements be presented to the MOHSD in a coordinated manner. In early 2004, USAID/Russia asked MCHI to take the lead in coordinating the various USAID-funded projects with regard to PMTCT. Thus, as of February 2005, to ensure that the efforts of the various USAID-funded health projects complement and not duplicate each other, MCHI has assumed responsibility for co-coordinating the PMTCT component among the USAID-funded health projects as formally set out and agreed to by both. As part of this co-ordination function, MCHI serves as the key communication channel on PMTCT with the MOHSD.

PMTCT+FP Study

MCHI staff increasingly recognized the need to know more about 1) family planning method use among HIV+ women, and 2) existing PMTCT practices in order to better understand the challenges related to family planning and PMTCT among HIV+ women so as to develop better strategies for improving the quality of family planning and PMTCT services for HIV+ women.

The study design has been developed by MCHI staff together with other Russian experts. The objectives are to collect quantitative information on 1) the awareness of family planning options among HIV+ women who have recently delivered or had an abortion; 2) the use of modern contraceptive methods by HIV+ women; 3) the involvement of HIV+ women's partners in decision making about family planning issues; 4) healthcare workers' counseling of HIV+ women on family planning; 5) HIV testing practices; 6) PMTCT practices antepartum, peri partum and post-partum; and 7) the risk of MTCT. The study will also look at social and demographic factors and the prevalence of STIs and other risk factors. Additionally, the prevalence of stigma and discrimination by healthcare workers of HIV+ women will be determined, as well as the HIV+ women's level of satisfaction with the healthcare provided to them.

Strong safeguards to assure informed consent, privacy and confidentiality have been built into the study design. Nine regions with relatively high HIV prevalence rates and previous experience with quality data collection have been selected as study sites: Altai Krai, Irkutsk Oblast, Khabarovsk Krai,

Krasnoyarsk Krai, Murmansk Oblast, Orenburg Oblast, Perm Oblast, Primorsky Krai and Tyumen Oblast.

As a follow-on to the mid-March PMTCT Guidelines Workshop in St. Petersburg, the resulting protocol was reviewed and discussed by a wide range of individuals and institutions: MOHSD and MOHSD's Center for Assisting Pregnant Women and Children with HIV; the Federal Service for Surveillance in Consumer Rights Protection and Human Welfare; USAID/ Russia and the MCHI regions' Mother and Child Health Departments and HIV/ AIDS Centers. It has also been reviewed by two of JSI's core competency centers – the JSI/WEI Center for HIV/AIDS and the JSI/ Center for Health Information, Monitoring and Evaluation (CHIME).

During this assessment, the final draft protocol was submitted to USAID/Russia for approval, after which teams from the regions involved in the study will receive refresher training in data collection. The study is in process now.

Finding: MCHI's strong technical and managerial capabilities provided the flexibility needed to allow MCHI to smoothly incorporate a major new component, PMTCT, into their program and thus be responsive to evolving external needs.

Finding: The planned PMTCT+FP Study should be expected to provide valuable data for decision making to inform the development of strong future policy and service standards.

Conclusion: Although not included in the original MCHI Contract, in response to external realities and the needs of USAID/ Russia, MCHI has become a major leader in Russia for PMTCT policy development and service standards of care

Conclusion: The MCHI project design provides an excellent mechanism for humanizing, "horizontalizing" and integrating the care of HIV+ women and their infants into the health care system, a need that will grow exponentially as Russia's HIV/ AIDS epidemic progresses.

Recommendation: Given MCHI's considerable investment of time and resources in PMTCT activities, the need for a contract amendment to include this important area of involvement should be discussed with USAID. PMTCT activities are in workplans that are approved by USAID and are referenced in the "Background" section of Contract Amendment #3 but, just as the regions would feel more comfortable with a federal pre-approval on FCMC, so would JSI be more comfortable with a contract amendment.

K. Documentation and Dissemination

The Result: Overall project results documented and disseminated in the pilot regions and nationwide

- The replication focus of the MCHI project design implies a large amount of dissemination of ideas and materials throughout the MCHI regions and beyond.
- MCHI has worked with the mass media for wide coverage of selected events.
- MCHI staff and health authorities in the 14 regions have used media, the Internet, conferences, and other available outlets to share Project information and preliminary results. The number of known Internet articles used to disseminate information about MCHI is already over 300.
- An MCHI website has been developed and will be launched early in year three.

- The JSI regional session, “Implementing Modern Maternal Child Health and Reproductive Health Practices in Eastern Europe and the Newly Independent States,” was part of the opening day of RSOG’s 2004 Annual Meeting in October 2004. RSOG and participants were extremely interested in the exhibited materials from MCHI.
- A comprehensive Documentation and Dissemination plan was developed in January 2005.
- Another important channel of dissemination for MCHI models and results is the use of formal and informal advocacy networks. Advocacy networks exist in all 14 MCHI regions, a few created by the USAID-supported Policy Project, some created independently and spontaneously, and others growing out of the MCHI-supported activities. The advocacy networks in MCHI regions try to disseminate MCHI methods and findings throughout the staff of Health Departments and sometimes Social Affairs Departments, as well as through various committees or councils related to women and children’s health. Several regional MCHI advocacy networks work especially well with the press, including influencing journalists and public relations staff at the regional level.
- Influencing the Russian professional medical community has been a great challenge, even in the context of a strategy of evidence-based international standards. Much work remains to be done for new MCH practices to be disseminated and accepted throughout Russia, and for federal standards to reflect evidence-based best practices.

L. Monitoring and Evaluation

The Result: New activities included and monitored in the overall monitoring and evaluation plan

In early March 2004, several weeks after the Launch Conference, the RCT members responsible for conducting the baseline facility surveys in their respective regions attended a two-day Monitoring and Evaluation Workshop in Moscow. The Workshop further introduced the Project’s monitoring and evaluation system and trained participants in facility-based survey techniques and data entry using SSPS software. Prior to the Workshop, the survey questionnaires had been finalized and field tested by Project experts and staff. Shortly thereafter, baseline data collection for the facility-based surveys started in all new regions and was completed in May. The collection of official medical statistical data at the facility, municipal, and oblast levels was also begun.

- Two new regions received monitoring and evaluation training, including the methodology for conducting their facility-based surveys. The MCHI database now includes questionnaire results from 4545 antenatal women, 4585 post-partum women, 3491 abortion clients, and 4888 clients at women’s consultation clinics.
- A special monitoring form was developed for follow-up supervision visits, to be done twice yearly to monitor progress, provide technical assistance, address implementation issues, and adjust Project activities if necessary.
- Experience to date is that the Project may be collecting more quantitative data on these visits than is necessary or useful or can be effectively analyzed and used in a timely manner. The follow-up team will conduct further analysis of monitoring and evaluation needs and achievements.
- All 16 regions will receive endline surveys. At this point in the Project, MCHI’s expectation is that each region will definitely show positive changes. However, it is not realistic to expect changes of the magnitude seen under WIN, as the MCHI regions are much more independent and the Project oversight and supervision much less intense than that under WIN.

Regional visits: Anecdotally, facilities reported changes noted already: close to 100% rooming-in, up from 70-80% at one Tyumen maternity; also 30% of deliveries with family support in first month after FCMC training, up from 6% month before training.

Finding: The strong monitoring and evaluation system developed by WIN is also, with minor modifications, serving MCHI well.

Finding: The new regions and activities added by Modification #2 have been fully incorporated in the MCHI monitoring and evaluation plan.

Recommendation: MCHI should review the amount of data collection involved in the supervision visits with an eye to defining what is really useful and what might be set aside.

III. Influencing Eastern Europe: MCHI and USAID-funded Projects outside of Russia

The MCHI Project has been a leader in the region through both hosting and participating in a variety of regional conferences and meetings, as well as sharing of materials and experiences. The project design, implementation lessons learned, and successes of first WIN and now MCHI has greatly influenced the design and implementation of several USAID-funded projects outside of Russia, especially in the EE/AA region. The Ukraine Maternal and Infant Health Project was designed in large part based on the WIN model, and nearly all the expert trainers used by the Ukraine project were trained by the WIN/MCHI expert trainers. The Healthy Women Georgia Project also incorporates many WIN/MCHI approaches in its design and key technical staff have visited MCHI for more in-depth technical assistance regarding curricula and training approaches.

QUARTERLY PERFORMANCE REPORT

TASC Task Order: Logistics Technical Assistance/South Africa

Quarter 1, 2005 (including April 2005)

Contractor: John Snow, Inc.

Contract Number: OUT-HRN-I-806-98-00032-00

Reporting Period: January 1 through April 30, 2005

Person Completing Report: John Wilson

Narrative

1. Background

The objective of this Task Order is to provide long and short-term technical assistance to the South African National Department of Health (NDOH) and NGOs to establish an effective and efficient procurement, distribution and monitoring system for male and female condoms. The central feature throughout this activity is to build the capacity at national and provincial levels, within the DOH, to design, maintain, and utilize an effective logistics system. The expanded scope of the Task Order included HIV related commodities.

2. Expected Results

The Task Order lists 13 key results and anticipates additional results:

- Situation Analysis completed
- Five year forecast completed for condom procurement
- Field Site sampling completed
- Review of tracking system
- Training needs identified
- Training plan developed, implemented and continually updated
- Condom logistics management system developed
- Monitoring and Evaluation Program developed and implemented
- Quality assurance measures developed
- Staff trained in quality assurance
- Policy awareness campaign developed and implemented
- Logistics Managers, service providers, provincial/national directors and health facility managers trained on condom logistics
- LMIS system reviewed and revised

3. Current Activities

The two key Activity Areas for this reporting period were the continued dramatic increase in public sector condom distribution following the launch of choice™ and the “live” field testing of the biometrics/smart card information system for ART in a static and community outreach palliative care setting.

❖ **Condom Distribution/Logistics Management Information Systems (LMIS) Training**

A total of 131,840,000 male condoms and 144,000 female condoms were delivered in the reporting period to the primary distribution sites that the NDOH is responsible for. This dramatic volume represented over 30 million male condoms per day or over 1 million condoms per day – a result of the substantial impact of the branded and packaging redesign of the choice™ condom. It is becoming evident that the branding and repackaging exercise has dispelled the lingering public perceptions regarding poor quality government condoms that hampered the program substantially prior to JSI’s technical assistance began in 2000 to put a quality assurance program in place and eradicate shortages and stock outs. The branding and redesign of the packaging is considered a value added activity, initiated by JSI, that has had a major impact in elevating this program’s effectiveness to the highest level.

This period marked a milestone for the project as *male condom distribution surpassed the 1 billion mark* in this final reporting period – an impressive statistic for the final reporting period of a five-year contract.

A total of 138 participants were trained in logistics and LMIS:

- 32 participants at the Gauteng Region 9 workshop, 2nd February
- 32 participants at the Gauteng Region 9 workshop, 5th April
- 74 participants, Western Cape Province (four regions), Cape Town, 7-11 March

❖ **The STAT™ Biometrics and Smart Card System for ART**

Significant progress in the development of the biometrics and smart card system for ART was made during this reporting period.

Until this point the JSI/Net1 partnership to develop the biometrics and smart card application for ART was informal, a collaborative effort built through two companies having a similar goal of developing an innovative IT solution to assist in the roll out of ART services in South Africa.

In this collaborative effort, Net1’s role was to develop the front end database, provide the technology to operate the system off line, and enable the data transmission from participating ART sites on a 24 hour update basis, and make the data available to a central reporting database. JSI’s role was to provide the public health environment and clinical settings to ensure the system was responsive to clinician and patient needs as well donor and government reporting requirements, and develop the central reporting database to where NET1 would transmit the data.

Before the system could go “live” – that is begin transmission of data from sites to the reporting database, NET1 and JSI signed a licensing agreement (January 12) that specified these respective roles and responsibilities and ensured the protection of NET1’s intellectual property rights relating to their Universal Electronic Payment System (UEPS), the patented technology that the new system would adapt for ART. The licensing agreement also included equipment and data transmission pricing for the sites in which JSI might eventually implement the system. There was, however, no expectation in terms of the number of sites or the timing of any future implementation as these parameters were unclear and could not be determined at that stage nor could future funding be guaranteed.

During the reporting period JSI/South Africa developed the name STAT for the biometrics/smart card system (Secure Technology Advancing Treatment). This name was deliberately chosen not to be associated with HIV/AIDS as it is envisaged that STAT will become a standard patient retained medical record in the long term and not be limited to HIV/AIDS alone. The acronym STAT refers to the overall system and the JSI reporting database.

The first “live” transmission of data occurred successfully on April 8th at the CRS/SACBC site at St. Joseph’s Care Centre, Sizanani, in Bronkhorstpruit and at the Palliative Care Project in SOWETO. The data were successfully decrypted onto the JSI reporting database and standardized reports were generated. By the end of April a total 52 ART patients were enrolled on the system and included in the reports.

❖ **Transition of TASC Contract to DELIVER Contract**

As the TASC contract closed out during this period and the USAID Mission in South Africa and NDOH were keen to ensure that logistics technical support continued, the Mission decided to continue funding the activity through the ongoing DELIVER contract. Thus this period involved both TASC and DELIVER funding.

The LTA received a DELIVER orientation at JSI headquarters in Arlington from January 15 to 25.

To assist in the TASC close out, and facilitate a smooth transition to DELIVER, Afua Ofuso-Barka from the JSI Boston office was in country from 28 February to March 18.

❖ **LTA/JSI Staff Participation in National HIV/AIDS & STI Meetings/Conferences**

- The LTA and LMIS Officer supported Northern Cape counterparts for STI week and the national even on February 12 in Uppington, Northern Cape
- STI Quarterly Meeting in Kimberly, Northern Cape, February 22-24
- The LTA and STAT Project Manager attended a workshop on HIV/AIDS Management organized by the Foundation for Professional Development and Discovery Health, February 15-17

- Malswitch Team from Malawi to JSI/South Africa to learn about the JSI STAT system and explore the feasibility of introducing STAT in Ministry of Health sites in Malawi. The Malswitch team is based in the Reserve Bank of Malawi and the team utilizes a NET1 switching device installed in country to process and track banking transactions
- NDOH Bosberaad for Annual Operational Planning, Pretoria, March 10-11
- Free State University hosted the provincial HIV/AIDS ART programme, inviting JSI to share experiences in the roll out and demonstrate ongoing efforts including STAT, Bloomfontein, March 30-31

4. Performance

All activities are on target at the end of this reporting period.

**JSI/TASC UKRAINE
MATERNAL AND INFANT HEALTH PROJECT
ANNUAL & QUARTERLY TECHNICAL REPORT
USAID CONTRACT NO.: HRN-I-00-98-00032-00,
GSH-I-801-03-00026**

**THIRD YEAR ANNUAL AND FOURTH QUARTER OF YEAR III TECHNICAL REPORTS OF MIHP
1 JULY - 30 SEPTEMBER 2005
SUBMITTED 31 OCTOBER 2005**



Overview of MIHP YEAR III Annual Activities

MIHP Third Year – Annual Activities Overview

10. Summary

In Year III, MIHP focused on new TASC I and TASC II activities and improved MIHP sites through continuous training, follow-up, BCC, and M&E interventions. Due to the overall MIHP activities, Zhitomir Maternity became a center of excellence where effective perinatal technologies have been implemented. For TASC II, several new sites joined the project: 22 women's clinics in Donetsk, Donetsk maternity N 6, Zhotomir maternity and Kiev - oblast maternity N 1. By request of the Ministry of Health additional sites (Kirovodrad and Komsomolsk-city maternities) also joined MIHP. The TASC II PMTCT component was implemented in three MIHP regions: Donetsk, Simferopol and Kiev. The major success of MIHP this year was that Dr. Mykola Polischuk, the Minister of Health of Ukraine organized an extended MOH meeting in Volyn oblast on the base of Lutsk Maternity N 3 on 26 August 2005. After visiting the maternity and during a meeting at Volyn State Administration, the Minister thanked USAID for providing the opportunity to implement MIHP and made an appeal for every region of Ukraine to come close to the achievements of Lutsk maternity within 68 months. Please see the Year III activities summary below for details.

11. Clinical and training activities

Year III of MIHP was marked by several training activities for different health care professionals in MIHP sites. There were 9 categories of clinical trainings conducted (MNH, antenatal, Infection control, tutorial, EBM, ToT trainings etc.). In total there were 49 trainings in Year III, which covered 713 MIHP maternities' staff, 51 educators from medical universities, 22 Heads of Oblast Healthcare Departments and 13 specialists were trained to conduct follow-up visits to monitor and evaluate post-training activities. Together with the JSI-WIN Project and International experts, MIHP personnel participated in the development of an antenatal training module and the clinical staff took part in the development of the National Reproductive Health Program for 2006-2010 initiated by Policy Project. At the end of Year II, MIHP had three centers of excellence (Lutsk maternity, Donetsk maternity N 3 and Zhitomir-city maternity). Numerous delegations from other Ukrainian oblasts visited these centers in order to become acquainted with effective perinatal practices for further implementation in their institutions.

12. Protocol development component

Working in close collaboration with the Ministry of Health of Ukraine (MOH) MIHP conducted 4 working groups on protocols' development: OB/GYN, Neonatal, Pediatric and Epidemiological TAGS. In Year III there were 17 TAG meetings which resulted in 11 protocols. Protocols on preeclampsia, pre-term deliveries, abnormality in labor, post-partum hemorrhage were very timely and important protocols to improve birthing outcomes. There were also 2 MOH prikazes (orders) developed by the TAGs: Prikaz # 676 "About Improvement of Clinical Protocols on Obstetric and Gynecological Care" and Prikaz N 152 "About Improvement of Protocol on Healthy Newborn Medical Care". By the request of the MOH, MIHP supported the publication of all the developed protocols and Prikazes for further dissemination among Ukrainian Oblasts. The Main achievement of Year III was that Epidemiological Department of MOH approached MIHP and expressed its desire to revise old Prikaz N 59.

13. BCC component

BCC/IEC activities in the Year III were aimed at the development of informational materials and trainings on breastfeeding and counseling skills. The following IEC materials were developed, pre-

tested and distributed among MIHP sites: (1) Posters on hand washing, HIV/PMTCT, Anti-smoking and Anti-alcohol (during pregnancy); (2) Booklets on Breastfeeding, Baby Health Card, and Postpartum Contraception. There were 4 trainings conducted on IEC counseling skills for 65 health care providers of MIHP sites, one ToT training on Breastfeeding (28 HCP trained), 2 trainings on Postpartum contraception (35 HCP trained). In cooperation with UNICEF, MIHP/BCC specialist and clinical personnel conducted 2 trainings on perinatal technologies and optimum infant feeding for national experts assessing baby-friendly hospitals (60 experts were trained).

14. PMTCT activities

The PMTCT component started in three MIHP sites in October 2004: Simferopol, Donetsk and Kiev. During Year III, MIHP/PMTCT specialists established contact with local AIDS centers, NGOs working in HIV/AIDS area including Network of People living with HIV/AIDS (NPLWH/AIDS). Needs assessments were conducted in the three mentioned oblasts. PMTCT staff took active part in adaptation of a generic PMTCT training module and development and national VCT protocol initiated by the Policy Project. During the last project year one extended training on PMTCT for ob/gyns, antenatal HCP, neonatologists, social workers from 3 MIHP PMTCT oblasts was conducted in Simferopol. MIHP PMTCT Workshop in Donetsk with participation of heads of women outpatient clinics, AIDS Center workers, deputy heads of maternities, social workers and city authorities as well as representatives from other MGOs and Projects made it possible to establish links among different HIV/AIDS-serving organizations. A PMTCT monitoring form was developed and integrated into the existing MIHP/M&E format. Collected M&E/PMTCT data analysis is in *attachment 1* to this report.

15. Equipment procurement

Necessary equipment was purchased and delivered to the MIHP sites according to the schedule in Year III. The TASC I equipment procurement plan is almost finalized with some minor items to be procured to the sites. MIHP has already procured 60% of the planned equipment as to TASK II of MIHP. By the end of 1st Quarter of MIHP/Year IV all the planned equipment will be provided to the Project sites.

16. M&E /Achievements

The M&E department performed routine data collection and processing for data analysis and reporting. The M&E database was reviewed and adapted to the current needs of MIHP activities. EpiInfo data analysis software helped to effectively and more accurately analyze the received data. M&E has incorporated MIHP TASC II activities into existing M&E formats. Also the MIHP cost study impact was one of the priorities this year. Please see the M&E graphs for Year III in *attachment 2*.

17. Cooperation

During Year III MIHP collaborated with UNICEF, POLICY Project, Swiss Cooperation, CURE organization, Ministry of Health and local Health authorities. The biggest achievement was that MIHP by request of UNICEF trained National BFHI specialists and helped to revise criteria of BFHI. CURE organization supported press-tours in Lutsk and Donetsk maternities which resulted in dissemination of Lutsk and Donetsk maternities' achievements in 3 oblasts: Volyn, Rovno and Donetsk.

18. Challenges

Major challenges this year were difficulties in implementation of effective perinatal technologies in Kiev-oblast maternity N 1 and Lviv Oblast Maternity due to unwillingness of city and

local/maternal health management to change their attitudes and practices towards International evidence-based perinatology. According to M&E data as well as follow-up visits there was little to no improvement in delivery and newborn care practices in the mentioned sites.

MIHP Year III Fourth Quarter activities

I. EXECUTIVE SUMMARY

MIHP conducted various activities this quarter. There were 16 successful training seminars, 5 working group meetings on development of national neonatal and obstetrical protocols, and 4 follow-up visits in MIHP sites. This quarter BCC activity was focused on development of survey format to evaluate impact of IEC materials among post-partum women. Also there was one press-tour held in Donetsk maternity # 3. The MIHP Cost Impact Study was almost finalized this quarter. The PMTCT component started its training activities in Simferopol and a PMTCT coordination Meeting was held in Donetsk with participation of different HIV-serving organization. MIHP continued to cooperate with Policy Project and UNICEF this quarter. One of the biggest successes was that the Minister of Ukraine conducted MOH Meeting in Lutsk with tour in Lutsk maternity (*attachment 23*). Equipment was completely procured according to TASC I. Please see these and other activities below for details.

II. PROJECT PROGRAMMATIC ACTIVITIES

A. CAPACITY BUILDING /STANDARDS DEVELOPMENT COMPONENT

1. Technical working group meeting on neonatal protocol development.

The TAG on neonatal protocols development was conducted on June 29 – 30, 2005 at the MIHP office. 16 specialists took part in the meeting. The purpose of the TAG was to revise the following protocols: «Convulsions», «Small baby», «Resuscitation +Newborn Asphyxia + Respiratory Distress at birth», and «Infections». The TAG members outlined the general format of the protocols: they should be shorter and simplified. It was also suggested to review protocols on “asphyxia”, “resuscitation”, “breathing difficulties” in order to make them shorter with focusing only on care at birth. Please see *attachment 4* for details.

2. Ob/Gyn Working Group meeting on national clinical protocols development.

The TAG on National protocols development was held on July 1-2 2005 at the MIHP office. There were 14 specialists present during the TAG. The purpose of the task was to continue updating and revision of the following protocols: «Delivery management in premature water discharge», «Fetal growth retardation», «Fetal hypoxia», «Clinically narrow pelvis ». Please see *attachment 3* for details.

3. OBGYNs TAG group meeting on national clinical protocols development

The TAG was conducted on September 05-06, 2005 at the MIHP office. The purpose of the meeting was to review two clinical protocols: fetal growth retardation, modern approaches to diagnostics and management; diagnostics and treatment of fetal hypoxia with regard to perinatal period. During the meeting evidence-based documents on fetal growth retardation were presented as well as all stages of fetal growth retardation with focus on diagnostics and management tactics. The next OB/GYN TAG meeting was planned for October, 25 – 26, 2005. During that meeting the following protocols will be discussed: perinatal infections and management of premature water discharge.

4. Pediatric Working Group Meeting on clinical protocols development

The TAG was held on September 26-27, 2005 at the MIHP office Dr. Ivan Lejneva, EBM WHO expert was leading the Group.

The main purpose of the Meeting was the development of the structure of Protocol «Well Baby Care». Also the Group discussed materials prepared by the Group members and evaluated them from the EBM viewpoint. The next meeting of the WG will be conducted on December 5 – 6, 2005.

5. WHO TAG Meeting on Revision of Training Materials on Effective Perinatal Care for Eastern European Countries.

The WHO TAG meeting was conducted on 23-26 August 2005 in MIHP office. The Purpose of the Meeting was to revise and adapt existing WHO Perinatal Care Training Module to the needs and reality of CIS countries. 10 International/WHO and local experts participated in the meeting. Please see the WHO TAG program in the *attachment 19* to this report.

B. CLINICAL AND TRAINING COMPONENT

1. Antenatal Care Training

A training on antenatal care was conducted in Simferopol Antenatal clinic on July 11 – 16, 2005. The Goal of the training was implementing in the Antenatal Care modern perinatal technologies based on the evidence and training of Antenatal Care specialists in order to change current antenatal care practices addressing the needs of the women and their families. The training proved to be very successful as all the participants demonstrated obtained skills in practical sessions and were satisfied with new EMB information. For more details please see *attachment 6*.

2. Training of Trainers “Effective Antenatal care”

A ToT on Effective Antenatal care was conducted on July 18 – 19, 2005 in Simferopol City Antenatal Clinic. The purpose of the training was to train a team of facilitators-trainers for further MIHP training activities in antenatal clinics using WHO Euro training package for “Essential Antenatal, Perinatal and Postpartum care”. 15 health care professionals from MIHP pilot sites were trained by local and international trainers. Please see a detailed report in the attachment 4.

3. MNH Training course for University teachers

The training for Medical university educators was held in Lutsk maternity on June 27 – July 2, 2005. The Goal of the training was to train Medical Universities’ teachers (Professors, Associate Professors) on evidence-based technologies in Perinatology in order to include the WHO principles of effective Perinatal care into pre and post services training curriculums. During the training, the participants showed high interest to new knowledge and wiliness to change the current curriculums in their own Universities, to initiate changing of all-Ukrainian curriculum both for medical students and professionals in post-graduate education as well as to disseminate received knowledge among their colleagues. Please see a detailed report in the *attachment 5*.

4. Tutorial Training Courses on Infection Control.

Tutorial trainingsw on infection control took place Kovel-rayon maternity in on July 14 - 15, 2005 , Torez City Hospital on July 28 - 29, 2005 and Lviv Oblast Hospital on September 26 - 27, 2005 . 63 specialists participated in three trainings: ob&gyn’s, midwives, neonatologists, pediatric nurses and anesthesiologist. All participants were from kovel and Torez City Hospital. During the trainings the following topics were raised:

Hand washing as one of the most important anti-epidemiological measures, Gloves in the infection control system, universal precautions, waste management. Trainings included both theoretical and practical sessions. It is important to stress on the great interest of participants in training (especially

epidemiologists from Rayon SES and Hospital bacteriologists) and willingness to implement infection control system in the maternity. Please see a detailed report in the *attachment 7, attachment 8, attachment 9*.

5. Tutorial MNH Training in Zhytomir Oblast Center of Mother and Infant Health Care

A Tutorial MNH training course was held on August 8 – 17, 2005 in Obstetrical department of Zhytomir Oblast Center of Mother and Infant Health Care. The Goal of the training was mastering the modern Evidence-Based approaches in Perinatal Care. Please see the full report for details in *attachment 10*.

6. Trainings of record reviewers

These trainings were designed and conducted for HCP in order to effectively and correctly review clients' records in the maternities for their further process within the Cost Impact Study. The training was held on July 16 – 18, 2005 in Lutsk maternity, Kovel maternity, Donetsk#3 maternity, and Donetsk SSP. Trainings were based on Record Review Form and Instruction jointly prepared by M&E Advisor (Sascha Lamstein), M&E specialist (Alaoui Idriss), and MIHP consultant (Viktor Galayda). For full report please see *attachment 11*.

7. Pediatric training “Health of Newborns and Infants”

The pediatric training was conducted on July 18-23, 2005 in Pediatric Policlinic of Donetsk Hospital # 3. The goal of the training was implementing modern EBM principles of Newborn and Young Infants care; implementing the integrated approach in children diseases management; and counseling skills. Training participants mastered the main principles of integrated IMCI approach in the assessment of sick children status and the basic principles of counseling, they actively participated in practical sessions and role plays. Please see full report in *attachment 12*.

8. Training course Perinatal prevention of MTCT.

Training on perinatal prevention of PMTCT was conducted in Simferopol maternity N 2 on July 25 – July 29, 2005. The purpose of the training was to train Ob/Gyns from Maternities and ANCs and Neonatologists on evidence-based technologies in Perinatal prevention of MTCT and to update and develop their practical skills in the sphere of perinatal prevention of MTCT. As a result of the training the participants received up-to-date information of effective treatment, care and support of HIV-positive women. A model of interaction among various organizations was established. Please see the full report for details in *attachment 13*.

9. Training seminars “Quality improvement (QI) of neonatal resuscitation”

Trainings on QI of neonatal resuscitation were conducted in Lutsk-city maternity (July 14, 2005), Kovel-city maternity (July 13, 2005), Donetsk-Oblast Maternity (September 13, 2005), Donetsk maternity N 3 (September 14, 2005) and Torez Maternity (September 15, 2005). In total 131 health-care providers were trained. The Purpose of the training was to raise knowledge and improve practical skills of health care providers on quality Improvement of neonatal resuscitation and to create QI assessment mechanism in the maternities. Please see the full report in *attachments 14, 15, 16, 17, 18*.

10. Post-partum contraception training in Lutsk Maternity

Post-partum contraception training in Lutsk Maternity was conducted on 27 – 28 July 2005. The purpose of the training was to raise knowledge and practical skills of ob/gyn and midwives of the maternity on modern postpartum contraception (PPC) methods. 230 health care providers participated in the training. Participants of the trainings received up-to-date information on modern

PPC methods and acquired counseling skills. Practical sessions among postpartum women made the participants confident in routinely counseling women on PPC upon discharge from the maternity. Further internal trainings among other ob/gyns and midwives in the maternity have been scheduled.

11. MNH Tutorial Training courses in Novovolynsk and Komsomolsk maternities

MNH tutorial training courses in Novovolynsk and Komsomolsk maternities were held on 26-30 September 2005. The purpose of the courses was improvement of obstetric & neonatal theoretical and practical skills among health care providers in the maternities. All personnel of the mentioned maternities were trained during the course. The training included: hand-to-hand work in delivery rooms and post-partum women as well as in NICU. As a result of the training all maternities' personnel improved their practical skills through their hand-by-hand work with experienced trainers and learnt how to use EBM in their routine work.

C. INCREASE PUBLIC AWARENESS OF HEALTHY LIFESTYLES COMPONENT

1. Development of IEC Materials:

This quarter the brochure on HIV pre - and post-test counseling was finalized and revised by the MIHP staff. Further pre-testing of the brochure among target population will be conducted next quarter.

2. Press-tour in Donetsk maternity N 3

A Press-tour in Donetsk maternity N 3 was organized and conducted by CURE Center of Reform and MIHP on 28 September 2005. The Purpose of the press-tour was to communicate main effective perinatal practices to general public of Donetsk oblast through mass-media. There were seven journalists representing different mass-media of Donetsk region. After the press-conference the journalists visited the maternity departments and took interviews and pictures of mothers and their relatives. The journalists were impressed by friendly, family-like atmosphere in the maternity. They assured the maternity staff that they will write articles about their visit and will send the newspapers with the articles to MIHP and the maternity staff.

3. MIHP/IEC materials impact on postpartum women/Survey

A questionnaire for survey on impact of IEC materials on postpartum women was developed this quarter and the data collection was initiated. The purpose of the survey is to evaluate the effectiveness of MIHP IEC materials and their impact on women in the maternities. It is planned to conduct up to 500 interviews in order to collect valid data for the survey.

D. PMTCT COMPONENT

MIHP PMTCT staff finalized the PMTCT training module and pre-tested it during PMTCT training in Simferopol this quarter (please see section Training and Clinical component above for details). Also a PMTCT Coordination Workshop was conducted in Donetsk on 6-7 September 2005. The purpose of the Workshop was to identify barriers and establish effective linkages among various HIV-serving organizations. During these meetings the main focus was made on future training activities among social workers who work with HIV+ people in MIHP oblasts.

III. MONITORING & EVALUATION (M&E)

M&E activities this quarter were focused on the following aspects: M&E database revision (combining quarterly data); data collection and processing for the period of July 2005 – September 2005 (monthly-based data) were conducted as usual as well as M&E Data analysis and Interpretation (including pMTCT monitoring forms); monthly briefing of MIHP staff and local coordinators on project progress; the Cost Impact Study was almost finalized this quarter. The final Cost Study Report will be submitted to USAID in a separate document upon its final revision. Also there were 4 follow-up visits this quarter in Zhitomir maternity (August 1-2, 2005), Novovolynsk-rayon maternity (Sept. 12, 2005), Donetsk Maternity # 6 (12 September, 2005) and Komsomolsk maternity (14 Sept. 2005). Please see *attachments 20, 21, 22* for details.

IV. EQUIPMENT SUPPLY TO MIHP SITES

The equipment procurement for the MIHP sites this year is being done almost according to schedule. Still some minor equipment still remains to be purchased for TASC I MIHP. TASC II MIHP equipment is being procured according to the schedule.

V. SUCCESS STORY

Sahki-rayon maternity is one of the best second-level maternities of MIHP. MIHP received many appraisals from women and their families who delivered in the mentioned site. Especially, MIHP was touched by a letter from Maria Yarmakova who said: “For the first time in my life, since 15 years of marriage I’ve seen my husband with different eyes when he helped me during labor and delivery of our son. I realized how tender and reliable he is. Before the delivery we had squabbles all the time and the reasons were that he always complained about the fact that pregnancy and delivery is completely women’s business. Thanks to Dr. Ludmila Belobaba our obstetrician who insisted that Nikolai (my husband) visited birth-preparation classes. It was not an easy task but when Nikolay saw other men at the classes his resistance vanished. During the labor and delivery my husband was always holding my hand and massaging my back the part of my body which ached the most especially during 2 second period of delivery. Dr. Ludmila was so kind encouraging Nikolay to talk to me and helped choosing comfortable delivery position. I myself realized that I never experienced such an emotional bond with anyone in my life as with my husband. I delivered our son on the chair with my husband holding me from behind. When I turned around to see his face – he was crying and said “It seems as if I felt all your pain myself as if I was pregnant and delivered the baby together with you”. I’m so grateful to the maternity and the personnel for their support and kind attitude to me and my husband. That delivery made us rethink our feelings and we’re sure that our next baby will be a girl and we’ll call her Ludmila.” – This success story was placed on USAID website.

VI. STAFFING

At the end of this quarter, Zhanna Baskakova was hired by JSI/MIHP in the position of Operations Manager.

VII. COOPERATION

MIHP Clinical personnel participated in Policy Project Working Group Meeting on development of the draft of National Program «Reproductive Health of Nation – 2006-2015» on September 9-10, 2005 at Hotel «Prolisok» , Kiev. The Goal of the meeting was the development of National Program –

«Reproductive Health of Nation 2006 - 2015» and development of monitoring and evaluation tools for Program implementation.

VIII. LOCAL COORDINATORS MEETING

The quarterly meeting of Local Coordinators (LC) was held on July 20-21 2005 in Kiev. There were 23 representatives on all MIHP sites, among them: MIHP local coordinators, head doctors of maternities and head neonatologists. The purpose of the LC Meeting was to identify and overcome barriers of MIHP implementation and share successes and achievements. LC and head doctors of the MIHP sites identified barriers and gaps in project implementation. Among barriers the following were identified as important ones: women are rarely informed about the medical procedures or examinations the health care providers perform on them. IEC materials are distributed among clients without counseling, reduction of personnel in some of the maternities due to the fact that women are discharged from the maternities on the 3rd day after delivery (vs 5-8th day postpartum before the project) – the number of staff is calculated against the number of bed occupancy but not against the number of deliveries. To solve this problem the MIHP sites and the MIHP office will address the MoH with the request to assist in revision Prikaz 33 on health staffing.

IX. CONSTRAINTS

The previous quarter constraints remained this quarter - the timely delivery of the monitoring forms by post from the MIHP sites. Postage services sometimes caused delay in delivering M&E forms for 20 days which made it impossible to process the data on time. MIHP is looking for better ways to deliver M&E forms from the regions.

X. ANTICIPATED PROJECT ACTIVITIES IN THE NEXT QUARTER:

MIHP Ukraine is planning to conduct the following activities for the next quarter: quarterly MIHP Local Coordinators meeting; National dissemination meeting of MIHP results and technologies; preparing a Perinatal Care video; Trainings for antenatal care in MIHP regions region; Training courses on resuscitation of newborns Zhitomir, Kirovograd; pMTCT training course in Donetsk; host and coordinate different Working Groups of pediatricians, neonatologists, obs/gyn and epidemiologists on protocols' development; conduct follow-up visits MIHP sites; finalize equipment procurement to MIHP sites TASC II; conduct Work-planning and budgeting meeting for the year IV of MIHP with regard to MIHP extension (roll-out) activities; Needs assessment visit to Lugansk oblast; BCC activities will be focused on development of behavior change tools to conduct surveys among women on their attitudes toward new birthing practices implemented by MIHP. MIHP will continue its cooperation with MoH and UNICEF on revision of BFHI criteria and trainings on effective perinatal practices.

**Making Medical Injections Safer
John Snow, Inc.:**

**Annual
Performance Monitoring Report
for Activities from
October 1, 2004 – September 30, 2005**

Submitted to USAID on October 21, 2005



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Background

With funds from the President's Emergency Plan for AIDS Relief (PEPFAR), the United States Agency for International Development (USAID) contracted John Snow Inc. (JSI) to implement *Preventing the Medical Transmission of HIV: Reducing Unsafe and Unnecessary Injections in Selected Countries of Africa and the Caribbean* in Ethiopia, Mozambique, Nigeria, and Uganda. The original 11-month USAID project began officially in early March 2004. A no-cost extension was granted from the original end date of January 2005 to March 31, 2005 while the project negotiated for additional funding with USAID.⁵ On March 21, 2005, a contract cost extension was granted that continues the project to September 30, 2009 under the new title: *Immediate Relief to Decrease Unsafe Injections Under the President's Emergency Plan for AIDS Relief: Uganda, Ethiopia, Mozambique and Nigeria*. The project is still commonly known by the abbreviated name: Making Medical Injections Safer (MMIS).

This report summarizes the accomplishments of the MMIS Project in Ethiopia, Nigeria, Uganda, and Mozambique from October 2004–September 2005.

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

Project Management and Partnerships

As of September 30, 2005, the combined USAID and CDC projects have twelve full-time and two part-time JSI staff including a project director, a project manager, a monitoring and evaluation officer, two technical advisors, communications strategist, an administrator, and three project coordinators and half time technical officer and M&E coordinator. Two full-time MMIS global staff are based in South Africa: a senior logistics advisor and the regional financial and administrative coordinator for Africa. In addition, the project and its country programs benefit from technical assistance as needed from subcontractor organizations. These include the Program for Appropriate Technology in Health (PATH) for procurement and waste management and the Academy for Educational Development (AED) and the Manoff Group for behavior change and communications (BCC). Staff from JSI's DELIVER project provides on-demand technical assistance.

In all four USAID countries, MMIS has field offices staffed with a country director, a logistics advisor, waste management advisor, a BCC advisor, and an administrative / finance officer (a few countries have additional part- or full-time administrative support). Each country is backstopped by a technical advisor at headquarters who serves as a Country Team Liaison (CTL) to facilitate the day-to-day management and coordination with the Country Director.

In-country teams provide technical guidance and collaborate with the Ministry of Health (MOH), USAID, CDC, the World Health Organization (WHO), the Safe Injection Global Network (SIGN), and other stakeholders in injection safety. At the international level, MMIS has established a close

⁵ It should be noted that work in injection safety continued but at a reduced pace during the interim period between contracts while the new budget was being negotiated. To support commitments with local partners, some countries scaled back activities (including training) to economize until new funding was awarded.

working relationship with the WHO Africa regional office (WHO/AFRO) and with WHO headquarters in Geneva.

Expansion of MMIS Technical Staff from May – September 2005

In June 2005, Dr. David Pyle was hired as a part-time Technical Officer and will serve as the technical advisor for Uganda and Guyana. Dr. Pyle has over 30 years of international health experience and has traveled to and worked in over 35 countries. His career in international health began in India, and he has worked for JSI for over 16 years. In addition to working closely with Uganda and Guyana as Technical Officer, he provides support to PATH in waste management coordination and works with donors and other key partners to coordinate and leverage MMIS project efforts. Further, Dr. Pyle serves as a resource in monitoring and evaluation.

In July 2005, MMIS hired Ms. Sarah Melendez, as a Communication Strategist for the MMIS project. She has recently served as the Communications Director of the Population, Health, and Nutrition Information Project (PHNI). She has worked with the Communications Consultant to finalize the communication strategy for the project, launch the new project website, and implement the project knowledge management and global advocacy plans. She will be working to coordinate additional training material being developed and evaluating need for new products. Additionally, she will implement a quality assurance process, as well as further standardizing of global products and reporting requirements.

Technical Approach

In the four countries supported by USAID funding, MMIS is implementing the strategy recommended by SIGN, which is elaborated in greater detail in the contract extension task order, and includes the following components:

9. ***Commodity management and procurement*** support for estimating, financing, procuring, and distributing injection equipment and waste disposal containers
10. ***Capacity building and training*** in injection practices, supply management, waste handling, and interpersonal communications
11. ***Behavior change and advocacy*** to reduce demand for injections
12. Standardized system for proper sharps ***waste disposal***
13. Strategies for working with ***private providers***⁶
14. Establish a ***policy environment*** that supports injection safety with guidelines, resources and monitoring of injection practices
15. ***Monitoring and evaluation*** of the content and process of care, identifying quality gaps, and developing and implementing interventions
16. ***Travel*** to venues for sharing lessons learned

At international and national levels in each of the four countries, the MMIS strategic approach consists of mobilizing stakeholders inside and outside the Ministry of Health to ensure that the policy and action plans developed with the contribution of our staff are coherent and sustainable. The JSI team already collaborates with many of these organizations in country, and new partnerships continue to be developed as needed.

⁶ This work is scheduled to begin in Year 1 in Uganda and in Years 2, 3, or 4 in the other countries.

MMIS Participation in the 2004 Safe Injection Global Network (SIGN) Meeting

The annual international meeting of the Safe Injection Global Network (SIGN), a coalition of safe injection experts from around the world, was convened in Cape Town, South Africa from October 20–22, 2004. In the planning stage of this meeting, MMIS coordinated with USAID and other PEPFAR contractors on agenda topics. At the invitation of the Network, MMIS staff from five countries made presentations on their progress to date in implementing interventions to improve the safety of injection practices and to reduce the use of unnecessary injections. Dr. Glenn Post of USAID made a presentation on the overall philosophy, strategic objectives, and funding of the PEPFAR initiative. Dr. Jules Millogo, Project Director, and the MMIS teams and host government counterparts from Kenya, Mozambique, South Africa, Tanzania, and Uganda presented on this project's work. The presentations were well received by and generated much discussion among the meeting participants, as project efforts represent the PEPFAR's groundbreaking work to address the issue of injection safety in the curative sector in Africa. Most MMIS presentations were led by a national counterpart from the Ministry of Health who had been involved in the program in each country.

The successful participation of MMIS in the 2004 SIGN meeting, has led to the projects' planned participation in the November 2005 annual international SIGN meeting in Hanoi, Vietnam. Dr. Jules Millogo, Project Director, Ms. Vanessa Richart, Technical Officer, and the MMIS teams and with host government counterparts from Côte d'Ivoire, Ethiopia, Nigeria, and Rwanda will present an update on the project's work and highlight recent country successes, innovative approaches, and challenges.

Sustainability Workshop

In October 2004, subsequent to the SIGN meeting, the MMIS project staff had a second opportunity to meet as a large technical group at a workshop near Johannesburg, South Africa. The goal of the workshop was to share information and ideas on the project to date and to work together to identify the critical elements of national safe injection sustainability strategies. The workshop objectives included exchanging information on the status of injection safety initiatives; identifying best practices and emerging strategies for overcoming constraints in project implementation; identifying methods for sustaining injection safety; and developing strategic approaches for sustainability plans at the country level in injection device security, health care waste management, logistics and supply management, advocacy, BCC, financial sustainability, and capacity building. Workshop participants included MMIS Country Directors, Logistics and Waste Management Advisors, Behavior Change and Communication Advisors, key technical staff from JSI, PATH, AED and the Manoff Group, the South Africa PEPFAR Coordinator, and representatives from the South African Ministry of Health, CDC/South Africa, WHO/Geneva, WHO/AFRO, and UNICEF/South Africa.

Among the key conclusions of the workshop were progress made since the project's inception in March 2004, best practices, technical aspects of the project, and questions related to funding. A full report from the MMIS Sustainability Workshop has been shared with all partners and is available on request.

MMIS 2005 Annual Meeting

In September 2005, the MMIS project staff held the MMIS Annual Meeting in Dar es Salaam, Tanzania. The annual meeting of the project was an opportunity to meet and collaborate as a large

technical group and also included international project partners (WHO Geneva, WHO AFRO, IASIT) and other PEPFAR projects in injection safety (Chemonics, University Research Corp., and Initiatives). The goal of the meeting was to share information and ideas on project implementation to date, to share key experiences and lessons learned, and to discuss strategies and approaches for scaling up. The overall theme was meeting the challenge of scaling up injection safety interventions to build capacity and ensure sustainability. The meeting objectives included: identifying effective approaches and emerging strategies to meet the challenges of scaling up; identifying priority areas for 2006; gaining a clear understanding of major technical issues affecting the MMIS technical scope and role, including commodity provision, advocacy, infection prevention/control, and waste management innovations; and continuing to foster coordination and collaboration among partners working in injection safety and infection control.

During the meeting, an MMIS Country Expo was presented to share experiences and lessons learned by each country program with project and partner colleagues. Emerging approaches, effective processes, and methods for overcoming various challenges were highlighted in poster presentations and displays from each MMIS country. The PEPFAR funded injection safety projects in Guyana, Namibia, and Zambia, and the International Association for Safe Injection Technology (IASIT) also presented displays. A broad range of topics was represented including strategies for Information Education Communication (IEC), BCC, procurement, sharp waste disposal, scaling up, training, commodity registers, needle-stick survey, and capacity building. Materials, resources and tools developed by country teams were also displayed at the Country Expo, which was accessible in the main hall throughout the meeting, as discussions among project staff and partners continued between sessions.

Workshop participants included MMIS Country Teams, key technical staff from JSI, PATH, AED, and the Manoff Group, representatives from the Tanzanian Ministry of Health, local representative from the WHO office in Tanzania, CDC, USAID, WHO/Geneva, WHO/AFRO, IASIT, and staff from JSI DELIVER Tanzania. Also, representatives from the PEPFAR funded injection safety projects in Guyana, Namibia, and Zambia attended and presented in the meeting. A full report from the MMIS Annual Meeting has been drafted and will be shared with all partners and available upon request in November 2005.

Commodity Management and Procurement

Procurement assessments continue in countries that have not been assessed, and specific follow up activities are moving forward in other countries. To address needs that emerged in assessments, two regional workshops are being planned, with the objectives of strengthening the understanding of quality standards for safe injection materials, providing current sourcing information for international suppliers, and forecasting issues related specifically to injection material and safety boxes.

Meetings have been planned in Tanzania, Uganda, and Nigeria to sensitize private sector importers to the activities and goals of the project and to support the private sector's ability to continue to support public health. Country-specific activities included new product registrations in Ethiopia and Nigeria, two countries in which registration is a formal requirement. One of the manufacturers of auto-disable syringes, *Hindustan*, successfully identified reputable local importing agencies, and with the support of MMIS, registered materials in those countries. Additionally, in Ethiopia, a pilot data collection exercise is underway to assess impact on cost recovery systems and also to establish the most reasonably complete set of data on products in the market place to compare with estimated needs.

Project area expansion plans are being supported by commodity procurement. Tenders have been completed; however, product shipments from the 2004 tender were extended while countries re-assessed their needs relative to expansion plans.

Total Estimated Procurements for MMIS			
Syringes	USAID Total	CDC Total	Overall Total
Syringe, standard disposable	11,262,000	781,200	12,043,200
Syringe, anti-re-use, fixed	25,632,069	3,912,600	29,544,669
Syringe, anti-re-use- w/ detached needle	13,470,053	9,312,000	22,782,053
Syringe, anti re-use and needle stick	20,296,000	3,875,200	24,171,200
Total Syringes	70,660,122	18,123,105	89,638,580
Other Equipment	USAID Total	CDC Total	Overall Total
Safety Box, 5 L	855,353	242,105	1,097,458
Needle Removers	1,931	795	2,726

Note: Above quantities may vary from actual shipments due to manufacturers' to account for packing units and other minor adjustments.

In June 2005, PATH began conducting evaluations of the injection safety products introduced into MMIS countries. Using a standardized questionnaire developed by PATH, the evaluation collected specific user feedback on the use of the products. The objectives were to learn about the acceptability of these products, to identify problems, and to provide specific quality feedback to equipment manufacturers. The questionnaire has been implemented in three MMIS countries: Ethiopia, Kenya, and Tanzania.

This preliminary evaluation highlighted the need for better training in the use of injection safety products. Most health workers have previous experience with safety boxes, so acceptability and proper use were high. Some quality problems were found in one type of safety box. The manufacturers have been informed and changes are underway. Needle removers were well accepted, but a need for improved training and the assurance that needle pits are available was noted. The autodisable (AD) and retractable syringes were typically highly accepted for their safety features, but improved training is needed to clarify for which medical procedures these syringes can and cannot be used. Many respondents demonstrated some gaps in their understanding of the device features, how to properly use them, or the reasons for using safety syringes.

Although preliminary, the results from this evaluation have been used to refine training materials, to demonstrate the need for better training, to provide feedback to manufacturers, and to guide the procurement tender. The evaluation is expected to continue in the remaining countries.

Waste Management Meetings

A series of meetings is underway to accelerate improvement in waste management practices in MMIS countries. An initial meeting was held in Geneva in June 2005 to clarify WHO policy on waste management, including clarifications on the acceptability of incineration as an interim treatment solution, the use of needle-removers, limitations in the practice of chemical disinfection of waste, limitations in advanced treatment systems such as autoclaves and shredders, and the importance matching waste solutions to infrastructure settings.

A second meeting is planned for October 2005 in Ethiopia for all MMIS medical waste staff, their MOH and/or Ministry of Environment counterparts, and technical experts. The goal of this meeting is to identify approaches and technologies for waste management that are best suited for African infrastructure settings. Approaches that combine appropriate systems, people, and technologies will be discussed and detailed. Each country will document and compare its existing or proposed medical waste management strategy. Representatives from other countries that have PEPFAR-funded projects in injection safety have been invited to attend as well.

Coordination with Other PEPFAR Partners

MMIS participated in several PEPFAR partner meetings during the progress period. In October 2004, USAID convened a meeting of PEPFAR injection safety projects to coordinate their contributions to the 2004 Safe Injection Global Network (SIGN) meeting. Because of his extensive experience working with the Network, the MMIS Project Director gave an orientation on SIGN to the other partners at that time. At the December 2004 PEPFAR meeting, the MMIS Project Director and CTO from USAID debriefed the other contractors who had been unable to attend the SIGN meeting in South Africa. In February, the MMIS Project Manager and M&E Advisor participated in a half-day meeting of PEPFAR injection safety partners, and further coordination meetings were planned to assist the partners in sharing lessons learned. In July, MMIS hosted a half-day meeting of PEPFAR partners that included projects in Namibia and Zambia by URC and Chemonics. At this meeting it was decided by the group to hold regular meetings every other month. Two additional meetings of a sub-group to discuss indicators were held. The MMIS monitoring and evaluation officer attended both meetings for MMIS, and staff from MMIS continue to attend and participate in the scheduled meetings.

On January 12, 2005 at JSI's main office, MMIS hosted a briefing by Dr. Jorge Emmanuel, a well-known expert in health care waste management who is currently an independent consultant affiliated with Health Care Without Harm (HCWH). Representatives from the Chemonics, University Research Corporation (URC), and Initiatives injection safety projects, JSI's DELIVER Project, and USAID were invited to this presentation. Dr. Emmanuel presented on HCWH's experience in implementing waste management alternatives to incineration. In the question and answer period that followed, issues were raised related to the feasibility of the alternatives he recommended at the country level. Although these issues could not be resolved at this meeting, this briefing is seen as the first step of an ongoing dialogue on waste management challenges.

Standardization of Training Materials

In response to requests from country directors expressed at the Sustainability Workshop in South Africa (see above), MMIS hired a consultant to develop a standardized training curriculum for training health workers in injection safety and selected aspects of infection prevention and control, including waste management. This activity is being carried out in close collaboration with WHO/AFRO. In February, the consultant and the HIV/AIDS advisor from WHO/AFRO met with

JSI/MMIS staff in Washington, DC to plan this activity. After a planning meeting with WHO/AFRO in January at JSI headquarters, the consultant prepared a draft training manual, which was reviewed by MMIS at all levels of the project. The Facilitators Guide is based on a series of documents from WHO, SIGN, MMIS country materials, training materials prepared by AED in interpersonal communications, by PATH on waste management and logistics and commodity management, the MMIS Project Norms and Standards, as well as other materials related to injection safety.

In April, a two-week workshop co-sponsored by the WHO/AFRO regional office was conducted in Harare, Zimbabwe to finalize the Injection Safety Facilitators' Guide. Participants included, but were not limited to MMIS local and headquarters staff, WHO, AED, PATH, Africa University, the University of Zimbabwe, and a curriculum development specialist. Following the workshop, a training workshop was conducted at an African medical university for key trainers from selected MMIS project countries. MMIS Country Directors identified trainers for participation in this training and the IS/IPC Facilitators Guide was used. At the end of the workshop action plans were created to strengthen Injection Safety and Infection Prevention and Control training activities to take place in the medical institutions in each country.

Following the Harare workshop, MMIS worked closely with WHO/AFRO and the consultant to create a final draft Facilitators' Guide for presentation and distribution at the MMIS Annual Meeting in September. Discussions at the annual meeting included future uses for the Guide and accompanying pieces for this document, which will include a *Participants' Handbook* and job aids. A camera-ready document is expected in December and will be published through WHO channels. The final version has been translated to French and Portuguese in order to maximize its usefulness. Currently, the document is being used and adapted by MMIS teams with the injection safety task force in selected countries.

Monitoring and Evaluation

In this reporting period, several new monitoring and evaluation tools were developed for use by country staff. The first tool was a needle stick injury report form, developed from materials received from PATH and similar to the tool developed by the University of Virginia. This tool was distributed to all MMIS country programs.

The second tool was a list of Norms and Standards of the MMIS project, developed from an appendix in *A Guide for Supervising Injections*, published by WHO (February 2004 version). This list guides revisions in training materials to ensure injection safety messages for health workers are clearly defined. The third tool is a test of health worker attitudes to be administered at the beginning and end of training workshops; this tool tests the degree to which the staff being trained have absorbed (and intend to follow) key aspects of injection safety knowledge and practices. Both of these tools were developed for the standardized training materials mentioned above.

Once health workers have been trained in injection safety, supervisory visits are a prime opportunity for observing actual practices and reinforcing messages on the desired practices that constitute a safe injection. Accordingly, a supervisory checklist tool was developed for use by MOH staff as they visit health facilities in their areas.

A set of tools including a standard survey protocol, analysis plan, reporting guidelines, sample data entry program, revised data collection tools, and training support for data collectors were developed for health facility assessments to improve the quality of the assessments and to ensure that data are

analyzed and reported in accordance with MMIS indicators. Ethiopia, Nigeria, and Uganda received technical assistance in surveys of their expansion areas during this reporting period; technical assistance to Mozambique will follow early in the next fiscal year.

The health facility survey materials listed above are also being used to assess the effectiveness of the current strategy and progress to date in pilot implementation areas. This analysis will be invaluable in guiding the project as it prepares to expand to new implementation areas. In this progress period, Uganda collected follow up data in December 2004 and Ethiopia collected it in June 2005. Mozambique, Nigeria, and Uganda have surveys planned for the upcoming fiscal year.

In addition to the health facility survey materials, the project also began work under the leadership of AED to develop tools and a methodology for community surveys. These surveys will be used to assess the effectiveness of BCC materials.

Concurrently with the MMIS project-specific work, the contracting agencies with PEPFAR funding met as a group in July and August 2005 to build consensus on a standardized set of indicators for reporting on all USAID countries. The list of indicators was reviewed in September and finalized in the first few days of October 2005; this list will be an important tool for the monitoring and evaluation plans which are under development for all four USAID country programs.

Communications, Advocacy, and Knowledge Management

Following the hiring of the Communications Consultant, a communication strategy was developed and contained components of knowledge management and global advocacy plans. Implementation activities to date include the development of the project logo and branding guidelines, development of a project brochure and fact sheet, prototypes of a project newsletter and information resources for staff, and launching of the project website. Following the addition of the Communications Strategist to HQ staff, the knowledge management plan to improve internal project communications was finalized and has been introduced to country teams; this plan includes archiving systems and a quality assurance protocol for material production. The upcoming qualitative audience survey was also finalized and will identify strategic activities to promote safe injection technology and practices and share project experiences with key international policy and implementing partners.

Site visits to four country programs (Ethiopia, Nigeria, Rwanda, and Tanzania) were conducted by the consultant in July and September 2005 to assess country team communications needs, to provide technical assistance in implementing the knowledge management plan, to gather input into the architecture and resources for the website, and to collect background material, interviews, and site visits for forthcoming case studies. In addition, several cross-program issues were identified for follow up with technical communications products, such as policy papers and technical toolkits.

With participation from country program staff, the communications staff also facilitated a communications and knowledge management session during the internal portion of the MMIS Annual Meeting. This session reinforced the branding guidelines, introduced the knowledge management plan and protocols, and provided guidelines for writing success stories and taking photographs for programmatic use.

Country Progress to Date

◆ Ethiopia

In the area of *commodity management and procurement*, the procurement for Ethiopia included more than 1.6 million new disposable syringes with reuse and/or reuse and needle stick prevention features, over 25,600 safety boxes, and 238 needle removers. All procured materials—safety boxes, syringes, and needle removers—arrived in the country between October 2004 and January 2005 and were distributed to the regions. In addition, 2,900 packs (100 pieces each) of examination gloves and 3,800 pairs of heavy duty gloves were purchased locally and distributed to laboratory staff and waste handlers in December. Distribution of supplies to all pilot phase woredas has been completed and redistribution has been completed in some facilities. A supply forecast was completed and approved by the country team and PATH for both the pilot and expansion woredas.

A logistics tracking tool (LMIS) adopted from the regional coordinating office has been implemented in some of the pilot health facilities. Discussions were held with local manufacturers to explore the production of syringes and safety boxes locally.

In the area of *capacity building and training*, 37 health workers drawn from pilot implementation sites participated in two training-of-trainers (TOT) workshops organized in September and October 2004. Beginning in November 2004, a more intensive four-day training in interpersonal communications has been conducted with prescribers of injections (with advocacy to reduce the number of injections given) and representatives of training institutes that may include this material in pre-service curricula.

Training of 241 health workers in injection safety was completed by November 2004 using the two regional core teams of trainers. In December, another 77 health workers were trained, followed by 48 in January, 117 in February, and 31 in March 2005. In addition, 17 workers were trained in interpersonal communications and waste handlers were trained in January. Twenty workers were trained in procurement and supplies management in March 2005, and 20 trainers from Harari region, an expansion area, were trained in August 2005 using the new standardized training materials (Draft 4). At the end of the training, participants developed training plans for health workers in their areas. In total, 608 health workers and approximately 200 auxiliary staff were trained on injection safety.



Trainees in procurement and supplies management training

In *behavior change and advocacy*, job aids, posters, and brochures were produced and pre-tested in December 2004 and disseminated to the pilot areas in January 2005 in coordination with the distribution of procured commodities. A dramatized 20-minute documentary film on injection safety was developed in December 2004, and was launched at a validation workshop in February 2005. The Health Education Centre of the MOH participated in final editing in March. A total of 300 copies of the film were duplicated and partially distributed, mainly by request of donor organizations working with the PEPFAR network. Another product that was developed was the *Pocket Size*

Reference Guide for Health Workers on Safe Injection Provision, finalized in January 2005 and 2,000 copies were printed and distributed in February. At the validation workshop for the five-year strategic plan 200 promotional T-shirts targeted to prescribers and injection providers with the message of rational use of injections and provision of safe injections were distributed. As part of the overall communications strategy, an article on safe injection was printed in the *Reporter*, a widely circulated private Amharic and English newspaper.

As part of the next phase of the communication strategy, a quarterly newsletter for health workers, *Dewel*, was developed and published in the first week of July 2005. The newsletter is a forum for exchange of information and experiences among health workers, disseminates best practices in injection safety and waste management, shares research findings and upcoming events, serves as an advocacy tool with national policy makers, promotes rational use of injections, and stimulates dialogue among professional associations. All MMIS implementation sites, partner organizations, and academic institutions have received the newsletter. In preparation for the next issue (November 2005) of *Dewel*, interviews have been conducted and the articles have been drafted.



Trainees in procurement and supplies management sporting T-shirts from the validation workshop

The National Injection Safety Task Force met January 14–16 to develop an advocacy strategy. A consultant was hired locally to prepare the draft report and to finalize the strategy based on comments received.

In **waste management**, the draft waste management plan was finalized in September 2004, based on experience gathered in nine early intervention health facilities. As a strategy in addressing the waste management issue, it was decided that some health institutions would be identified (where an incinerator is available) to incinerate waste from other health facilities in the area. The constraint in implementing this plan was the poor state of the available incinerators. Accordingly, maintenance of seven incinerators was completed. Ash pits and needle pits have been constructed in the areas with the rehabilitated incinerators. Training of waste handlers in these facilities took place in January as reported above.

An exposure site visit for outgoing nursing students was organized to acquaint the students with the best injection and sharps waste management practices. Prior to the visit, a half-day interactive classroom discussion was held by the MMIS technical staff. 19 graduates and 2 instructors participated in the visit.

After the TOT training in the Harari region mentioned above, waste management committees were established for the region. Also, the Ethiopia team has divided the Logistics and Waste Management Advisor position, and recruited a Waste Management Advisor. As part of the five-year country strategic framework, MMIS with the MOH developed Terms of Reference for a consultant to be recruited for the development of healthcare waste strategies and policy formulation. The bid was posted in the newspaper and applicants are requested to submit technical and financial proposals.

In *policy*, the National Injection Safety Task Force was formed with the participation of the MOH, WHO, UNICEF, USAID, CDC, HIV/AIDS Prevention and Control Office (HAPCO), UNAIDS, RPM+ and FHI. The revised terms of reference for the committee and list of participants for the expanded committee were negotiated with the MOH. The national committee was officially launched in November 2004, and is led by the Health Services and Training Unit of the MOH. A core technical working group charged with drafting the five-year national strategic plan was identified. They held a three-day retreat in December to identify strengths, weaknesses, opportunities and threats, and to formulate strategic questions and develop an activity plan. In January 2005, the national task force met to comment on the five-year plan, and based on these comments, the final draft was for the next meeting held on February 1. At this meeting, the draft was discussed and an action plan was developed to launch the strategic framework in a validation workshop held February 28-March 1. Participants in this workshop included six department heads from the MOH, health service training department heads from regional health bureaus, international organizations, the bilateral project, and non-governmental organizations. Comments received at this meeting were incorporated into the document, which was discussed with the management committee of the Ministry of Health for endorsement as a national strategic framework. Refinement of the document is ongoing to address the needs of the Ministry of Health. Meanwhile, based on the document, regional health bureaus have already included injection safety issues in their Health Sector Development Programmes (HSDP).

MMIS has initiated some recent contacts with other organizations outside the Task Force. For example, Ethiopian Public Health Association (EPHA) representatives met with MMIS staff in March 2005 at which time EPHA agreed to publish an article on the objectives of the project in their newsletter, to publish the safe injection assessment report in the Ethiopian Journal of Health Development, and to organize a panel discussion on injection safety during their annual conference to be held October 26–28, 2005. Similarly, during the annual conference of the Ethiopian Nurses Association to be held November 4–6, injection safety will also be a topic of discussion. In both cases, JSI/MMIS will co-sponsor the conferences.

In February 2005, MMIS staff attended a one-day meeting of the Ethiopian AIDS Emergency Plan (ETAEP) partners, organized by the American Embassy and the USAID/Ethiopia Mission and funded by PEPFAR. The meeting enabled USG programs to exchange information and paved the way for further collaboration in the sphere of HIV/AIDS prevention, treatment, care, and support activities. In March 2005, the MMIS BCC advisor attended a second partners meeting focused on BCC issues. The objectives of this meeting were to share lessons learned, to establish a forum for linking the projects, to brainstorm on new audiences to target, and to discuss joint planning and sponsorship of events such as World AIDS Day. The project is planning to buy air time for this year's World AIDS Day, and a local media agency is being subcontracted to develop a three-hour program. In addition, the USAID mission is leading a group of PEPFAR partners including MMIS, JHPIEGO, Intra Health, and FHI in mapping facilities to identify areas of overlap and to harmonize expansion plans.

Also in March, MMIS staff met with Linkages Project staff to share expertise and lessons learned in prevention of mother-to-child transmission of HIV (PMTCT), particularly related to post-natal transmission and infant feeding.

In the area of development of *strategies for working with private providers*, MMIS has begun meeting with nongovernmental organizations (NGOs) involved in injection-related services including Pathfinder International, DKT Ethiopia, and FHI. These NGOs support reproductive health/family

planning and voluntary counseling and testing (VCT) services in country. A two-day meeting to identify areas of collaboration in activities such as health worker training is in the planning stage. (It is worth noting that this initiative is commencing in advance of the USAID Task Order to begin work with private providers in Year 2 of the MMIS extension project.)

Recently, the country team held discussions with the Carter Center, an organization mandated on curriculum review of training materials for public health initiatives. The discussions focused on how to include injection safety in the existing curricula. It was decided to have all training institutions participate in the adaptation process of the harmonized training materials developed by MMIS and WHO/AFRO. It was also agreed with the MOH that MMIS will participate in the TOT program for health extension workers instructors, and materials on injection safety will be distributed to participants.

In *monitoring and evaluation*, MMIS participated in supervisory visits to 39 pilot health facilities in February 2005. During the visits, the team observed injection practices, sharps waste disposal practices, and injection device storage and stock management, and identified areas for improvement and compiled lessons learned on implementation strategies and experiences from the best sites. The newly developed MMIS supervisory tool was used to assess the situation at the health facility level. This tool is also being adapted by the bilateral JSI/ESHE project for use in supervision visits in their 64 districts.

In March, the MMIS Country Director attended a national dissemination meeting at which the results of 12 baseline health surveys conducted in Amhara, Oromiya and SNNP regions were discussed. These surveys were conducted by the bilateral JSI/ESHE project and include some data on injection practices.

An assessment was conducted in the pilot phase woredas in June-July 2005. An interim draft evaluation report was submitted for comment and is being reviewed. In June 2005, assessments were completed in the new expansion area using the newly developed tools for higher and lower institutions. In mid-November, the document will be finalized and disseminated in a debriefing session.

◆ **Mozambique**

In the area of *commodity management and procurement*, the procurement for Mozambique included more than 1.3 million new disposable syringes with reuse prevention features, over 13,200 safety boxes, and about 400 needle removers. In December 2004, the shipment of needle cutters arrived and was cleared from customs. The syringes arrived in January 2005, but clearance from customs was delayed due to a restructuring of the Ministry of Planning and Finances into two ministries. Once clearance was received, distribution commenced.

The Injection Safety Technical Group (ISTG) in each program city prepared a distribution plan and transportation was arranged. MMIS distributed a total of 1,069,130 AD syringes, 10,681 safety boxes, and 61 needle cutters to the cities of Nampula, Quelimane, Xai-Xai and Mavalane Health District in Maputo City. MMIS supported the ISTGs in the premiere distribution and introduction of AD syringes and accessories to 39 health facilities, including in-service training and follow. Waste management material was distributed to 39 health facilities and included 161 color coded buckets and 39 kits of protection equipment. Follow-up visits on the use of the new material (specifically use of AD syringes) were conducted to each of the four cities.

The injection devices included in the MMIS procurement are a departure from the Mozambican practice of using sterilizable glass syringes. The transition to the new auto-disable syringes was supported by additional in-service training so that all facility-level staff would become familiar with the new devices.

Tools developed by MMIS Mozambique include a register book for injections that is providing the project with consumption data on the number of syringes needed, the injectable preparations used most frequently, and the patients who receive them by age and gender. Data from November 2004 through February 2005 were collected from register books and entered into a database for analysis. These data were used to forecast the number, size, and kind of syringes needed at each health facility. In February 2005, a meeting was held with key stakeholders to evaluate the first year of MMIS. At this meeting, the participants began using the data collected to organize the distribution of the commodities to project implementation sites. Training and supportive supervision to the ISTGs on the use and management of the Register Book database was provided.

In the area of *capacity building and training*, training is taking place within the framework of the biosecurity/infection prevention and control effort in Mozambique. Training on the elements of biosecurity is being conducted at the province and hospital level by JHPIEGO and at health units by MMIS. To support this effort, a database of all health unit staff in the selected sites was built with categories of staff, year of training, time of service, and position. This database continues to be an asset in tracking training programs. In fact, this database was so well received at the MOH that they would like to build upon it for their other information needs.

During this period, MMIS also participated in other training-related activities such as reviewing materials, consolidating the training kits, and printing them. The training kit was reviewed and prepared for handover to each of the ISTG of the four cities. This included putting together a complete facilitators' guide with all the necessary documents for future reproduction according to local needs.

In this reporting period, 20 trainers were trained in injection safety and waste management as well as 99 health workers. Some of these staff were drawn from an HIV/AIDS daycare and health center supported by MSF. This brings the total of workers trained in injection safety to 86% of the MOH health workers in the four early implementation districts. In addition, 362 staff from MOH facilities were trained in interpersonal communications, and 283 janitors were trained in waste management.

One new partner that emerged in this period was the Institute of Medical Sciences in Maputo, which provides pre-service training for nurses, and preventive and curative technicians. This Institute requested that two teachers be included in the injection safety trainings, and they were integrated in the March 2005 trainings. In addition, one of the ISTG members who teaches environmental health at the Institute requested and received MMIS training materials for use in his curriculum.

After his installation in February, the new Minister of Health openly discouraged health workers from leaving their job sites for training. This may delay progress in training, but MMIS is working to partner with the MOH on their planned training activities in order to stay on course with training in the project expansion areas.

In *behavior change and advocacy*, the draft BCC strategy was finalized in March 2005. The strategy addressed each of the subgroups involved with actions related to their specific role or responsibilities. The subgroups identified are the providers-prescribers; the providers applying injections; the waste handlers (janitors); the supervisors and health managers; and the community. In July, the country team and the national ISTG, made numerous modifications to the detailed BCC strategies. Plans for a workshop for wide review and finalization of the strategies had to be rescheduled several times due to lack of MOH approval; however, MMIS drafted detailed plans for additional formative research to inform improved approaches to reducing unnecessary injections, which is a significant problem in Mozambique. The Mozambique team continues to work and meet frequently with the ISTG. Detailed creative briefs for BCC materials, as well as plans and instruments for thorough pretesting were drafted in July. These materials are planned for production during the next quarter.

A highly participatory training methodology, training materials, and a CD-ROM to facilitate additional trainings were created. All medical staff of the 39 health facilities in 4 cities have been trained on injection safety, waste management, and interpersonal communication and counseling (IPCC). All cleaners and waste handlers of the 39 health facilities in four cities have been trained in WM. In addition, in-service training was provided to the “injectors” at the facility level simultaneous to the distribution of new AD syringes. In the last quarter, a TOT in one province is planned, as well as hospital-level training in the project’s expansion areas.

In *waste management*, the findings of an assessment of waste management practices and infrastructure conducted in July 2004 identified options that were used to develop in November 2004 draft waste management plans for the 38 lower-level facilities in the early implementation areas. In February 2005, the ISTG in each city prepared a distribution plan for color-coded buckets and protection material for waste handlers that were distributed at the same time as the injection commodities.

MMIS continues the development and planning of waste management activities. MMIS participated in the recruitment and briefing of a waste management official. A guide on maintenance of needle cutters for staff health facilities is in development. Also, MMIS participation in three meetings at the MOH on the National Waste Management Strategy for presentation at National Hospital Council meeting are planned for November. A field visit to Quelimane to support the ISTG in preparation of

needle pit construction in health facilities is planned. MMIS continues coordination with other organizations (specifically Village Reach project in Cabo Delgado) on waste management and planning of training staff facilities in Pemba, Montepuez, Mueda, and Mocimba da Praia. Follow up activities in facilities on the use of materials—specifically needle cutters—are also being planned.

In *policy*, during October and November 2004, the protocols for treating sexually transmitted diseases were revised as a strategy to reduce the number of un-necessary injections.

In December 2004, a new government was elected in Mozambique, and sweeping policy changes were instituted. The new Minister of Health called for replacement of all provincial health directors and began a series of changes among high-level MOH staff. With the new government in place, one area of concern at the MOH was the availability MMIS for ongoing technical assistance in injection safety. The change in the local MOH occurred at the same time that the project was negotiating the contract extension with USAID/Washington. When the final budget and task order were received from USAID, MMIS worked with the national MOH and the new officials to finalize the 2005 work plan.

JSI, with JHPIEGO, contributed in March 2005 to drafting the MOH National Plan for Quality Assurance, including specific injection safety and waste management sub-programs. Also in March, JSI was asked to comment on and add to the draft national MOH plan for in-service training, which contains injection safety issues and plan calls for setting up a national database of health staff with trainings they have received. An initial meeting with the MOH and MMIS has taken place.

In August, Mr. Americo Ubisse was identified and selected as the new Country Director of the MMIS Mozambique office. Mr. Ubisse will start this position in October 2005 and receive his formal orientation to MMIS. Presentation of Mr. Ubisse in all cities and preparations on integrated planning with all four cities/provinces will take place. Negotiations continue with the MOH on the future of project and its continued integration. Also, a technical meeting with Nursing Department on planning for 2006 (MOH fiscal year is January to December) is planned for October 2005. The first meeting on integrated planning and expansion areas of MMIS in province of Gaza is being planned.

In *monitoring and evaluation*, the local MMIS staff hosted an evaluation workshop in February 2005 where members of the ISTG in the four project sites presented their lessons learned, results and challenges. At this workshop, the MMIS counterpart at the USAID mission spoke of the exceptional results seen by the project in the short time that it had been working in Mozambique. The Minister of Health reinforced its' perspective that this project urgently needs to be scaled to national level and integrated into MOH activities, and he expressed appreciation for the tools such as the training database which can be used by the MOH. The main activities of the 2005 plan were also discussed. In addition to this workshop, the ITSG also continues to supervise health facilities on an ongoing basis.

Follow up and supportive supervision after introduction of AD material and needle cutters is being planned to build upon the training in new technologies mentioned above. Analysis of data from the Injection Register Book was used to inform the forecast for new procurement and will continue to be conducted. Terms of Reference for a consultant to manage data collection and analysis activities for a baseline in expansion areas and a follow up evaluation of the first phase pilot facilities was developed. This consultant will be hired in October 2005.

◆ Nigeria

In the area of **commodity management and procurement**, the procurement for Nigeria included more than 2.8 million new standard disposable, reuse prevention, and reuse / needle stick prevention syringes, almost 29,000 safety boxes, and about 600 needle removers. These quantities were calculated to ensure that a sufficient supply would be available in the early implementation sites.

The first air freight shipment arrived in October 2004 representing 10% of the total quantities of syringes ordered for Nigeria and all of the needle removers. Subsequent to the clearance of this air freight consignment from customs in November, storage and distribution strategies for focal local government areas (LGAs) were developed and implementation commenced. This stock began to be distributed to the project's implementation areas in December 2004, and now covers 127 facilities of the 241 target facilities. The remaining stock came in as ocean freight and was received in five consignments between February and March 2005. These shipments were delayed in clearing customs due to some administrative bottlenecks. As a result, the project was billed for demurrage fees on two containers and distribution to LGAs was delayed. Injection safety equipment from the ocean supplies is currently being distributed. This supply is expected to last about one year based on population estimates.

In spite of the delay in clearing all of the containers, a ceremony was held on January 24, 2005, at which time the commodities were officially presented as a USAID donation to the Federal Ministry of Health. The Director of Public Health, Dr. Abebe, gave the welcome address at this event. The local Nigerian press covered the event and published it in the Nigerian *Punch* on January 27th. (See *the Highlight on Commodity Procurement*). The Director of Primary Healthcare and Disease Control in Lagos State asked for a local official hand-over ceremony of the commodities destined for Lagos to either the Governor or the Commissioner for Health in order to ensure the highest level of political support for the project.

The country team facilitated the registration of the single use syringes with regulatory body (NAFDAC) for the first time in the country, thereby opening the market to buyers even beyond our focal states. Storage space was advocated for in Anambra State and at the Oshodi Medical Stores through the Logistics Sub Committee Chairman. The monitoring of inventory was conducted at all focal sites to ensure regular supplies of the AD syringes. No stock outs were recorded in any of the focal sites this quarter.

Procurement planning for the new scale up areas was completed with PATH. The Nigeria country team took an active role in the criteria development for the bids and contributed to the final selection exercise with other countries. The logistics sub committee met once to deliberate on the utilization rate and the best way to solve challenges of implementation of the project. The major objective achieved was the review of the inventory management tools.

In March 2005, Mr. Isa Iyortim was hired as the Logistics and Waste Management Advisor and in April 2005, Mr. Joseph Bonatson was hired as the Logistics Advisor. Mr. Iyortim continues as the Waste Management Adviser.

In the area of **capacity building and training**, training of master trainers took place in October 2004 followed by training of health workers. Eleven trainers (two per LGA and one each from the three focal states and the Federal Capital Territory) were trained. They, in turn, trained 40 national-level

health workers, 174 health workers in implementation areas, 120 waste managers and 123 community members. Amino Kano Teaching Hospital trained an additional 30 health workers in November while Gwagwalada LGA trained 20 in March 2005. In addition to training in injection safety, local government and facility-level store keepers were trained by the logistics sub-committee to build their capacity; 15 were trained from each LGA, for a total of 60 people trained. Once the new funds from the contract extension became available, the local team was able to continue large-scale training. Between April and June 2005, 139 national trainers were trained in injection safety along with 173 MOH and 49 NGO staff in the Federal Capital Territory. Seven MOH and 14 private for-profit staff were trained in interpersonal communications, 20 MOH staff were trained in logistics, while 70 were trained in waste management.

Between July and September 2005, 115 national trainers were trained in injection safety. This group included refresher training for 28 trainers trained in 2004, 38 trainers from the expansion areas, 21 immunization program managers and 28 assessment consultants. In addition to TOT, 314 MOH health workers were trained in injection safety and interpersonal communications, and 392 district-level MOH staff were trained in waste management.

In addition to training workers, MMIS also collaborated with local partners to develop a strategic training plan that describes training timing, districts, and staff level. Adaptation and finalization of training materials is an ongoing process and incorporates experience from the initial implementation areas and the larger project-wide meetings to standardize training materials. Project staff have also initiated discussions with pre-service training institutions to examine the existing curriculum related to injection safety.

In *behavior change and advocacy*, the National BCC strategy was finalized by the BCC Committee in November 2004 after review by the Technical Working Group and AED. BCC materials were adapted from Kenyan materials distributed at the Sustainability Workshop in October 2004 to create a poster, fact sheet, and health worker information leaflet. A communication workshop was held in June to develop and design communication messages and additional materials. Following this workshop and pre-testing, materials were standardized and revised to ensure all feedback received were incorporated. Professional printers were contacted to bid on production. The materials will be strategically distributed to trained healthcare providers, implementing partners, donor organizations, associations, health facilities, and at special events, which included the MMIS annual meeting in Dar es Salaam in September 2005. These materials have been finalized and distributed to the local government areas.

The need for injection safety champions to assist with promoting injection safety activities in Nigeria was identified as a high priority. Three tiers of Injection Safety Champions were identified in order to ensure coverage of the Nigerian three-tier system of government. The identified individuals were informed of their roles and responsibilities and clarifications were made. The identified individuals at all three levels all agreed to be advocates for change. At the national level, MMIS identified the Director General of the National Food and Drugs Administration and Control (NAFDAC) as the National Injection Safety Champion. Professor Dora Akunyili who has been honored with 350 awards since assuming the position of Director General and recently launched an educational campaign (“Pharmaco Vigilance”) to educate Nigerians on adverse drug events that follows medications including injections. Since her successful identification, the MMIS Nigeria team plans to work with her to develop a mass media campaign to educate individuals on injection safety as well as promote oral medications when available. NAFDAC and other major partners such as WHO support

will be critical to reducing unnecessary injections and revising the Essential Medicine's List. These actions will encourage rational drug use in general and rational injection use in particular.

Other advocacy visits have been made to the Ministries of Health at the federal level and in Lagos, Kano, and Abuja States to establish proper working linkages and to obtain government approval for activities being conducted. The First Lady, Kano State, Hajia Shekarau (a former practicing nurse) was identified as an Injection Safety Champion at the state level, and Dr. T. Ameh, Chief Medical Director of Gwagwalada Specialist Hospital, Federal Capital Territory, Abuja was identified as the Local Government Injection Safety Champion.

In new expansion states, MMIS staff made advocacy visits to state officials, MOH staff, State Action Committee on AIDS (SACA) representatives, professional associations as well as private medical practitioners in Anambra, Cross River, and Edo States. Advocacy visits were also made to the current implementation sites of Lagos, Kano, and the FCT to inform states coordinators and ministries of health representatives of the plan to scale up in these sites, which advised them of their part in the larger implementation in the country.

MMIS officially joined USAID's IT Newsletter Editorial Board and two articles have been published in the premiere edition. The newsletter is a joint venture of all PEPFAR funded project in Nigeria and will be produced quarterly to highlight salient activities implemented by each contributing organization.

In *waste management*, the report on the December 2004 assessment of waste management practices and infrastructure was used to develop waste management plans for the three federal and state hospitals in these LGAs. The Federal Ministry of the Environment offered to finance procurement of some waste handling equipment but the process is ongoing due to bureaucratic bottlenecks. There is a renewed attempt to get the implementing local government to directly write a proposal to be facilitated by MMIS. The national health care waste management plan that was drafted during the pilot phase of the project is now being finalized, with the Minister of Health completing his Preface and top management committee officials of FMOH are vetting it in anticipation of the Minister's signature. In addition, the Ministry of the Environment has made a commitment to producing guidelines for waste management, as they are currently working with the Basel Convention and WHO on a HCWM policy and plan.

WHO/Nigeria, the European Union Partnership for Reinforcing Immunization Effort (EU/PRIME), and the National Program on Immunization (NPI) sent a consultant on a fact-finding mission to MMIS project sites in December 2004 as part of a proposed collaborative intervention for waste management in six states, including the possible donation of incinerators in Kano State. Meanwhile, Kano Hospital repaired its large incinerator, and the Teaching Hospital



Needle Pit at Badagry Local Government Area in Lagos.



Needle Pit at Gwagwalada Local Government Area in FCT Abuja

management has proposed creating a revolving fund to cover the costs of repairs to incinerators. MMIS has advocated the use of color-coded disposal buckets with lids and liners to facilitate segregation of waste, thereby reducing the amount of waste that needs to be incinerated.

Needle pits were constructed in each of the pilot LGAs for teaching and practical exercises. Yellow bin liners and biohazard stickers were also made for plastic buckets being utilized as hazardous waste bins. Needle drums are in place as an alternative to needle pits in areas with high water tables, such as Ajeromi Ifelodun Local Government areas. Initial site visits to new LGAs and States were conducted to identify best waste management plan that would be developed at the various level of implementation in the next few months.

In local government areas where neither incineration nor burial is an option, arrangements are being made to transport waste for proper disposal. Most of the private facilities have problems of limited space within their premises; thus, their wastes will have to be transported to other primary and tertiary health facilities for proper waste management. Arrangements are being made to this effect, which will precede the Task Order for the project to work with private facilities.

The National Measles Campaign committee requested technical assistance on appropriate waste management. Gwagwalada LGA is being planned to pilot the best options for the campaign in December 2005. The two proposed options are Santapur Concrete Ring burner with secured sharp pits and needle pits.

In the area of development of *strategies for working with private providers*, in addition to activities mentioned above, MMIS Nigeria attended a meeting at the Ministry of Health in Kano on the subject of building public and private sector partnerships for community ownership of health sector reform and revitalization of the health system. MMIS also participated in a series of activities in collaboration with other organizations to further promote the issues of injection safety and healthcare waste management in Nigeria. The Nigeria team attended a media roundtable that was organized by INTERNEWS, as well as meetings with NACA and interaction with Lagos and Cross Rivers States Action Committee on AIDS (ACAs) to develop strategic implementation plans for the coming months.

MMIS Nigeria participated actively in the development of the Five Year Strategic Framework facilitating the inclusion of injection safety/universal precaution and health care waste management issues in the public and private sectors. MMIS facilitated injection safety training session for routine immunization organized by COMPASS for the organization's 21 program managers.

An advocacy visit was made to GHAIN in order to complement their prevention and care activities at PEPFAR sites. They offered the use of their training conference hall free of charge and in return, MMIS had the second set of training of national trainers there. ENHANSE was also visited to chart the best way forward to maximize the impact of the PEPFAR projects in Nigeria. In addition, NACA and SACAs invited MMIS to meetings as partners working together with national HIV/AIDS prevention efforts, which included attending the PAC (Partners Advisory Committee) by NACA and Lagos State partners' forum.

In the area of *policy development*, MMIS has worked with various stakeholders including the Federal Ministry of Health, Department of Public Health, Department of Hospital Services, Ministry of the Environment, Ministry of Occupational Health, National Committee on AIDS, WHO/Nigeria, UNICEF, and other partners on institutionalizing injection safety policies. The Safe Injection

Coordinating Committee, which was formed with the participation of these stakeholders and CDC, is chaired by the National AIDS and STI Control Program of the MOH and is meeting quarterly. The Stakeholders' Forum and sub-committee meetings discuss relevant issues and provide input and review to policies and guidelines related to the promotion of safe injection practices in the country, and resolved that Immunization Injection Safety be expanded to cover a wider scope of curative services, infection prevention and control, and other areas that expose communities to unsafe injections.

The Technical Working Group was inaugurated by the MOH and partners to upgrade the draft policy, guidelines, and BCC Strategy and to adopt the assessment methodology for the country.

The *Standards for Injection Safety Practice* has been reviewed by all partners at a Stakeholders Forum in December. The Technical Working Group (TWG) continued to meet throughout this reporting period and contributed immensely to the development of a National Policy on Injection Safety and Health Care Waste Management. The TWG also completed the review of the standards for universal precautions and health care waste management practices and the MMIS Nigeria BCC Strategy. The *Standards for Injection Safety Practice* were developed based on the Ugandan norms and standards because there was no pre-existing Nigerian standard in injection safety. They are already in use on the field by the health workers and awaiting execution by the FMOH.

A five-year strategic plan was developed with members of the MMIS Technical Working Group, sub-committee chairmen, ministries of health, education, associations, and HIV+ networks. The process included a review of MMIS activities and an overview of injection safety issues. A SWOT analysis was conducted to assess the Nigerian environment and participants were divided into groups to develop a work plan and appropriate budget. The document is undergoing review before production.

In ***monitoring and evaluation***, monitoring by designated focal persons and MMIS Nigeria staff has been ongoing in the implementation areas (although changes in MMIS Nigeria staff delayed this process). This monitoring uncovered a few problems such as health workers who had not been exposed to MMIS training who were returning the new injection devices in favor of the old disposables. MMIS quickly arranged for ad hoc training for the health workers concerned and continued with on-the-job training and supportive supervision.

A baseline assessment of new scale-up states and LGAs was conducted. An instrument developed and adapted from the WHO Tool C was used to train consultants that went out for data collection from the identified hospitals and health facilities, public and private. All public health facilities were automatically assessed if their total number was less than 25 in the LGAs. At this time, data collection and entry are completed and analysis is ongoing; a first draft document is expected to be completed in early 2006.

◆ Uganda

In the area of *commodity management and procurement*, the project procured 3.9 million new disposable syringes with reuse prevention features, 39,300 safety boxes, and over 300 needle removers. The first batch of air freight supplies arrived in country in September 2004 and was distributed to 279 of the 289 facilities⁷ in the target districts, where it was anticipated that they would provide a 6- to -9-month stock of commodities lasting approximately through June or July 2005. The remainder arrived by sea in December 2004 and was distributed in January 2005 after a brief delay related to the long Christmas holiday in country. This delay resulted in brief stockouts in January, but they were quickly resolved. Additional materials such as cotton wool, paraffin, waste baskets, boots, and surgical gloves were procured. Site visits to health facilities planned to track commodities through the process of distribution all the way to the end user were intended as “preventive maintenance” of regular quality stocks. These visits were delayed pending new funding, although monitoring of stock outs, analysis of their causes, and planning for preventive measures continued during this period.

To strengthen this area of the project, support was given to the four implementation districts (Nebbi, Mbarara, Mpigi, and Pallisa) in timely forecasting and submission of requirements to national medical stores. All four districts were able to submit their orders in time. There had been recent stock outs of 2 ml and 5 ml syringes with detachable needles, and MMIS worked to resolve them quickly. Between June and August 2005, 1,084,500 syringes and 10,845 safety boxes were distributed to all four districts.

Careful monitoring of the distribution to the four districts from October 2004 to August 2005 shows an average ratio of 1.1 syringes distributed per person in the project districts. In Mbarara, the current ratio is 0.9, where the initial assessment completed showed an average use of 3–5 syringes per person per year, showing a reduction in injection use. An annual procurement forecast has been determined and is being reviewed by PATH. Additionally, an emergency order was placed for September delivery that was split between air and ocean shipments. These amounts, along with the stock balances, will be used for rapid introduction of Ads in the new districts.

The position of the Logistics and Waste Management Officer was divided into two positions: Mr. Patrick Isonomy is now the Waste Management Advisor, and Mr. Sam Balyejjusa, has been hired as the Logistics Officer.

In the area of *capacity building and training*, the project has trained all of the health workers in the initial target districts in the prior fiscal year. During this reporting period, with the exception of assisting the Uganda EPI program in addressing issues related to injection safety during mass measles and tetanus immunizations in Nebbi district, no new training was conducted and a planned review of the injection safety training package was delayed due to lack of funds. However, in consultation with the Ministry of Health, Tutors Colleges, medical schools, and national referral hospitals, work has begun on training materials designed to reduce unnecessary injections. Once new funding was received, 62 trainers were trained in the early implementation areas along with 1,256 health workers and 319 waste handlers. The training in the early implementation areas focused on reducing unnecessary injections and exposure management. Training also began in expansion areas with 71 trainers and 745 health workers trained in injection safety.

⁷ The 10 additional facilities in the implementation districts which did not receive commodities, as per MOH policy, are for-profit facilities.

One constraint in training is that staff in private health facilities find it difficult to attend general training programs because of their busy work schedules. The project has found that such facilities need separate training programs.

In *behavior change and advocacy*, the AED training manual on interpersonal communications has been shared with stakeholders for their input. The meeting planned for February 2005 to revise the manual was delayed while the process of harmonizing training materials across all MMIS countries was in progress.

The final version of the communications strategy was handed to Top Management of the Ministry of Health in February 2005 for their signature; the strategy was approved by the MOH and distributed in August 2005. The final draft of the BCC advocacy strategy was also submitted and approved by the MOH in the same month. As part of this strategy, talk shows on radio and TV are bought at subsidized rates. Eight radio stations, originally under contract to broadcast five messages per day from November 29, 2004 to January 7, 2005, were advised to stagger their programs to extend this time during the no-cost extension. A total of 16,000 messages were aired covering promotion of oral formulations and raising awareness about safe injections. At the national level, talk shows are now being conducted monthly, and talking points for panelists on TV and radio are available. At the district level, talk shows are being conducted in local languages twice a month using local FM radio stations with the largest audience in each of the four districts. The topics covered in these talk shows at both the national and district levels focus on promotion of oral formulation, health worker safety, appropriate health care waste disposal, new injection technology, policy issues related to infection control, and vaccination against hepatitis B. To date, 16 talk shows were held in eight radio stations covering the project districts. Radio spots in local languages are similarly being disseminated.

The Uganda team held a one-day sensitization meeting with journalists from 27 media houses. The journalists pledged to produce injection safety articles and have offered free airtime for talk shows with 10 radio stations. Additionally, a firm has been awarded a contract to produce a video for community education.

In addition to this mass media approach, political leaders and NGOs that are not currently in the Task Force are targeted for advocacy and to encourage implementation of safe injection practices during supervisory visits. Community awareness activities other than mass media include a fact sheet for community leaders that has been revised and distributed.

Advocacy efforts resulted in UNISTAF endorsing a proposal suggesting the inclusion of injection safety in the curricula of training institutions. A draft has been created and is being shared between the Human Resource division of the MOH and the Ministry of Education and Sports. Meanwhile, a counseling kit for health workers has been developed and includes a fact sheet on injection safety as well as guidelines for prescribers, dispensers, and injection providers. In addition to MMIS activities, the local BCC advisor participates in development of advocacy strategies by different programs, and ensures that themes are covered at activities such as awareness weeks, talk shows, and HIV messages include injection safety. These other projects are also asked to disseminate the MMIS fact sheet.

Training materials include a wall chart showing correct injection procedures, a poster for health workers to remind them how to give injections safely (*see the South-to-South Collaboration Highlight for a sample*), a poster for patient education, a radio message promoting use of oral formulations instead of injections, a fact sheet advocacy tool for use with local leaders, and a leaflet

showing correct injection procedures and waste management. These materials were field-tested in the early implementation sites in September and finalized in October 2004; they are now in use. More materials targeted at prescribers of injections and community leaders are planned. To raise awareness among service providers, educational materials and WHO *aide memoires* on injection safety and health worker protection have been widely distributed.

At the level of the implementation districts, the offices of the Resident District Commissioner, the Local Council Chairpersons, and secretaries of health were given fuel to enable them to travel to their catchment areas to join health workers in communicating about the injection safety program with local communities.

In *waste management*, based on the findings of the assessment conducted in May 2004, district-specific waste management plans were written in September and October 2004 to reflect what each level of health facility is doing to manage the waste they generate. These plans were field-tested in January 2005. Health units adapt the district plans to their particular situations, and 279 units in the project area developed draft unit-specific plans by the end of March 2005. These plans are revised and updated as needed to assist health workers in addressing problematic issues related to variability in disease patterns and funding to support the plans. Districts have been supported to develop and try out unit-specific healthcare waste management plans.

A total of 319 waste handlers were trained in local languages in four project districts. In addition, 1,500 pairs of heavy duty gloves were procured and are being distributed to each district at the end of each training course. Kerosene for burning of medical waste has been provided to the initial districts. Contact has also been made with geographers working with the Ministry of Health and using the “Global Positioning System” (GPS) to develop maps by district indicating their current waste disposal options.

Other planned activities include biannual inter-district review meetings and a workshop to review training materials and monitoring tools in waste management. These activities were delayed due to lack of funds during the no-cost extension period and remain on hold until the outcomes of the regional health care waste management meeting in Addis Ababa in October 2005 are released. It is hoped that the decisions made in the meeting will be disseminated during the review meetings.

One concern in the area of waste management is that although the WHO *aide memoire* on HCWM discourages the use of small-scale incineration, in Uganda this is seen as a better alternative than open burning. However, funding cannot be provided for small-scale incinerators as long as this contradicts the WHO policy statement. Discussions have thus been held with WHO over the conflicting information and the best way to resolve this issue. The WHO Representative-Uganda promised to pursue this with the relevant authorities. In a Geneva meeting held this year; it was tentatively agreed that small-scale incinerators could be used where there is no other better option.

In the area of *policy*, a series of stakeholder meetings were held in February 2005 to revise the injection safety and waste management policy. The policy was then printed and is distributed via sensitization meetings with private for-profit and non-profit facilities. A review of existing standards and guidelines for health workers resulted in harmonized guidelines launched by the Minister of Health. The guidelines for health workers are already in use, and guidelines for the communities will be translated in local languages and include health messages from other programs, e.g. malaria control and HIV/AIDS. These translations were scheduled for February–April 2005, but were delayed due to lack of funds during the no-cost extension period.

Advocacy for rational drug use is ongoing. The project is promoting the use of national treatment guidelines to ensure that unnecessary injections are minimized. The guidelines were developed on the principle that injections are only given when there is no other suitable alternative.

A major advocacy achievement is that the MOH endorsed a recommendation to phase out reusable syringes and adopt the use of syringes with re-use prevention features in the curative sector nationwide over a period of six months. A press release was issued by the MOH announcing the phasing out of the standard disposable syringes in favor of syringes with re-use prevention features to take effect on July 1, 2005. Similar communication has also been sent to different directorates of medical services, medical superintendents of all hospitals, and to the private sector. Major medical stores have been advised to start stocking syringes with re-use prevention features. All were advised to ensure inclusion of strategies promoting the use of syringes with re-use prevention features and safety boxes in their annual work plans and budgets.

Several meetings were held with the Forum of Health Professional Associations with the aim of targeting private practitioners. Consequently, members of the forum have held talk shows on national TV to inform about the change over of devices.

A decision was made by top MOH management to immunize all health workers in service with the hepatitis B vaccine. This decision was reached following advocacy for implementation of activities related to health worker safety by the MMIS project. A recent study done by WHO/EPI which clearly showed that many health workers are exposed hepatitis B but are not protected played a big part in motivating top management to reach this decision. In addition, communication has been sent to the Ministry of Education to make it a requirement for all students doing medical and paramedical courses to receive the hepatitis B vaccine prior to joining the relevant courses.

The national immunization program supplies matching syringes, needles, diluents, and safety boxes for vaccines on a regular basis, but traditionally clinical services have not been successful in matching quantities of supplies because of the different doses required based on weight and age of the patient. Now MMIS is supporting a new effort to match curative injection devices and medications is now being piloted in one of the implementation districts.

As previously reported, stakeholder support is widespread and is a key element in the success of the MMIS project in Uganda. New partners continue to join in injection safety efforts. Currently, partners include the Ministry of Health, Ministry of Education and Sports, Ugandan EPI, Tutors Colleges, medical schools, national referral hospitals, medical associations, local government officials in the implementation areas, USAID, CDC, WHO/Uganda, JSI's DELIVER, AIM and UPHOLD projects, UNICEF, and the US Ambassador to Uganda. The Uganda National Injection Safety Force (UNISTAF) is meeting quarterly, and has been expanded with participation from medical associations.

UNISTAF endorsed a proposal suggesting the inclusion of injection safety in the curricula of training institutions. A draft has been created and is being shared between the Human Resource division of the MOH and the Ministry of Education and Sports. Four tutors from different training institutions were sponsored by WHO/AFRO to attend an orientation course in Harare to prepare them to facilitate the process of incorporating injection safety training into the existing training curricula upon returning to Uganda.

In the area of *development of strategies for working with private providers*, private providers are being trained by the project. Those that offer community services like immunization, reproductive health services, and treatment of sexually transmitted diseases receive assistance from the government and safe injection commodities from the project (while strictly for-profit facilities are excluded). Professional associations are playing an advocacy role for the project and will be involved in the training and supervision of health workers. WHO constructed an incinerator at Nkozi (private) hospital in Mpigi district as support to the injection safety initiative, and the acting WHO Representative promised to sponsor a representative to the regional waste management meeting in October in Addis Ababa. This participation will bolster support for waste management strategies for private providers.

In the area of *monitoring and evaluation*, during the period from September to December 2nd, 2004 supervision visits were conducted in each of the 287 health facilities in the four project areas. The main areas supervised included utilization of stock cards, availability of injection commodities (including needles and syringes, safety boxes, needle cutters and logistics manuals), injection safety practices of health workers, and waste management. Final waste disposal methods were studied and alternatives suggested. Avoiding exposure to needle stick injuries and post exposure management were emphasized at all these visits. The findings of these supervision visits confirmed that the commodities procured by this project had reached the districts (although some stockouts were subsequently reported in January 2005 as mentioned above). The visits also indicated that the incidence of injection abscesses had decreased.

Preliminary findings of supervision visits conducted in December 2004 using the MMIS health facility assessment tool showed an improvement in the proportion of injections being given with needles and syringes from sealed packs to over 90%. In exit interviews, patients expressed satisfaction that all injection devices used on them were coming from sealed packs and that they were not being given equipment to take home with them. They stated that this increased their confidence in the public health care system. Another improved practice among providers was a reduction in two-handed recapping to 22%. (This figure is still considered high, and the project is exploring alternative strategies to further reduce this practice). A reduction in needle stick injuries was reported from 44% at baseline to 22%. Provision of needle cutters for immediate removal of the needle after injection administration were seen as contributing to the reduction in needle stick injuries as well as increasing public confidence in the injections provided (as reported in exit interviews of patients). The fact that the patients see the needles being cut off proves to them that the equipment will not be used again. The proportion of facilities with needle cutters increased from 5% in July 2004 to 70% in December 2004. The presence of overflowing sharps containers was reduced from 15% to 5%, further reducing the incidence of needle stick injuries. Finally, the number of facilities with loose, used sharps around the health facility decreased from 21% to 5%. The analysis of these evaluation findings has yet to be finalized; a detailed report has been drafted and is undergoing technical review to solidify this preliminary analysis.

A health facility assessment was conducted in the first set of expansion areas in July 2005. Analysis of the baseline findings in these districts is being finalised and a detailed report is to be submitted for technical review soon.

Routine supervision findings indicate that the injection safety situation has improved in the project districts. Re-use of devices is markedly reduced by use of syringes with re-use prevention features. Area supervision teams are mentioning that there appears to be a big gap in terms of safety between injection safety implementation districts and other districts that are not yet benefiting from this

project. Supervisors' reports continue to show that there is a high level of awareness among service providers on injection safety issues and that stockouts are few and brief.

In other data collection outside the MMIS project, the EPI Surveillance Officer reported to the Ministry of Health that for the first time in many years, injection neuritis was not the major cause of acute flaccid paralysis. 2004 EPI data shows that the cases of acute flaccid paralysis dropped to less than half of what they used to be. It is thought that improved injection practices have contributed to this as there is no other readily available explanation or intervention.

Highlight: Safe Injection Commodities Arrive in MMIS Project Countries for Distribution to Project Sites

To support the increased availability of safe injection commodities in curative services, as well as safe disposal of the same, a pooled procurement was organized by JSI and its subcontractor PATH for all countries to achieve an economy of scale. To increase this scale even further, JSI's CDC-sponsored countries were included in the same procurement.

The procurement for the four USAID countries included over 9.5 million new disposable needles and syringes, more than 100,000 safety boxes, and over 1,500 needle removers. The vast majority of the syringes that were procured have reuse features and/or reuse and needlestick prevention features in accordance with host country preferences and policies.

All countries' supply needs were consolidated into one international tender, including transportation to the countries. The first shipments of the centrally-procured commodities were made in September 2004. Ethiopia, Nigeria and Uganda received the first air freight shipments of injection devices and distributed them to their implementation sites. Sea freight shipments of the remaining items (including all devices for Mozambique) arrived in the countries by the end of December 2004 in most cases and were distributed facilities in the project's initial implementation areas according to the local country plans.

Lessons learned in this first pooled procurement will provide valuable insights into planning for the second procurement, which is expected to provide increased numbers of commodities to support scaling up to additional districts in MMIS countries. The second procurement will start with a tender in April 2005. It is expected that shipments of commodities will arrive in project countries by August 2005.



Dr. Abdulsalam Nasidi, Director of Special Projects at the Federal Nigerian Ministry of Health receives the MMIS commodities procured by this project from Dawn Liberi, USAID Mission Director, and Dr. Abimbola Sowande, MMIS/ Nigeria Country Director in a ceremony in January 2005.

Highlight: South-to-South, Cross-Project Collaboration in BCC

In March 2005, Ms. Lonna Shafritz of AED and Mr. Richard Okwii, BCC Advisor for Uganda, visited Tanzania to orient the new BCC Advisor, Mr. Nassoro Ally, on behavior change, communication and advocacy approaches and activities for his new assignment with MMIS/Tanzania (a CDC- funded country program). Mr. Ally was thus able to benefit from Mr. Okwii's practical experience in developing and implementing an injection safety BCC strategy and activities. This visit also provided Mr. Okwii the opportunity to receive Ms. Shafritz' feedback on Ugandan products.



During this trip, Mr. Okwii presented the process of developing a communication strategy from his country's perspective and shared a copy of the strategy with them. The group reviewed the draft brochures, posters and radio messages from Uganda which were developed as part of the communication strategy. They also reviewed the draft advocacy strategy for Uganda to show the Mr. Ally what areas of advocacy are being promoted by the MMIS Project. They then reviewed the Tanzanian advocacy strategy (developed by the prior advisor) and revised it to reflect clear advocacy issues. Mr. Okwii also contributed to revising the BCC materials, the proposed logo for Tanzania, and the interpersonal communications training manual for all the MMIS countries.

Following this visit, Mr. Okwii and Mr. Ally have remained in contact for further collaboration.

In addition to the joint discussions with Tanzania, Mr. Okwii collaborates with the BCC Advisor of Kenya to share ideas in the development of materials and other BCC tools such as monitoring and evaluation forms. The MMIS Project as a whole remains open to other opportunities for this type of inter-country collaboration.

Sample Ugandan poster

Highlight: Getting Key Local Government Officials to Advocate for Injection Safety in Mozambique

On the first day of the two-day workshop on Injection Safety and Waste Management, Quelimane's Provincial Health Director, Dr. Mussa, and Quelimane's City Health Director, Mr. José Chiringa Sande, (better known as "Zeca") officially opened the workshop with a speech of welcome, motivation and support to the Injection Safety Project. After this official introduction and the presentation of the results from the baseline in Quelimane, the participants, including Mr. Zeca, joined one of four parallel working groups.

As a nurse with 26 years of experience and the responsibility for managing the providers of the city's health facilities who participated in this training workshop, Mr. Zeca made an invaluable contribution to the discussions.

He listened to health providers under his supervision as they mentioned their difficulties and worries related to injection safety and waste management. In the working groups, he was one of the more dynamic participants. He raised questions and doubts that spurred his fellow participants to feel free to voice their doubts in front of their director.



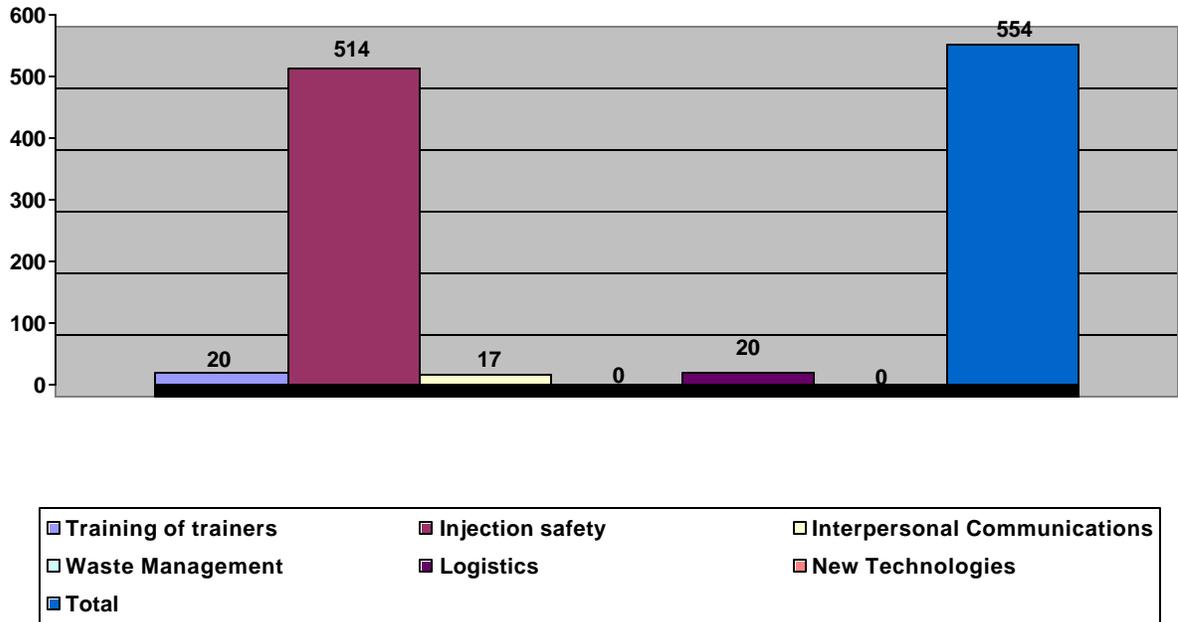
At the waste management workshop, the last of three trainings held in Quelimane, Mr. Zeca again was present. He participated in a program for the heads of facilities and their preventive medicine staff. After this workshop, he informed the local MMIS team that he wanted the topic of injection

safety to continue to be high on the agenda of all the facilities. To ensure constant attention to this issue and political support from the Province, he has advocated to have Safe Injection selected as the theme of this year's "*Concelho Coordenador*" (the coordinating council of the province) where JSI presented its injection safety project and the results of the baseline conducted in Quelimane's facilities.

Mr. Zeca also set up an Injection Safety Core Group (*núcleo de IS*) within the city to promote continuity and follow up on injection safety (IS) and waste management (WM) issues. All facility heads and heads of preventive medicine are in this group, as well as the members of the Injection Safety Technical Group that facilitated the trainings. Beginning in December 2004, this working group started gathering once a month to follow up on IS and WM and to exchange ideas and discuss problems that are being encountered in the facilities as they work to follow the IS guidelines. The local MMIS team was pleased to see this local initiative emerging as a result of the first rounds of training.

Annex 1: Summary of Training Data by Subject

Ethiopia

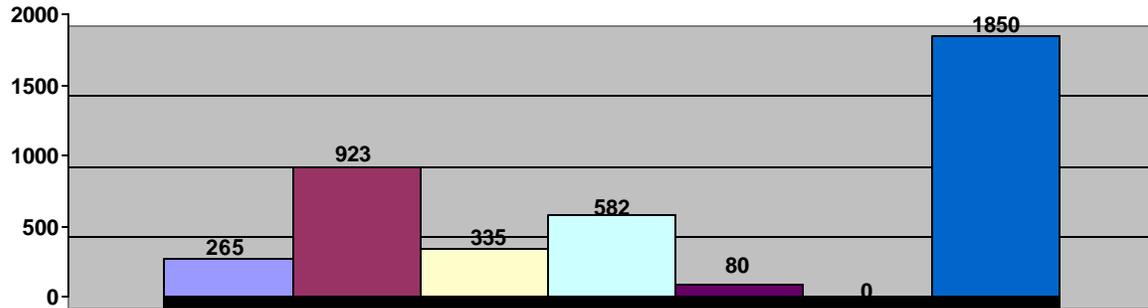


Note: Training in interpersonal communications and new technologies is assumed to involve the same health workers who were trained in injection safety so those figures are not included in the “Total” column in order to minimize duplication.

Mozambique



Nigeria



Uganda

