

MILESTONE COMPLETION REPORT
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To : Chris McDermott
Chief, Population and Health
USAID Mission to Egypt

CC : Gary V. Kinney
Director, Contracts Division
USAID Mission to Egypt

From : Jestyn Portugill
Chief of Party



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Comments: Submitted in draft three months ago and now presented in final form, the Expansion Plan for New Methods was reviewed by Dr Moushira El Shafie, then First UnderSecretary, MOHP, and the MOHP Population Sector staff, and takes into consideration all their comments and recommendations. The plan is currently being implemented by the relevant staff at the Ministry of Health and Population.

**MINISTRY OF HEALTH AND POPULATION
POPULATION SECTOR
(MOHP/PS)**

EXPANSION PLAN FOR NEW METHODS
October 1, 1999 - June 30, 2002

USAID Project # 263-98P-005
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Table of Contents

| | <i>Page</i> |
|---|-------------|
| INTRODUCTION | 1 |
| BACKGROUND | |
| I. Safe Reproductive Health Program (SRH) | 2 |
| Situation Analysis | 3 |
| II. Progestin-Only Pills (POP) | 4 |
| III. Lactation Amenorrhea Method (LAM) | 4 |
| TARGETS | |
| I. SRH Program | 5 |
| II. POP | 6 |
| III. LAM | 6 |
| ACTIVITIES | |
| I. SRH Program | |
| 1. Upgrading of Facilities | 6 |
| 2. Training | 7 |
| 3. Providing Services | 8 |
| 4. Program Management | 9 |
| 5. Sustainability | 11 |
| II. POP | |
| 1. Pilot Testing | 11 |
| 2. Service Delivery | 12 |
| 3. Training | 12 |
| 4. IEC | 12 |
| III. LAM | 12 |

Time Schedule

Appendices

EXPANSION PLAN FOR NEW METHODS

October 1, 1999 - July 31, 2002?

INTRODUCTION

The need for postpartum / post abortion (PP/PA) contraception is highly recognized in Egypt. The importance of spacing for the health of the mother, the present child and the future baby is well known. The 1995 EDHS shows the current contraceptive prevalence rate to be 47.9%, 8.6% for spacing and 39.3% for limiting. The 1998 EIDHS has these rates as 51.8%, 11.0%, and 40.8%. The unmet need for spacing was 5.3% in 1995, and 3.7% in 1998. Mothers giving birth at hospitals are eligible for contraceptive use for spacing. According to the 1995 EDHS, facility delivery represents 32.5% of all births, 17.9% in public facilities, and 14.6% in private facilities (these rates for urban areas are 54.7%, and 30.2%). Many of these deliveries are at-risk cases referred to hospitals; these may especially need contraceptive use for spacing and possibly also for limiting.

A study by the Egyptian Fertility Care Society (EFCS) estimated that approximately 28,000 women come to Egyptian public sector hospitals each month for post abortion treatment or about 336,000 per year. All these cases need post abortive care. Only about one third of the cases are classified as spontaneous mis-carriage with certainty; the remainder can be considered as being largely avoidable through the provision of family planning¹. This group is potentially legible for post- partum insertion.

A study carried by El-Azhar University during the period from July 1997 to June 1998², revealed that out of 945 abortion cases given careful examination and counseling, 338 (35.8%) accepted IUDs. Of this total, 183 women accepted immediate insertion, while 155 accepted late insertion after 2 weeks. However, only 117 actually came for the insertion. The actual acceptance rate is thus 31.7%.

Two other methods are useful for lactating mothers, namely the progestin-only pills (POP), and the Lactation Amenorrhoea Method (LAM). Both these methods are considered for expansion in the POP IV project.

¹ The Egyptian Fertility Care Society, "Post abortion Case Load in Egyptian Public Sector Hospitals," February 1997.

² EL-Tagy A, Sakr E, "Post Abortive IUD Insertion," Research Management Unit, NPC, September 1998.

BACKGROUND

I. The Safe Reproductive Health Program

The safe reproductive health (SRH) program started in Egypt in 1993. The purpose was to improve maternal and child health in Egypt by increasing contraceptives access and options for Egyptian women. The strategy was to focus on the needs of high-risk women through a perinatal model, which forms the centerpiece of this strategy. The two key elements of the model are perinatal counseling for family planning and high quality postpartum contraceptive services. The main components of the program are postpartum IUD (PPIUD) and post abortion IUD (PAIUD) insertion, in addition to tubal ligation for medical indications. The success of the perinatal model rests on developing systems for informing and referring clients from different service points within the institution (in reach) and from external service sites (outreach).

Ambitious objectives were set. The program was to be introduced in 12 medical schools, eight Teaching Hospitals Organization (THO) hospitals, and over 100 MOHP hospitals³.

The key elements of the strategy were

- Comprehensive hospital-based service delivery package including PPIUD technologies, minilaparotomy under local anesthesia, infection prevention, information and counseling for clients, record system, client referral system inside the hospital, and follow-up systems.
- Involvement of University Medical schools.
- Setting of norms and standards.
- Involvement of nurses.
- Whole site orientation and training.
- Management committees.
- Quality improvement approaches and tools
- Emphasis on sustainability.

The situation at the end of 1999 was as follows

- The program is part of the MOHP/USAID SDP and is run by an SRH program coordinator.
- A Technical Assistance Committee (TAC) is in action and meets every three months. The First Undersecretary of the population heads the committee. Committee members include professors of Ob/Gyn from several universities; the First Undersecretary for Curative Health Sector; and representatives from THO, HIO, USAID, the MOHP/SDP project director, SRH program coordinator, and the POP IV technical advisor

The SRH program has been introduced in 4 medical schools, Alexandria, Mansoura, Ain Shams, and Assiut. University physicians were sent to Mexico for orientation and training on PPIUD, and to Kenya and the Dominican Republic for training on tubal ligation.

³ Evaluation of Egypt's Safe Reproductive Health Program, AVSC international, November 98.

- The postpartum program is active in eight governorate hospitals. These are: Dar Ismail in Alexandria, Kafr El Dawwar in Behera, Zagazig General Hospital in Sharkeya, Talkha Hospital in Dakahleya, Boulak El Dakroul Hospital in Giza, Helwan Hospital in Cairo, El Minya General Hospital in El Minya, and Assiut General Hospital in Assiut.
- Tubal ligation (minilaparotomy / local anesthesia, ML/LA) was introduced in five out of the eight hospitals: Helwan in Cairo, Boulak El Dakroul in Giza, Dar Ismail in Alexandria, El Minya General Hospital, and Assiut General Hospital.
- Comprehensive training curricula has been developed for Egypt.
- A 'whole site' systems orientation and training approach has been established.
- A collegial working relationship has been forged between the university medical schools and MOHP.

(See appendix 1 for achievements by the end of July 1999 & appendix 2 for the year 1999 situation)

Situation Analysis

The program does have many strengths, including:

- Intra-sectoral cooperation took place through Central Committees involving the Curative Sector, and Hospital committees, including relevant departments at the hospital
- Criteria for hospital selection are well established.
- Standards for facilities and equipments are available.
- A comprehensive service package has been designed.
- Training curricula are available.
- Training opportunities are provided through selected university hospitals.
- IEC material has been developed

On the other hand certain points need to be considered:

- Management systems are only partly in place.
- No Quality Assurance criteria have been developed to date.
- No supervisory checklist is yet designed.
- Supervision is not regular.
- The MIS is not yet designed, indicators have not been established, and there is no regular reporting.
- Management committees at central and local levels do not hold regular meetings.
- IEC material, though developed, is not available. It needs to be updated, distributed, and properly used.
- Infection control needs more training.
- The current number of trained physicians cannot provide 24 hours service.
- Nurses need more on-the-job training.

Potential for the SRH program includes:

- Involvement of the primary health care services for counseling and referral during the antenatal period.
- Coordination with MCH activities, and HM/HC project.

- Involvement of medical schools.

The program may be jeopardized by some factors:

- The physicians trained for SRH are Ob/Gyn specialists; while residents, who usually attend labor, are not included in the training program.
- The present incentives system for the SRH hospital staff is insignificant, while other hospital staff members do not receive any incentives. The success of the program depends on cooperation of other hospital staff for referral of cases. This staff may be unaware of the program, or they may be reluctant to communicate information, provide health education, or to refer legible cases.
- Mothers coming for delivery in the hospital are usually in labor. The time available for counseling is usually very short. Mothers may not stay in the hospital long enough to receive counseling, accept IUD insertion, and receive the service. There is a need to have mothers prepared before coming to the hospital.
- The agreement of the husband is a requirement, but he may not always be available at the time of labor. On the other hand, providing the husband with counseling and convincing him to approve PP/PA IUD, requires time and human resources, which are not always available in the hospital setting.

II. Progestin-Only Pills (POP)

POP was not introduced in the Public sector until the first half of 1999. Preparation for introduction began by including it in the updated Standards of Practice (SOP), which are now being printed by the MOHP/PS. Training on POP has been included in the basic training for physicians and nurses.

Organon pharmaceutical company is donating one million progestin-only tablets to the MOHP/PS over a period of five years, i.e., 7142 boxes per year. In return, the MOHP is expected to place POP on the list of contraceptives. This means that around 548 women per year can receive the POP. This group should be used for pilot testing. The quota for year 1 has been distributed on the 1st of August 1999 to 11 governorates, with directions to be distributed to MCH and Urban Health Centers. (See Appendix 3 for the distribution list)

POP is available in pharmacies and TV spots advertise the pills as not interfering with lactation. Some physicians working in MOHP service delivery points mentioned that the public asks for these pills.

III. Lactation Amenorrhea Method (LAM)

LAM is a method that depends on health education for successful breast-feeding. Its value is mainly for the health of the child. Information has been included in the Standards of Practice (SOP). LAM introduction is through integration with MCH services, and HM/HC project.

TARGETS

SRH Program

By program end, the POP IV project will achieve the following targets:

- All governorates will be covered by SRH program in the form of PP/PAIUD insertion. Phasing in of hospitals is shown in table 1. The number of hospitals is allocated to governorates according to its population. *(An ambitious target is to have the service available wherever a delivery room is available)*
- All government university hospitals will be offering PP/PAIUD
- In every hospital providing the service a trained physician and nurse will be available for educating and accepting mothers before discharge. Physicians and nurses will be trained in counseling skills, and infection control. The physicians are also trained in technical skills. Hospitals will have enough trained physician nurses to assure around-the-clock service availability
- Tubal ligation for medical indications will be available in eight MOHP hospitals and in all government University hospitals.
- Nine University hospitals will be providing training for ML/LA.
- Hospitals providing ML/LA will have at least three trained physicians and five trained nurses.
- IEC material will be available both for mass media and for counseling.
- As a modest target, for the first year, 10% of deliveries and post abortion cases would have PP/PA IUD successfully introduced. This should be increased to 20% thereafter.

Table 1: Phasing of SRH PP/PA IUD in different hospitals

| Date | Governorates | UH | GH | DH | THO | HIO | Total |
|-----------------|---|--|----|-----|-----|-----|-------|
| July 98-June 99 | Alexandria, Behera, Dakahleya, Sharkeya, Giza, Cairo, Menya, & Assuit | Alex, Ain-Shams, Assuit, Mansora | 7 | 1 | | | 12 |
| July 99-June 01 | Kalubeya, Menofeya, Gharbeya, Kafr-Elsheikh, Port-Said, Ismaileya, Suez, Fayoum, Beni-Suef, Souhag, & Qena, In addition to one hospital in each of the previous 8 governorates. | Cairo, Azhar, Suez-Canal, Tanta Zagazig, Menya, Souhag | | 36* | 9 | 12 | 64 |
| July 01-June 02 | The remaining 8 governorates, plus additional in the previous governorates | Benha, Fayoum? Beni-Suef? | | 23 | | | 26 |
| Total | | 14 | 63 | | 9 | 12 | 102 |

UH = University Hospital GH = General Hospital DH = District Hospital
 THO = Teaching Hospital Organization HIO = Health Insurance Organization

*To date 8 hospitals have been assessed

II. Progestin-Only Pill (POP)

By the end of the POP IV project

- POP training will have been introduced to all RH/FP physicians and nurses.
- POP will continue to be available in the private sector.
- Decisions will have been made on wide availability, pricing and source of funding for the public sector.

III. LAM

By the end of the POP IV project

- LAM will be included in the standard basic training for FP providers.
- LAM will be introduced with HM/HC activities in 5 governorates, and with MCH activities in all governorates.

ACTIVITIES

I. SRH Program

1. Upgrading of Facilities

1.1. Selection of hospitals

The priority in introducing the governorates is set according to the size of population. Within the governorate, selection of hospitals is based on the number of live births and birth terminations conducted by the hospital. In the governorates included in the HM/HC project, hospitals are renovated and equipped to provide Essential Obstetric Care (EOC) which will be added to the list of SRH activities. This has the following advantages:

- At-risk cases referred for EOC are eligible for SRH services
- The cost of renovation and equipment will be greatly reduced, as most of the renovations will be already made by the HM/HC project.

1.2. Renovations and equipment

The standards for renovations are already developed and implemented.

- Conduct institutional needs assessment for the selected hospitals
- Bids for renovations are handled by the governorates
- The list of equipment is standardized. Equipment for all hospitals included in the program is provided by the SDP project.

2. Training

SRH training programs have been available since the AVSC project in early 1990. Training covers technical skills, infection control, and counseling.

In each hospital, six nurses are trained in infection control and counseling. They are joined by four physicians in, and also receive technical training. This training is offered at the central and governorate level.

Central level training is conducted by universities and includes technical training for physicians (from other universities, MOHP, THO & HIO) on PP/PA IUD, and for selected hospitals on ML/LA tubal ligation.

Governorate training covers counseling and infection control, and is offered to both physicians and nurses.

The basic training courses for PHC workers will include training on counseling for PP care and referral systems.

Training activities include:

2.1. Review SOP

The SOP and the system for training are going to be reviewed. This is the responsibility of the SRH coordinator, SRH consultant, the training unit and Pathfinder. This activity will also include:

- Development of guidelines for the hospital staff and for PHC workers to counsel clients and refer to hospitals.
- Development of guidelines for medical indications for tubal ligation, with a scoring system.
- Designing and printing formats for consent for tubal ligation.

2.2. Implement training programs

For each selected hospital, identify the staff to be trained. At present training for PPIUD is conducted by the RCT, while ML/LA is provided by the four university hospitals (Ain Shams, Alexandria, Assuit, and Mansoura). With expansion of the program staff from the General hospitals will receive TOT For PPIUD, and will contribute to the training of staff from their own hospitals (on-the job-training), as well as train district hospital staff through attachments to the general hospital. The training will also be provided to residents, as they are the physicians that could be made available for the 24 hours..

Training will include

- Pre-placement training before introducing the program in new hospitals
- In-service training for new staff in hospitals providing the service. The training will cover PPIUD insertion as well as child spacing in general.
- Residents are will also be included in the training programs and will also receive on-the-job training through apprenticeship.
- Refresher training related to the needs identified through supervision.

2.3. Pre-implementation orientation seminars

Introduction of SRH program in a new hospital will start with an orientation seminar attended by the SRH hospital team, the hospital director, and key staff from relevant departments including Ob/Gyn., pediatrics, internal medicine, and others. This may be especially important to orient staff for cases medically eligible for tubal ligation, whether it is done in the hospital or to be referred. The SRH program coordinator, and trained hospital staff conduct these seminars.

2.4. Refreshing seminars

Twice per year the meeting of the hospital team building committee will be devoted to:

- Refreshing seminars on SRH issues,
- Self-assessment and evaluation for improvement of service.

2.5. Coordinate with Medical School curriculum development activities

One of the activities of POP IV is to develop the curriculum of medical schools in RH/FP topics. The SRH package will be included in this activity to develop both undergraduate, and postgraduate teaching.

3. Providing Service

The hospital-based service delivery package will include PPIUD technologies, mini labarotomy (ML/LA) under local anesthesia, infection prevention, information and counseling for clients, record system, client referral system inside the hospital, screening, and follow-up systems.

A package for safe abortion will be introduced. In addition to safe evacuation (the use of Manual Vacuum Extraction is considered), abortion care will include counseling for rest, resumption of marital life, resumption of fertility / PAIUD, etc.

3.1. Counseling

Acceptance of PP/PA IUD insertion immediately after delivery or within 48 hours, and before discharge from the hospital is highly dependent on counseling. Counseling is to be provided by the nurse and the physician attending labor. A limiting factor however, is that women coming for delivery usually come in labor. The time available for counseling is usually very short, and the mother in labor pain is not in the mood to be receptive to FP messages. On the other hand, after delivery women may be discharged after several hours, without enough time to provide counseling, or services.

As our ultimate goal is to increase contraceptive use for spacing, which has several advantages for reproductive health as well as the general health of the mother and the baby, the scope of health education and counseling will be increased to cover the following activities:

- 3.1.1. Revising and updating IEC material to be used inside and outside the hospitals in PHC facilities and the community.
- 3.1.2. Counseling inside the hospital and internal referral

- Counseling for women in labor wards, before or after delivery will be provided by the trained nurses and physicians. Messages would emphasize PPIUD. However, other methods suitable for lactating mothers would also be mentioned, e.g., 40th day IUD, injectables, POP, and Norplant as suitable. Mothers will be referred to appropriate service delivery points to obtain the method.
- Counseling for women in other hospital sections including: hospitalized cases for complicated pregnancy, cases eligible for ML/LA identified in any section, or even cases from outpatient hospital clinics.

3.1.3. Counseling outside the hospital and external referral

- Antenatal care specific messages are relevant to the SRH program. They encourage hospital delivery, taking into consideration availability of resources and prevailing culture; and the importance of spacing, the role of PPIUD as well as other methods for lactating mothers. Through this counseling the mother will have enough time to make an informed choice.
- The Raeda Rifeya (RR) provides health education to pregnant mothers at home, emphasizing the above-mentioned messages.

3.1.4. Mass Media: Mass media plays a very important role. It reaches the public as well as the health care providers. Relevant messages will be developed for spacing and PP/PAIUD.

3.2. Cross referral

Safe reproductive health is provided through the selected hospitals. The program will establish links between these hospitals and PHC in the area for cross referral and feedback. Health centers refer legible cases. Hospitals refer cases back to PHC for follow-up, to assure client satisfaction and support, check for IUD expulsion...etc. This feedback mechanism allows for continuity of client care.

4. Program Management

At the central level the program is managed by the SRH coordinator who is responsible for follow-up of the implementation of all program activities. Other SDP staff participates in some of these activities, under his direction. The SRH coordinator also participates in other SDP activities, specially the supervisory visits.

4.1. Management Committees

Two committees are planned to continue:

Technical Assistance Committee (TAC): The purpose of this committee is to provide technical advice related to the introduction of new contraceptive technologies, specially PP/PAIUD, and tubal ligation for medical indications. The committee is headed by the First Undersecretary of the Population Sector. Members include professors from university Ob/Gyn departments the First Undersecretary for Curative Health, representatives from the THO, HIO, USAID, SDP project director, technical advisor, and the SRH coordinator. This committee holds quarterly meetings.

Hospital Team Building Committee: The purpose of this committee is to enhance hospital activities and to initiate the concept of Continuous Quality Improvement (CQI). The meeting is to include heads of all relevant departments related to recruitment of clients for SRH interventions. The committee is headed by the hospital director, and includes ob/gyn., pediatrics, internal medicine, and the nurse director. A meeting will be held monthly to discuss progress, identify problems, suggest solutions, and follow-up implementation through a process of CQI.

Held twice per year, this meeting is used to conduct the semi-annual refreshing seminar to update the staff on recent knowledge.

Once a year the meeting will be devoted to discuss the results of evaluation (see 4.5)

Activities will include:

4.1.1. Review the role of each committee to assess its contribution to program development.

4.1.2. Develop guidelines and protocols for committee meetings at each level. The protocols will describe the role of the committee, the points to be discussed and expected outputs.

4.1.3. Conduct regular meetings with a preset agenda and points for discussion

4.1.4. Use committee recommendations for program development.

4.2. Management Information Systems (MIS)

4.2.1. Record System:

Records currently include personal medical records, log books for IUD insertion, referral cards, and client cards. However, there is no regular system for on-time reporting. Review the present recording system and develop records and logbooks to support technical care, referral, and follow-up of clients; and to provide data for supervision, monitoring and evaluation. The developed records should be simple, valid, and include relevant information only.

4.2.2. Develop a reporting system:

A system for timely, simple reporting will be developed to facilitate supervision, monitoring and evaluation. A provisional list of indicators is being developed.

4.3. Quality Assurance

Standards now used for assessment, renovations and equipment have to be further developed as quality improvement indicators (similar to the QIP program) to include performance indicators as well. A program similar to the Gold Star will be investigated.

4.4. Supervision

4.4.1 Supervisory checklist will be developed. The checklist will be based on the above-mentioned indicators.

4.4.2 Develop a supervision plan form the Central Level to assure continuity of providers motivation, compliance and good performance.

4.4.3 Involve the governorate FP director in follow-up of activities.

4.5. Evaluation

Ongoing evaluation is part of the monitoring system. Routine data collection should be used for evaluation and health systems research. Such data may be used to calculate service statistics, acceptance rates, expulsion rates, and effectiveness of the referral systems. Evaluation results are discussed during the meeting of the Hospital Team Building Committee.

5. Sustainability

Sustainability is an important issue. Pathfinder will provide technical assistance to assure that effective steps are being made towards sustainability. From a financial point of view, the cost of the program could be taken over by the MOHP which would eventually expand the program nationwide.

Technical training will be expanded to all university hospitals. It is also going to be introduced in postgraduate curricula. This process is starting during the LOP.

Large MOHP hospitals and THO hospitals will be used for technical training through attachments and apprenticeship.

Governorates will continue the training on counseling and infection control.

At present, the incentives for the physicians are very low, and not provided through project funds. They are paid by the price of the IUD inserted. Study the feasibility of developing a government incentive system, and other non-financial incentive mechanisms.

II. POP

1. Pilot Testing

The amount of POP donated by Organon pharmaceutical company will be used to test the operational as well as technical issues related to the acceptability, side effects and effectiveness of POP. MOHP still has to decide on who is going to take over this activity.

This will entail

- *Selection of the team to implement the pilot with the support of the TA*
- *Designing the methodology and tools for conducting the pilot*

- *Selection of two sites to implement the pilot (the amount donated per year is too small to be adequately distributed over a larger number of units).*
- *The sites selected should fulfill special criteria: (1) enough mothers attending for antenatal, natal postnatal and infant care in order to select the eligible women, (2) enough staff to provide services (3) the clinic should be well managed as evidenced by being a Gold Star clinic card and (4) should be easily accessible to the supervisory teams.*

2. Service Delivery

The MOHP decided to make POP available in the Public Sector in some governorates. MOHP will identify the source of funding.

4

3. Training

Training is already included in the basic training courses and will continue

4. IEC

Development of relevant IEC material

III. LAM

LAM is already included in the basic training for both physicians and nurses. This will continue.

Emphasis will be made on coordinating with MCH activities and breast-feeding promotion to:

- Explain the value and limitations of LAM
- Cross referral for more effective contraception methods

**Expansion Plan for New Methods
July 1999 - June 2002**

| | | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|------|------|------|------|------|------|------|------|------|------|------|------|
| I. SRH Program: | | | | | | | | | | | | | |
| 1. Upgrading of facilities: | | | | | | | | | | | | | |
| 1.1 Selection of hospitals | SRH coordinator & local consultant | | | 10 | 10 | 12 | 12 | 12 | 12 | 12 | 12 | 10 | |
| 1.2 Renovation and equipment | Governorate under-secretary & FP Director | | | | 10 | 10 | 12 | 12 | 12 | 12 | 12 | 10 | |
| 2. Training: | | | | | | | | | | | | | |
| 2.1 Review SOP | Training unit & Pathfinder TA | X | X | X | X | X | X | X | X | X | X | X | X |
| 2.2 Implement training | Training unit | X | X | X | X | X | X | X | X | X | X | X | X |
| 2.3 Orientation seminars | SRH coordinator & local consultant | | | | X | X | X | X | X | X | X | X | X |
| 2.4 Coordinate with medical school curriculum development | Training unit, Pathfinder TA, & EFCS contractor | | | | | | X | X | X | | | | |
| 3. Providing Service : | | | | | | | | | | | | | |
| 3.1 Counseling | | | | | | | | | | | | | |
| 3.1.1. Review and update IEC material | IEC unit & Pathfinder TA | | | | | X | X | | | | | | |
| 3.1.2. Counseling inside the hospital | Hospital staff | X | X | X | X | X | X | X | X | X | X | X | X |
| 3.1.3. Counseling outside the hospital | PHC staff | X | X | X | X | X | X | X | X | X | X | X | X |
| 3.1.4. Mass Media: - message development - broadcasting | IEC unit & Pathfinder TA | | | | | X | X | | X | X | X | X | X |
| 4. Program Management: | | | | | | | | | | | | | |
| 4.1 Management committee | | | | | | | | | | | | | |
| - TAC | SRH Coordinator | X | X | X | X | X | X | X | X | X | X | X | X |
| - Hospital team building committee | Hospital directors | X | X | X | X | X | X | X | X | X | X | X | X |

**Expansion Plan for New Methods
July 1999 - June 2002**

| | | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|--|---|------|------|------|------|------|------|------|------|------|------|------|------|
| 4.2 MIS | | | | | | | | | | | | | |
| 4.2.1. Review present record system | SRH coordinator local consultant & Pathfinder TA | | | | | | X | | | | | | |
| 4.2.2. Develop the reporting system | SRH coordinator, local consultant & Pathfinder TA | | | | | | | X | X | | | | |
| 4.3 Quality Assurance Develop Indicators Directors | SRH coordinator, & STTA | | | | | | X | | | | | | |
| 4.4 Supervision | | | | | | | | | | | | | |
| 4.4.1. Develop supervisory checklist | SRH coordinator, & STTA | | | | | | X | | | | | | |
| 4.4.2. Develop supervision plan | SRH coordinator, & governorate teams | X | X | X | X | X | X | X | X | X | X | X | X |
| 4.4.3. Implement Supervision | SRH coordinator, & governorate teams | X | X | X | X | X | X | X | X | X | X | X | X |
| II. POP | | | | | | | | | | | | | |
| 1. Pilot testing | | | | | | | | | | | | | |
| - Selection of organization to conduct pilot | First undersecretary POP Sectors | | | | | | X | | | | | | |
| - Conduct pilot | Selected organization | | | | | | | X | X | X | X | X | |
| 2. Service delivery | PHC staff | | | | | | | X | X | X | X | X | |
| 3. Training | Training Unit | X | X | X | X | X | X | X | X | X | X | X | X |
| 4. IEC material | IEC unit & Pathfinder TA | | | | | | X | X | | | | | |
| III. LAM | | | | | | | | | | | | | |
| Implement in coordination with MCH | PHC staff | | | | | | X | X | X | X | X | X | X |

APPENDIX 1

إنجازات برنامج الصحة الإنجابية الآمنة

تركيب اللولب بعد الولادة PPIUD

ربط الأنابيب الاختيارى لدواعى طبية ML/LA

- ادخل برنامج الصحة الإنجابية الآمنة (تركيب اللولب بعد الولادة PPIUD وربط الأنابيب الاختيارى بمخدر موضعى ML/LA) في وزارة الصحة والسكان في يناير ١٩٩٨ مشاركة بين قطاع السكان وتنظيم الأسرة و القطاع العلاجى بالوزارة.

- تم اختيار ٨ محافظات كمرحلة أولى بناء على توصيات اللجنة الاستشارية العليا (TAC) للعمل بها . وكان الاختبار على أساس التوزيع الجغرافي والمحافظات هي :

| | |
|------------|---------|
| الإسكندرية | القاهرة |
| البحيرة | الجيزة |
| الشرقية | المنيا |
| الدقهلية | أسيوط |

- تم اختيار ٨ مستشفيات في هذه المحافظات : وكان الاختيار طبقا لعدد الولادات في هذه المستشفيات وهي :

- م / دار اسماعيل للولادة - الإسكندرية
- م/ كفر الدوار العام - البحيرة
- م/ طلخا المركزى - الدقهلية
- م/ الزقازيق العام - الشرقية
- م/ بولاق الدكرور العام - الجيزة
- م/ حلوان الجديد - القاهرة
- م/ المنيا العام - المنيا
- م/ أسيوط العام - أسيوط

- قامت لجنة الإدارة العليا (٤ أطباء من مشروع تنمية النظم ، ٤ أطباء من القطاع العلاجي) بعمل زيارات للمستشفيات لتقييم واختيار المكان المناسب لعيادة الصحة الإنجابية الآمنة داخل قسم الولادة بالمستشفى .
- تم تجديد وتطوير الأماكن المختارة لعيادة PPIUD في المستشفيات التي دخلت البرنامج.
- تم تجهيز عيادات الصحة الإنجابية الآمنة بجميع التجهيزات الطبية والآثاثات الغير طبية منها جزء محلي والجزء الآخر من الولايات المتحدة الامريكية بتمويل من هيئة AVSC الدولية .
- تم عمل حلقات عمل للتعريف بالبرنامج في كل مستشفى للتوعية بالبرنامج ومكوناته والتركيز على منع انتشار العدوى.
- تم إعداد المطبوعات الخاصة بعيادات الصحة الإنجابية الآمنة وتشمل سجلات قيد المتنفعات بتركيب اللولب بعد الولادة وكروت خاصة بالمتنفعات وكروت تحويل من العيادات الأخرى لعيادة الصحة الإنجابية الآمنة . وقد تم توزيعها على جميع المستشفيات التي تقدم خدمة تركيب اللولب بعد الولادة.
- تم عمل مطويات خاصة بتركيب اللولب بعد الولادة وكذلك مطويات ربط الأنابيب لدواعي صحية بمخدر موضعي كما أعدت الملصقات الخاصة بالبرنامج وتم وضعها في المستشفيات التي تقدم الخدمة .
- تم عقد المؤتمر السنوي الاول لبدء العمل في برنامج الصحة الإنجابية الآمنة في وزارة الصحة والسكان وكان الهدف من المؤتمر تدعيم التعاون بين الجامعات المصرية ووزارة الصحة والسكان لتقديم خدمات الصحة الإنجابية الآمنة.
- قامت لجنة تقييم البرنامج من هيئة AVSC الدولية من الولايات المتحدة الامريكية بزيارة المستشفيات التي بدأت بها الخدمة لتقييم عيادات الصحة الإنجابية الآمنة وقد أشاد التقرير بحسن سير العمل والنظام في العيادات.

- بدأت الخدمة الفعلية في عيادات الصحة الإنجابية الآمنة PPIUD بالمستشفيات في يناير ١٩٩٩ .

التدريب :

- يوجد ٤ مراكز تدريب بأقسام النساء والتوليد بالجامعات للقيام بالتدريب العملى على تركيب اللولب بعد الولادة PPIUD وربط الأنابيب الاختيارى بمخدر موضعى ML/LA
- جامعة عين شمس
- جامعة الإسكندرية
- جامعة المنصورة
- جامعة أسيوط
- تم تدريب عدد ٥٤ أخصائى نساء على تركيب اللولب بعد الولادة PPIUD.
- تم تدريب عدد ١٠ أخصائى نساء على ربط الأنابيب الاختيارى بمخدر موضعى ML/LA
- تم تدريب ٢٥٢ مشارك (أطباء وممرضات) على منع العدوى Infection Control
- تم تدريب عدد ٩٨ مشارك (أطباء وممرضات) على المشورة Counseling
- تم عقد دورة تدريب مدرين TOT لعدد ١٦ مشارك (رئيس قسم النساء + رئيسة التمريض بالمستشفى) في الثمانى مستشفيات التى تقدم الخدمة.
- قام عدد ٥ أطباء من قطاع السكان والقطاع العلاجى بزيارة دراسية لدولة الدومينيكان للإطلاع والاستفادة من الخبرة فى مجال تركيب اللولب بعد الولادة PPIUD.

APPENDIX 2

ملخص تقرير عن خدمات الصحة الآمنة (SRH) المقدمة بمستشفيات وزارة الصحة

| تنشئ | نوع الخدمة | | عدد العاملين بقسم النساء والتوليد | | عدد من تم تدريبهم وعلى رأس العمل | | حالات الولادة والأجهاض عام ٩٩ | حالات تركيب اللوالب بعد الولادة والإجهاض وحالات ربط الإنابيب والنسبة المئوية عام ١٩٩٩ | | | | | | |
|--------------|------------|-------|-----------------------------------|--------|----------------------------------|--------|-------------------------------|---|------------------|----------------------|-------------------|--------------|--------|--------|
| | T.L | PPIUD | أطباء | حكيمات | أطباء | حكيمات | | تركيب بعد الولادة | تركيب قبل الخروج | تركيب أثناء القيصرية | تركيب بعد الإجهاض | ربط الأنابيب | إجمالي | % |
| طلخا | - | + | ٢٤ | ١٣ | ٩ | ٦ | ١٥٠٤ | ١٢٣ | ٨٤ | ٢٣ | ٢٢ | - | ٢٥٢ | ١٦,٧٥% |
| دار ماعيل | + | + | ٢٣ | ١٥ | ٦ | ٦ | ٨٢٨٨ | ? | ? | ? | ? | - | ٨ | ٠,٠٩% |
| الدوار | - | + | ٨ | ١٢ | ٣ | ٤ | ٥١٨٥ | ١٢٧ | ١٨ | - | ٣٩ | - | ١٨٤ | ٣,٥% |
| سيوط العام | + | + | ٩ | ١٢ | ٣ | ٣ | ٢١٩٩ | ٩ | ٥١ | - | ٧ | ٤ | ٧١ | ٣,٢% |
| نيا العام | - | + | ١٨ | ١٢ | ٦ | ٦ | ٢١٥٥ | ٣٣ | ١ | ٤ | ١٢ | - | ٥٠ | ٢,٣% |
| زقازيق العام | + | + | ٤٠ | ١٥ | ١٢ | ١٠ | ٥٠٤٥ | ١٣٥ | ١٣٨ | ٦ | ٣٢ | - | ٣١١ | ٦,٢% |
| بولاق لذكور | + | + | ? | ? | ٦ | ٣ | ٥٨٤٠ | ٢٣ | ٦٤ | ٧ | ٢٦ | - | ١٢٠ | ٢% |
| حلوان | + | + | ٤١ | ١١ | ٩ | ٩ | ٦٣٨٦ | ١٦ | ٦٠ | ٢٦ | ٧ | - | ١٠٩ | ١,٧% |

| التدريب | | | | معالجة انتشار العدوى | | | | IEC Material | | | | المشورة | | | | Referral System | High Risk Indicators | Standards | السجلات | | | | | | | |
|--|---------------|---|---------------|----------------------|-------|-----------------|----|---------------------|----|-------------------------|----|------------|-------|---------------|----------|-----------------|----------------------|---------------|--------------|----------------------|--------------|--|-----------|------------|---------------|---------|
| حكومات | | اطباء | | مستوى الاداء | | النظام المستخدم | | هل يتم توظيفها جيدا | | المحتوى يحتاج الي تعديل | | هل متوافرة | | مستوى التدريب | | | | | معد الحكومات | | مكان تقديمها | | سجل منظمة | كارت منظمة | استمارة منظمة | سجل علم |
| المسار الاحد | مستوى التدريب | مستوى الاداء | مستوى التدريب | تدريب | مركزى | الرن | لا | نعم | لا | نعم | لا | نعم | مستوى | جيد | غير كافي | | | | كافي | بعد الولادة والإجهاد | الحوامل | جيد | متفهم | متفهم | متفهم | علم |
| تحتاج الي زيادة تقديم الخدمة على مدار ٢٤ ساعة يوميا طوال الأسبوع | مستوى التدريب | تحتاج الي زيادة لتقديم الخدمة على مدار ٢٤ ساعة يوميا طوال الأسبوع | مستوى التدريب | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | لاستخدام دائما | + | | | |
| " | " | " | مستوى التدريب | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | لاستخدام دائما | + | | | |
| " | " | " | مستوى التدريب | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | لاستخدام دائما | + | | | |
| " | " | " | مستوى التدريب | + | + | + | + | + | + | + | + | + | + | + | + | + | + | لا توجد حوايل | + | + | + | لاستخدام دائما | + | | | |
| " | " | " | مستوى التدريب | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | لم يستلم القسم أي سجلات (الفتت بالمستشفى بعد تسلمها) | | | | |
| " | " | " | مستوى التدريب | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | لاستخدام دائما | + | | | |
| " | " | " | مستوى التدريب | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | لاستخدام دائما | + | | | |
| " | " | " | مستوى التدريب | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | + | لاستخدام دائما | + | | | |

اقتراحات العاملين بالمستشفيات لتحسين الأداء

| المستشفى | الاقتراحات والآراء |
|-------------|---|
| طلخا | <ol style="list-style-type: none"> 1. زيادة عدد مقدمى الخدمة ليتسنى تقديم الخدمة على مدار ٢٤ ساعة طوال الأسبوع . 2. عمل دورات تنشيطية فيما يتعلق بالمشورة و مكافحة انتشار العدوى On Job Training. 3. تزويد الخدمة بالمستهلكات اللازمة حيث يوجد نقص بها . 4. إيجاد مصدر للحوافز للعاملين المتميزين بالمشروع . |
| دار إسماعيل | <ol style="list-style-type: none"> 1. زيادة عدد مقدمى الخدمة ليتسنى تقديم الخدمة على مدار ٢٤ ساعة طوال الأسبوع . 2. عمل دورات تنشيطية فيما يتعلق بالمشورة و مكافحة انتشار العدوى On Job Training. 3. تقديم الخدمة مجانية للمتنفعة حيث أن مبلغ جنيهاً يعتبر مبلغ كبير بالنسبة لها !!!! 4. يجب حصول مقدمى الخدمة من الأطباء و الحكيمات على حوافز مناسبة حتى يتسنى الأهتمام بتقديم الخدمة (مثل مشروع الرضاة الطبيعية حيث تحصل الحكيمة على مقابل نظير تقديمها للخدمة) .!!!! |
| كفر الدوار | <ol style="list-style-type: none"> 1. زيادة عدد مقدمى الخدمة ليتسنى تقديم الخدمة على مدار ٢٤ ساعة طوال الأسبوع . 2. عمل دورات تنشيطية فيما يتعلق بالمشورة و مكافحة انتشار العدوى On Job Training. 3. تزويد الخدمة بالمستهلكات اللازمة حيث يوجد نقص بها . 4. إيجاد مصدر للحوافز للعاملين المتميزين بالمشروع و خاصة الحكيمات. 5. زيادة عدد أسرة قسم الولادة الى العدد المناسب للحالات المترددة على القسم يومياً (٢٥ حالة يومياً حيث ان عدد الأسرة الحالى ١٢ سرير مما يؤدي الى عدم بقاء الوالدة الوقت الكافى بقسم النساء بالمستشفى . 6. لابد من وجود علاقة بين المستشفى و وحدات تنظيم الأسرة فى محيطها حتى يتسنى للأطباء فى الوحدات التعرف على هذه الخدمة و كيفية متابعة الحالات اذا ذهبت اليهم . |
| أسيوط | <ol style="list-style-type: none"> 1. زيادة عدد مقدمى الخدمة ليتسنى تقديم الخدمة على مدار ٢٤ ساعة طوال الأسبوع . 2. عمل دورات تنشيطية فيما يتعلق بالمشورة و مكافحة انتشار العدوى On Job Training. 3. تزويد الخدمة بالمستهلكات اللازمة حيث يوجد نقص بها . 4. إيجاد مصدر للحوافز للعاملين المتميزين بالمشروع و خاصة الحكيمات. <p>تعليل سبب انخفاض معدلات تقديم الخدمة الى دور الزوج الرئيسى بالنسبة لموافقته على استخدام وسيلة من عدمه .</p> |

| | |
|--------------------|--|
| <p>المنيا</p> | <p>١. زيادة عدد مقدمي الخدمة ليتسنى تقديم الخدمة على مدار ٢٤ ساعة طوال الأسبوع . ٢. عمل دورات تشييطية فيما يتعلق بالمشورة و مكافحة انتشار العدوى On Job Training . ٣. تزويد الخدمة بالمستهلكات اللازمة حيث يوجد نقص بها . ٤. إيجاد مصدر للحوافز للعاملين المتميزين بالمشروع و خاصة الحكيمات . ٥. إنشاء عيادة متابعة حوامل بالمستشفى حيث لا توجد حاليا عيادة متابعة حوامل .</p> |
| <p>الزقازيق</p> | <p>١. زيادة عدد مقدمي الخدمة ليتسنى تقديم الخدمة على مدار ٢٤ ساعة طوال الأسبوع . ٢. عمل دورات تشييطية فيما يتعلق بالمشورة و مكافحة انتشار العدوى On Job Training . ٣. تزويد الخدمة بالمستهلكات اللازمة حيث يوجد نقص بها . ٤. إيجاد مصدر للحوافز للعاملين المتميزين بالمشروع و خاصة الحكيمات . ٥. تزويد القسم بجهاز جديد U/S حيث ان الموجود حاليا قديم جدا منذ ٢٠ عام ليتسنى تقديم خدمة متابعة استخدام الوسيلة</p> |
| <p>بولاق العام</p> | <p>١. زيادة عدد مقدمي الخدمة ليتسنى تقديم الخدمة على مدار ٢٤ ساعة طوال الأسبوع . ٢. عمل دورات تشييطية فيما يتعلق بالمشورة و مكافحة انتشار العدوى On Job Training . ٣. تزويد الخدمة بالمستهلكات اللازمة حيث يوجد نقص بها . ٤. لا بد من وجود حوافز للأطباء و الحكيمات ليتسنى لهم تقديم الخدمة ٥. تليل سبب انخفاض معدلات تقديم الخدمات الصحة الأنجابية الآن يرجع الى : < منطقة إجرامية (جاذبة الى العناصر الإجرامية) < زوج سي . < خروج مباشرة بعد نصف ساعة من الولادة . ٦. تتم الولادة بالمستشفى نظير " ٥٠ " جنيتها و لو شمل ذلك تركيب اللولب بعد الولادة سوف تتمسك السيدة بطلب اللولب و تركيبة ضمن تكاليف الولادة . ٧. تجهيز غرفة عمليات ولادة موجودة فعلا و لكن يمكن ان تساهم في رفع كفاءة تقديم الخدمة و نحتاج الى تجهيزات بسيطة (منضدة عمليات + أوتوكلاف أو فرن + جهاز بنج)</p> |
| <p>حلوان</p> | <p>١. زيادة عدد مقدمي الخدمة ليتسنى تقديم الخدمة على مدار ٢٤ ساعة طوال الأسبوع . ٢. عمل دورات تشييطية فيما يتعلق بالمشورة و مكافحة انتشار العدوى On Job Training . ٣. تزويد الخدمة بالمستهلكات اللازمة حيث يوجد نقص بها . ٤. التشجيع المعنوي : < مؤتمرات . < خطاب من رئيس قطاع السكان بالثناء على المجهود المبذول</p> |

APPENDIX 3

وزارة الصحة والسكان
قطاع السكان وتنظيم الأسرة

صناديق
٤٧-
١٩٩٩/٩/١٨

السيد الدكتور / مدير التموين الطبى بالعباسية
تحية طيبة وبعد ،،،

إيماء الى خطابنا صادر رقم ٥١٢ بتاريخ ١٩٩٩/٨/١ بشأن استلام كمية سبعة
آلاف ومائة واثنين واربعون علبة Exluton tab .
نأمل الاستلام من مندوب شركة اورجاتون والتوزيع منها كالاتى بالمجان :

| | |
|-------------------|-----------|
| محافظة القاهرة | ١٨٤٢ علبة |
| محافظة بورسعيد | ٣٠٠ علبة |
| محافظة الاسكندرية | ١٠٠٠ علبة |
| محافظة الجيزة | ٥٠٠ علبة |
| محافظة البحيرة | ٧٠٠ علبة |
| محافظة المنيا | ٥٠٠ علبة |
| محافظة الدقهلية | ٥٠٠ علبة |
| محافظة الغربية | ٥٠٠ علبة |
| محافظة الشرقية | ٥٠٠ علبة |
| محافظة اسيوط | ٣٠٠ علبة |
| محافظة الفيوم | ٥٠٠ علبة |

وتفضلوا بقبول وافر التحية ،،،



رئيس قطاع السكان وتنظيم الأسرة

د. مشيرة الشافعى

١٩٩٩/٩/١٨