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YEMEN - Basic Health Services Project

SECTION I: PRESENTATION OF ACTIVITIES BY INTERMEDIATE RESULTS AS PER WORK PLAN

Activity by IRs and Sub-IRs	Accomplishments in this Reporting Period	Progress to Date (Since inception of activity)	Status (Ongoing/Completed) and Challenges/Constraints
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Project Name	Basic Health Services		
Project Number	279-A-00-06-00004-00		
Project Duration (LOP)	Dec 13-2005 – December 13- 2008		
CTO/TA	Iman Awad / Bryn Sakagawa		

IR 5.1: Increased Access to Quality Health Services and Participation at the Community Level

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<p>5.1.1: Health facility refurbishments in all five Governorates</p>	<p>Construction: Among the 649 health facilities in the 5 governorates, BHS targeted the 84 largest facilities for assistance (usually the main facility in each district).</p> <p>A total of 22 health facilities started to be renovated in 2006 and were completed in 2007. In many cases the existing clinics were expanded by adding housing for health providers and an extension for normal delivery services if one was not available.</p> <p>Furniture & Equipment: In 2007, furniture and equipment were supplied to 62 facilities including substantial medical equipment to health centers that were refurbished and basic instruments and equipment to smaller health units which are visited by mobile teams.</p> <p>More needed refurbishments were planned for 2007 and 2008 as per the needs assessment, but due to shortage of funds from USAID, no new renovations were initiated in 2007.</p> <p>The assistance to the targeted governorates was at risk of being stopped due to security concerns. USAID director has indicated that while committed to continue support to the original five areas USG assistance will be focusing on new governorates that show high need and where local authorities have better security preparedness. . Deadly attacks by terrorists against foreigners in July and December 07 and regular infighting in various regions have contributed to this overall assessment.</p> <p>Supervisory visits and activities including deliveries of equipment and furniture were often delayed due to security restrictions in the current 5 governorates</p> <p>Maintenance of facilities and equipment provided will be a constant concern as facilities budgets are very inadequate and staff are not trained in maintenance. BHS Coordinators are instructed to deal with needs for repairs. BHS carries out regular checks on buildings, vehicles and equipment, and repairs of PHS provided equipment are done anytime a need arises.</p>
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<p>5.1.2: All BHSP assisted health facilities fully staffed per MOPHP standards</p>	<p>The Ministry of Health does not have sufficient resources to employ medical staff in all the facilities. Not enough trained personnel to meet the needs especially for doctors. There is a severe imbalance in the distribution of human resources across the country.</p> <p>Corruption and abuse are widespread in the system: numerous posts are occupied by unqualified staff or staff who are paid but do not report to work. Numerous facilities remain closed although they have staff –on paper . The staffing of facilities is regularly discussed with the governorate authorities and with the Minister of Health, particularly to bring doctors to new facilities and to hire newly trained midwives.</p> <p>The BHS project worked with the MOPHP- RH department to support its service statistics service and to have access to quarterly statistics collected by the RH department.</p> <p>Information is regularly sought out from the governorates on staffing in health facilities;</p> <p>The BHS project pre-service training of midwives and the provision of 10 mobile teams are some of the immediate solutions this USAID project has applied to the issue of staffing shortages. The BHS project has also completed building and repairs of 18 multiple housing units for health service providers to encourage migration of staff to understaffed areas and improve retention.</p>
<p>5.1.3: Staff from health facilities trained in delivery of quality FP/MCH services</p>	<p>This is an on going activity and a recurring need due to the very poor level of staff skills and absence of regular supervision and continuing education. Health service providers are often left alone for years without refresher training. The absence of programs for continuing education and the lack of regular and effective supervision makes it unlikely for staff to benefit from any kind of regular updating of their skills or knowledge. Furthermore, there are many positions on health facilities which are staffed by totally unskilled workers due to corrupt recruitment practices where positions are distributed among relatives and tribal members. New midwives are needed to improve coverage and increase the level of skilled attendance for home births. However newly graduated midwives face a challenge in securing employment in government facilities due to lack of resources as well as poor human resource management in the ministry of health. BHS has begun to address this challenge by encouraging private midwives</p> <p>In 2007, a total of 595 health care providers completed short term in-service training under this project, and 214 midwives started a basic 2 year pre-service training and will graduate in 2009, while 16 morshidat from Al Jawf are undergoing a 1 year pre-service training upgrading them to midwives.</p>
<p>5.1.4: Assist project health facilities to have adequate</p>	<p>BHS project mandate does not include direct provision of contraceptive supplies but there is apparently sufficient interest</p>

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<p>supplies of all project-related commodities, including contraceptives</p>	<p>in supporting supplies among other donors.</p> <p>The scarcity and irregular supply of essential drugs from the MOPHP poses a major obstacle to the acceptance and quality of health services. Clients often refuse to use health facilities or mobile teams if they know these have no medicine supply to distribute- Provided vehicle to Al Jawf Governorate which to be used for logistics support including delivery of supplies to health facilities.</p> <p>- BHS staff participated in relevant meetings with other donors especially UNFPA and Netherlands to ensure adequate supplies to governorates supported by the BHS project. BHS provided support to 3 governorates for transportation and distribution of supplies.</p> <p>In 2006 the numbers for contraceptive users were as follows:</p> <table style="margin-left: 40px;"> <tr> <td>Sa'ada</td> <td style="text-align: right;">16,837</td> </tr> <tr> <td>Shabwa</td> <td style="text-align: right;">1,848</td> </tr> <tr> <td>Al Jawf</td> <td style="text-align: right;">1,195</td> </tr> <tr> <td>Amran</td> <td style="text-align: right;">22,253</td> </tr> <tr> <td>Marib</td> <td style="text-align: right;">1,515</td> </tr> <tr> <td>Totals</td> <td style="text-align: right;">43,648</td> </tr> </table> <p>For all of 2007 the number of users who visited the clinics was 56,299 with two governorates not reporting for a quarter each. When adjusted for this fact, using the year's average clients per month for the relevant governorate, the number of users who visited clinics would be estimated at 67,619 representing an increase of 54.9% over 2006.</p> <p>BHS project distributed a limited quantity of medicines to the governorates after it received a donation by the US Embassy medical office in Sanaa. The medicines were much appreciated and made a real difference</p>	Sa'ada	16,837	Shabwa	1,848	Al Jawf	1,195	Amran	22,253	Marib	1,515	Totals	43,648
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<p>5.1.5: Strengthen facility-level management systems</p>	<p>The managers of health facilities lack basic training; the majority of managers are appointed by local authorities and have no health background.</p> <p>MOPHP has little or no supervision in place. BHS collected Quality assessment data collected as a baseline; and has planned interventions in cooperation with PHRPlus to ensure that facilities refurbished by BHS are or become and remain functional, including having functioning MIS. The curricula for training in management will have to be developed as current ones used by MOPHP are largely theoretical in nature and seldom competency based or case-specific.</p>												

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	<p>Input to date: - 16 managers were trained in supervisory skills</p>
<p>5.1.6: Mobile teams established and delivering services (BHS provides logistic support to the teams which are staffed and managed by MOPHP)</p>	<p>Doctors are seldom available to work for the MOPHP at the government pay scale in remote areas. The alternative is to have mobile teams who are staff of the MOPHP and who receive additional work incentives as mobile team members. Female doctors are much harder to find and are preferred for reproductive health services. When female doctors are not available BHS relies on well trained midwives.</p> <p>In 2007, there were 10 mobile teams as follows: Marib: 3, Sa'ada: 1 and 2 in each of the other three governorates. These mobile teams recorded a total of 63,045 clients in 2007. (a three- fold increase in comparison to 2006 numbers).</p> <p>Each mobile team covers 20 health centers per month; it spends five days a week in field visits and one day in organization, record keeping and maintenance.</p> <p>Patient encounter forms are filled out regularly for each client and which will provide an idea of the type of cases seen and services provided.</p> <p>Six teams were added in July 07, one per governorate except Al Jawf which received two teams. These however started operations only in November following a period of inactivity due to internal problems in the governorate. Another team was added in Marib governorate to bring the total to 10, after the health office there decided to have a vehicle BHS provided to them for administrative use be converted to use as a mobile team.</p> <p>The health facilities visited by mobile teams were provided with basic instruments and clinic furniture so that teams and clients find a suitable service environment and to improve the ability of the local facility personnel to provide some services in between mobile team visits.</p> <p>There is a large demand for this approach because most fixed health facilities in remote areas are not functional. MOPHP has requested the World Bank to fund similar mobile teams elsewhere and other donors have enquired with BHS and asked for details on how it has deployed its teams. GTZ and Oxfam have adopted this practice and UNFPA has also indicated interest in setting up teams in other governorates.</p> <p>The availability of medicines along with the diagnostic equipment and the services by qualified staff tends to make a huge difference in acceptance of the services.</p>
<p>5.1.7: Implement rural outreach by trained community midwives</p>	<p>Midwives in health facilities are being encouraged to conduct home visits and hold community meetings.</p> <p>A total of 432 community meetings were held in 2007 and were attended by 19,179 clients.</p>

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In comparison, 341 were held in 2006, attended by 13,139 people.

A mobile cinema unit was used as a venue in Amran governorate to broadcast health messages.

Building the capacity of the YMA:

National NGOs may not have presence in some of the governorates covered by BHS.

Community midwives are neither available in sufficient numbers nor well utilized when available.

Lack of transportation continued to be a major impediment to conducting outreach activities.

Midwives do not have proper business skills to establish themselves as strong and recognized providers, to market their services and develop plans to increase their clientele. Social barriers prevalent against women come into play as midwives try to establish their own clinics and run their own business.

Until the YMA came along in part through joint USAID (PHR and BHS) and UNFPA support there was no organized institution to speak on behalf of midwives and promote the profession or provide support and networking.

YMA membership increased from 117 in December 05' to 1,355 in July 07' bringing the total number of midwives to 1,472.

BHS and ESD conducted study visit for YMA members to Uganda (March 13-20) to learn from the Uganda Private Midwives Association's (UPMA) experience setting up mechanisms to establish themselves as a professional association; supporting their members by ensuring they are equipped with the most up-to-date technical skills; linking members to referral facilities; generating revenues; and supporting midwives in establishing private practices.

ESD, BHS and YMA worked to implement the Midwives in Private Practice project. The YMA made progress in finalizing criteria for the selection of midwives to be included in the first wave of providers supported for establishing their private practice. A national consultation was held on with a wide participation and excellent results in terms of the expressed support for the concept and approach proposed by the YMA.

ESD identified and shared with the Yemen BHS project and the YMA two community mapping tools: Radar de Gestantes, a surveillance tool developed and applied by Pathfinder in Peru to monitor pregnant and postpartum women, and Community Mapping Training: A Trainer's Guide developed and used by the MSH REACH project in Afghanistan to train illiterate community workers on conducting a community mapping, in preparation for a community mapping exercise,

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5.2: Increased Health Knowledge and Improved Behaviors at the Community Level			
5.2.1: Develop and disseminate health education messages in support of project interventions	<p>Among the major achievements in 2007 was the finalization of a comprehensive manual for health educators, developed in collaboration with MOPHP and various interested donors (UNICEF, WHO, UNFPA and GTZ), the manual was analyzed and the messages were reviewed accordingly after pilot testing was conducted by BHS in its five governorates and by the other partner agencies in their own respective governorates. The manual will be printed early in 2008</p> <p>The BHS health education activities were greatly helped by the development of 20 RH/MCH messages based on evidence based practices about prioritized health issues. The messages are as follows: 4 on breastfeeding including LAM, 2 on prenatal care, 2 on delivery, 2 on post partum care, 3 on birth spacing and 3 on nutrition in MCH and 4 on newborn and child care. The messages developed were updated to reflect the latest information such as HTSP (healthy timing and spacing of pregnancies) and changes in immunization protocols</p> <p>Each of the 20 messages was printed on 3,000 posters for a total of 60,000 posters. The posters were distributed as follows:</p> <ul style="list-style-type: none"> - 5,000 to each target governorate (Amran, Marib, Sadaa, Shabwa, and Al-Jawf) = 25000 - 10,000 to Health Education Center (Sana'a) to be distributed in other governorates not targeted by BHS - 100 to the University of Dhamar. - 500 to the members of community mobilization teams and Religious Leaders during the training courses <p>10 mobile team vehicles and one school bus for student midwives also display some of the new posters painted all over the vehicles.</p>		
5.2.2: Systematic counseling services in RH/MCH services	<p>In 2007, the emphasis was on supplying health facilities with health education materials and training their staff to organize education sessions.</p> <p>Community mobilization groups referred to below were also encouraged to use the health education room for community meetings.</p> <p>In 2007 a total of 163 health providers received training in counseling skills</p> <p>The maternity hospital in Shabwa was provided with a network to provide health education via TV in all rooms.</p>		

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<p>5.2.3: Mobilize community outreach workers, local council members, teachers and agriculture extension agents to deliver health messages</p>	<p>Throughout 2007, BHS coordinators in governorate held 358 meetings in various settings to provide health education reaching 19,722 people</p> <p>A Mobilization Group was formed in each governorate and includes representatives from 7 non health sector institutions (5 ministries: Education, Agriculture, Information, Religious Affairs, Youth and 2 NGOs: Women’s Union and National Women’s Committee. The group meets weekly and members carry out community activities in coordination with the MOPHP and BHS. In 2007, the mobilization groups in Amran, Marib, Shabwa and Al-Jawf governorates implemented 301 activities reaching 16,918 people</p> <p>Religious Leaders implemented 631 activities targeting 51,718 male and 10,993 female from August to December in Marib, Shabwa, and Amran Governorates. These numbers include people attending Friday main prayers which are well attended and where religious leaders include health messages in their sermon.</p> <p>The second phase of religious leaders training started as part of the roll out strategy, and 105 religious leaders from the districts wee trained. The national curriculum was adapted for use at this stage. The trainees developed plans for carrying out education activities in their respective areas.</p> <p>To date the Religious leaders implemented 1021 activities reaching 81,978 male and 19,117 female in Marib, Shabwa, and Amran Governorates (101,095 in total)</p>
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