Healthy Mother/Healthy Child Results Package
Mid-Term Assessment Report

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The assessment team hopes that the report contributes in some measure to documenting the excellent progress toward sustainable improvements in the health of women and their children in Upper Egypt. made by the MOHP and other health partners with the support of the John Snow, Inc Team and UNICEF.

ACRONYMS AND FOREIGN TERMS

ANC	Antenatal Care
ARI	Acute Respiratory Infection
BBP	Basic Benefit Package
BF	Breast Feeding
BFHI	Baby Friendly Hospital Initiative
BEOC	Basic Essential Obstetrical Care
BPS	Basic Package of Services
CDC	Centers for Disease Control
CDD	Control of Diarrheal Disease
CEOC	Comprehensive Essential Obstetrical Care
CHC	Community Health Committee
COP	Chief of Party
DHO	District Health Officer
DIC	District Information Center
DMT	District Management Team
EC	European Community
EDHS	Egyptian Demographic and Health Survey
EmOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
EOC	Essential Obstetric Care
FGC	Female Genital Cutting
FETP	Field Epidemiology Training Program
FMT	Facility Management Team
FP	Family Planning
GMT	Governorate Management Team
HIO	Health Insurance Organization
HM/HC	Healthy Mother/Healthy Child Results Package
HPN	Health Population and Nutrition
IDD	Iodine Deficiency Disorder
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
JSI	John Snow, Inc.
LBW	Low Birth Weight
MCH	Maternal and Child Health
MHIS	Management Health Information System
MMR	Maternal Mortality Ratio
MOHP	Ministry of Health and Population
NGO	Nongovernmental Organization
OJT	On the Job Training
OR	Operations Research
PASA	Participating Agency Service Agreement
PES	Package of Essential Services
PHC	Primary Health Care
QA	Quality Assurance

RP	Results Package
RTI	Reproductive Tract Infection
SAVE	Save the Children
SHIP	Student Health Insurance Program
SO	Strategic Objective
TA	Technical Assistance
TCA	TransCentury Associates
TT	Tetanus Toxoid
UE	Upper Egypt
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Dayas	Traditional Birth Attendants
Raidayats	Community health promoters

EXECUTIVE SUMMARY

The Healthy Mother/Healthy Child Results Package (HM/HC-RP) is contributing to the achievement of USAID/Egypt's Strategic Objective No.20, Healthier, Planned Families, through improving quality and increasing utilization of maternal, perinatal and child health services. The specific focus of the HM/HC-RP is to reduce maternal and child mortality in high-risk districts of Upper Egypt by establishing an essential package of maternal and child health services in health facilities, and by promoting appropriate care in households. HM/HC-RP interventions include a quality package of essential maternal, neonatal, and child health care services, health provider training, community education, and district-level planning and monitoring systems. The HM/HC-RP activities are being implemented primarily through the Ministry of Health and Population (MOHP) at the central, governorate and district levels.

The primary source of technical assistance for the program is a contract with John Snow, Inc. (JSI), signed on April 6, 1998. Although the JSI base contract period is for three and a half years, it provides for a possible "option period" of an additional three and a half years beyond September 15, 2001 (i.e. through March 14, 2005.) JSI has five subcontractors engaged in one or more tasks within the contract. In addition, within the HM/HC RP there is a grant agreement with UNICEF to implement a safe motherhood program in three governorates in Upper Egypt and other nationwide reproductive and nutrition activities (ends September 2001).

USAID/ Egypt assembled a team in August 2000 to assess the performance of the prime contractor, JSI, in implementing the contract. If satisfactory, the assessment is to be a determinant in recommending that the Mission exercise the option period and thus extend the JSI contact for an additional three and a half years. In addition, the team was asked to determine the feasibility of extending the HM/HC Results Package to other governorates if the program strategy and methodology are still valid; confirm that tasks and activities under JSI's option period are in accordance with SO 20's objectives; and review the approaches and process of UNICEF's grant and advise those activities which should be given consideration for future funding.

The assessment team reviewed relevant documents, reports, and other key materials and held orientation meetings and briefings with USAID, MOHP, JSI, and UNICEF. Site visits were made to seven governorates to observe project activities. Discussions and interviews were conducted with JSI, UNICEF, MOHP staff at central and local levels, University Medical and Nursing Schools, and USAID, as well as clients and NGOs. Interviews were held with several key collaborating partners. Debriefings were held with USAID, MOHP and JSI. The team consisted of Professor Dr. Mervat El Rafei, Cairo University Faculty, of Medicine, Department of Public Health; Dr. Miriam Labbok, Chief, Nutrition and Maternal-Infant Health Division, PHN, Global Bureau, USAID/W; and Mellen Tanamly, Health and Nutrition Consultant, Team Leader.

JSI has primary responsibility for providing technical assistance for national level HM/HC activities and implementation of program activities in 25 districts of the following five Upper Egypt governorates: Beni Suef; Fayoum; Aswan; Qena; and Luxor. JSI's main counterpart within the MOHP is the Maternal and Child Health Department of the Basic and Primary Health Care Directorate. In the governorates, JSI works with MOHP governorate and district management teams and community health committees to implement the basic package of services (BPS). JSI is also

responsible for coordinating activities of the other partners under the HM/HC-RP umbrella, including UNICEF and Wellstart.

The JSI contract has 11 Tasks to implement during the base contract period under a performance-based payment agreement, with 40 specific milestones. To date, 22 milestones have been successfully completed and submitted to USAID/Egypt according to the schedule. Performance in all of the task areas has been high quality. The accomplishments over the first 29 months of the contract have been many and are clearly contributing to the HM/HC objectives. JSI has strong management, uniformly capable staff and good monitoring and evaluation systems to track this complex array of activities. The involvement of subcontractors has generally worked well and the staffs of these five subcontractors are integrated into the overall JSI team. Coordination with the MOHP and other partners has been regular and JSI team members have made important contributions and links with other USAID programs.

Some highlights of progress to date are: The MCH Basic Package of Services (BPS), with a focus on Essential Obstetrical Care (EOC) and neonatal care, has been defined and clinical protocols and service standards set as official MOHP policy. The BPS is being implemented in 20 districts with another five targeted for start-up by the end of the baseline period, reaching 8 million Egyptians. The strategy for increasing access to quality care is through building a referral system in each district that includes the district hospital as the referral center and several primary health care units offering Basic Essential Obstetrical Care (BEOC). The capacity of local institutions to plan and manage interventions is being strengthened through creation of and ongoing support to decentralized teams in focus districts and governorates that include public and private providers. District Information Centers have been created in target areas to improve the availability and use of health statistics for monitoring program activities. Partnerships and understanding between communities and health providers are being promoted. An exciting national Information Education and Communication (IEC) campaign on Birth Preparedness has been developed based on careful behavioral analysis, technically important messages and good creative talent. This is complemented by health promotion activities of community health committees and NGOs. An innovative new program builds on the Student Health Insurance Program to prevent adolescent anemia through weekly iron supplementation and nutrition education. Considerable research has been conducted, including the MotherCare needs assessments and other preliminary survey work done during 96-98 needed for program development. A national maternal and perinatal mortality survey for 1999-2000 is ongoing with the preliminary report due April 2001. One operations research effort is underway in Beni Suef to test a promising new disposable safe birthing kit.

Training programs offered under the contract have been outstanding, using a competency-based approach to upgrade the skills of health providers in the five governorates. Classroom training sessions are followed by on the job training and clinical supervision in the practitioners' own public facilities in the 25 districts. This has been one of the most appreciated and probably successful features of the strategy to improve quality of care in these high-risk areas. In addition, JSI is collaborating with University Faculties of Medicine and Nursing to introduce competency-based essential obstetrical care and neonatal care into their curricula. This will help to produce nurses and obstetricians with technical competency to provide quality obstetric and neonatal care. Private providers, who play an enormously important role in home births, private facility based maternal care, and treatment of sick children, are receiving training in their home governorates. Physicians working in private offices, hospitals or NGO clinics, pharmacists in private outlets, and *dayas* have been invited for training to improve the quality and effectiveness of MCH services in the private sector as well as to involve them in the district health plans and referral systems.

Sustainability of new decentralized systems and quality of care improvements is a shared concern of the MOHP, USAID, JSI, and the assessment team. JSI has produced a "Continuum of Sustainability Analysis" that proposes some approaches to address this huge challenge. The MOHP Executive Director for HM/HC has recommended some strategies for consideration, which should be discussed and possibly tested. The decentralized strategy to manage and monitor health activities is a new approach in Egypt. These are actually health reform steps that can make an enormous difference in motivating staff to provide better care for their communities in response to increased community involvement and local authority. It is somewhat early to predict total success with this element of the project, but the foundation is being laid. The future of the overall national health reform process will have an impact on whether decentralized management as practiced in the target districts of Upper Egypt (UE) will continue.

It is clear that the HM/HC strategy is still a valid technical approach, appropriate for Egypt with good physical access to services and a high ratio of doctors per capita. The focus on EOC (including comprehensive, basic and maternal care) in general, district and integrated hospitals as well as primary health care clinics appears to be the correct approach for saving lives of women and their babies. Upper Egypt continues to be a high-risk area of the country and challenges remain in reducing maternal, perinatal, and child deaths. The problems are systemic and deep; improving the quality of care provided is a resource intensive and complex approach requiring the kind of multi-faceted program with which JSI is assisting.

It is recommended that USAID exercise the option period in the JSI contract based on the excellent performance of the contractor to date and the significant opportunities that exist to save the lives of more Egyptian mothers and children in additional governorates by building upon and extending the considerable investment already made in testing approaches and developing training programs. It is suggested that USAID include the following in the option period:

- Full coverage of 5 current target governorates (by adding 6 remaining districts)
- Full coverage of Upper Egypt, including Giza (78 districts total in UE of which 12 are in Giza)
- Possible additional districts in other parts of Egypt according to results of maternal and perinatal mortality study
- A phase out plan for the earliest districts

USAID should carefully review the tasks selected for the SO20 integrated contract and those that will remain in the JSI contract during the option period. (At this time, Tasks 6, 8,9,and part of 2 are not included in the option period.) In particular, consider the pros and cons of moving support for certain elements of the following under the joint SO 20 contract: Task 4 Management Health Information System (MHIS), Task 8 IEC, Task 2 Medical and Nursing School curricula, and Task 5 Research, and Task 6 Child Survival- certain elements only. TASK 9 Student Health Insurance Program (SHIP) should receive continued support through the JSI contract or other means. The actual number of target districts *vis a vis* modifications to other tasks should be negotiated, i.e. less than 85 districts to be covered if other tasks are extended in the option period.

The UNICEF Grant Agreement was reviewed by the team in order to look at the effectiveness of results and, in particular, models used in achieving the desired outcomes of the HM/HC program. An additional purpose was to identify lessons learned in the implementation that can perhaps be applied in the future within the JSI contract.

A grant agreement signed January 14, 1996 with UNICEF under the HM/HC-RP, outlined a program with four components:

1. Safe Motherhood: Maternal Health Care and Birth Planning
2. Women's Reproductive Health: Reproductive Tract Infections (RTI), early marriage, Female Genital Cutting (FGC), and family planning
3. Breastfeeding: IEC, health worker training, Baby Friendly Hospital expansion, and mother support
4. Micronutrients: Vitamin A, Iron, and Iodine Programs

Currently under its Healthy Woman/Healthy Child program UNICEF is focusing on three areas:

1. Women's Health including: (a). The Safe Motherhood activity supports national efforts to reduce maternal mortality through a pilot Emergency Obstetric Care (EmOC) Initiative in a total of nine districts in three Upper Egypt governorates (Minia, Assuit and Sohag). Twenty-four facilities were selected for upgrading and strengthening the obstetric skills of the staff to ensure proper management of referred complicated cases; and (b) The Reproductive Health activity supports improvements in reproductive health services in the same three governorates and FGC activities.

2. The Nutrition activity supports national efforts in controlling iodine deficiency disorders, Vitamin A deficiency, Iron Deficiency Anemia and in promoting good breastfeeding practices.

3. Youth Health with a focus on healthy life styles and control of HIV/AIDS.

The greatest achievements of this effort include a manual for managing complications and referral guide for primary care physicians, the refresher-training guide for d*ayas*, and the active and evident ownership by the MOHP staff in the governorates of the activity. UNICEF identified their challenges/constraints as difficulty in ensuring quality of care, availability of blood, building lab capacity, increasing utilization rates, availability of anesthesiologists, and availability of drugs for RTIs, and FGC issues. The focus on a vertical EmOC program may not be the most cost effective for Egypt where the more comprehensive maternal health approach implemented by JSI according to MOHP policy is more appropriate for this situation where there is easy physical access to care and a high ratio of doctors per capita.

The work in nutrition has been at the national level, with programs in iodizing salt, with all the commercial sector and government obstacles addressed in a creative manner; support for the MOHP maternal iron supplementation program development, revision and enhancement, as well as a preschool iron program; support to the MOHP Vitamin A supplementation program for infants and young children, as well as for postpartum women; and continuation of the Baby Friendly Hospital Initiative (BFHI); and general nutrition, including work on positive deviance approaches to nutrition education, and printing of the family food guide. Challenges/constraints include centralizing and sustainability of the Universal Salt Iodization activities with government procurement of the iodate, and Code of Marketing of Breastmilk Substitutes issues, as well as how to cost-effectively re-certify BFHI hospitals.

The Youth Health activity concentrates on HIV/AIDS and transition to adulthood, with activities including workshops, awareness focus groups and talk shows. Constraints/challenges include the relative novelty of these issues, and the national awareness of the importance of HIV prevention and good nutrition and habits in this age group.

I. Background[1]

A. Introduction – Unification of Health and Population Strategies into SO20

USAID/Egypt's recently approved Country Strategy Plan calls for a final ten-year phase of assistance to the Population and Health (P/H) sector. The Plan unified the previously individual P/H strategic objectives into one – "Strategic Objective 20, Healthier, Planned Families" -- with three common Intermediate Results: (1) increased use of family planning, reproductive health and maternal and child health services by target population; (2) healthy behaviors adopted; and (3) sustainability of basic health services promoted. A Transition Plan for the 1999-2009 strategy period will define the program parameters, technical content, funding and management arrangements for this final phase of assistance.

In the last 22 years, with USAID assistance, much has been accomplished to improve the health status of the Egyptian population and to lower fertility. USAID/Egypt projects that by 2009, major gains will have been achieved in health and population, and that conditions will be met for Egypt's successful graduation from USAID assistance. Further, with its expanded economy and human resources, Egypt should by then be able to independently meet the compelling basic family planning and health needs of its growing population. This is the legacy that USAID/Egypt intends to leave.

SO 20 will be planned and implemented in two phases: Phase 1 (1999-2005) places emphasis on service delivery to vulnerable and under-served groups, the testing of integrated models of health care, and reduction of geographic disparities. Existing results packages (RPs) in health and population that incorporate major contracts and grant agreements will be implemented and extended as necessary to allow for their synchronous terminations in early 2005. Phase II (2005-2009) signals the end of the "service focus", and emphasizes greater efforts toward capacity building and sustainability, prioritization of key policy reform measures including private sector enhancement, and the steady decline of USAID's annual P/H investments.

During the early phase of implementing SO 20's strategy, the Population and Health Division will conduct technical assessments of its major existing RP activities to determine the "bridging" of activities and mechanisms that will align them with the new Strategic Objective. This document reports on the assessment of activities implemented by John Snow Inc. (JSI), the prime contractor of the "Healthy Mother/Healthy Child" RP.

A three week mid-term participatory assessment took place during August. The prime focus of the assessment will be to review the JSI contract's progress to date in implementing the activities under the base period (March 15, 1998 to September 15, 2001), and also examine the option period (September 16, 2001 to March 14, 2005) tasks to confirm their alignment with SO 20 plans.

B. The HM/HC Project

[1] Excerpts from USAID/Egypt Scope of Work for the Assessment Consultant

The Healthy Mother/Healthy Child Results Package (HM/HC-RP) was originally designed to meet USAID/Egypt's Strategic Objective No. 5, to achieve sustainable improvements in the health of women and children by improving the quality and increasing utilization of maternal, perinatal and child health services. Although Egypt has shown impressive gains in child health in the past few decades, important health problems persist, especially in Upper Egypt (UE). Infant and child mortality are twice as high in rural UE as in Lower Egypt. The National Maternal Mortality Study of 1992 documented a national maternal mortality ratio (MMR) of 174, with 217 in UE (544 in Assuit and 386 in Qena). The most important constraints to improving health care status of mothers and children in UE are the lack of adequate reproductive and child health services and information in remote areas, poor quality services, weak referral systems among different levels, and lack of essential skills among recent medical graduates. Accordingly, the HM/HC-RP objective is to reduce maternal and child mortality in high-risk districts of UE by establishing an essential package of maternal and child health services in health facilities, and by promoting appropriate care in households. HM/HC-RP interventions include a quality package of essential maternal, neonatal, and child health care services, health providers training, community education, and district-level planning and monitoring systems.

The HM/HC-RP activities are being implemented primarily through the Ministry of Health and Population (MOHP) at the central, governorate and district levels. Technical assistance in implementing the activities are provided by the following mechanisms:

- A PASA with the Centers for Disease Control(CDC) to conduct the Field Epidemiology Training Program (ends September 2001);
- A grant with Wellstart International to strengthen the National Breastfeeding Program (ended in July 2000);
- A grant agreement with UNICEF to implement a safe motherhood program in three governorates in Upper Egypt and other nationwide reproductive and nutrition activities (ends September 2001); and
- A contract with John Snow, Inc. (JSI), Contract No. 263-C-00-98-00041-00, signed on April 6, 1998. Although the JSI base contract period is for three and a half years, it provides for a possible "option period" of an additional three and a half years beyond September 15, 2001 (i.e., through March 14, 2005), for which additional estimated costs were stated in the contract.

Both JSI and UNICEF will contribute to the following six major HM/HC-RP process outcomes:

1. All 34 HM/HC supported districts will become capable of planning, monitoring, budgeting, organizing, delivering, and partially financing their own integrated, quality reproductive and child health services. Public and private health units in these districts will be providing the essential HM/HC package and community health education programs.
2. Household members, particularly women, in the 34 HM/HC districts will have increased ability to provide and seek appropriate health care for themselves and their children through social mobilization.
3. The MOHP will have enhanced national capacity to set standards, policy, and management systems for cost-effective reproductive and child health services. It will have consolidated its management and health information system (MHIS) so that all data essential for monitoring and management are collected, while reporting burdens on service delivery units are minimized. Planning, budgeting, supervision, and support to districts at the governorate level will also be strengthened.
4. Medical and nursing school graduates will have improved skills and knowledge for delivering the HM/HC package through the strengthening of curricula and training programs at all undergraduate health professional schools and the programs of the national breastfeeding training center. This

activity will include all 13 medical schools in Egypt and all nursing schools in the target governorates.

5. National mass media campaigns will have increased popular awareness of, and demand for, essential reproductive and child health services and avoidable health risks behaviors.
6. Established national child survival programs shall be sustained. These include EPI, ARI, CDD, neonatal care, and *daya* training.

C. The JSI Contract: 5 SO-related purposes, 6 contractual process outcomes, 10 objectives, 11 Tasks

JSI has primary responsibility for providing technical assistance on national level activities and implementation of program activities in 25 districts of the following five Upper Egypt governorates: Beni Suef; Fayoum; Aswan; Qena; and Luxor. JSI's main counterpart within the MOHP is the Maternal and Child Health Department of the Basic and Preventive Health Care Division. In the governorates, JSI works with MOHP governorate and district management teams and community health committees to implement the basic package of services (BPS). JSI is also responsible for coordinating activities of the other partners under the HM/HC-RP umbrella, including UNICEF and Wellstart.

The JSI contract has 11 Tasks during the base contract period to implement under a performance-based payment agreement, with specific milestones (a total of 40). To date, 22 milestones have been successfully completed and submitted to USAID/Egypt according to the schedule.

The following are the 11 tasks of the basic period and the 8 tasks of the option period:

Base period (3/98-9/15/01)	**Option period (9/16/01-3/14/05)**
Task 1: Implement BPS in 25 districts	Same in 60 districts
Task 2: Pre/In-service training in neonatal and obstetric care	Only In-service
Task 3: District level planning (Public / Private)	Same in 60 districts
Task 4: Establish HIS* in district level	Same in 60 districts
Task 5: Research Activities	Research Activities
Task 6: Sustain child survival activities	No extension
Task 7: Community Services	Same in 60 districts
Task 8: IEC campaign	No extension
Task 9: SHIP **	No extension
Task 10: Small grant program (100 grants)	Small grants (70)
Task 11: Commodity Procurement	Commodity Proc.

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* Health Insurance Systems

** Student Health Insurance Program

D. The UNICEF Grant

UNICEF's overarching goals in health are the reduction of infant, child and maternal mortality. Its global approach is to place the family and the household at the center of health action and the child at the center of the household. UNICEF's program philosophy is guided by the Plan of Action of the World Summit for Children and the Convention on the Rights of the Child. Under the HM/HC-RP, UNICEF is focusing on three specific activities:

1. The Safe Motherhood activity supports national efforts to reduce maternal mortality through a pilot Emergency Obstetric Care (EmOC) Initiative in a total of nine districts in three Upper Egypt governorates (Minia, Assuit and Sohag). Twenty-four facilities were selected for upgrading and strengthening the obstetric skills of the staff to ensure proper management of referred complicated cases.
2. The Reproductive Health activity supports national efforts to reduce maternal morbidity and improve reproductive health services in the same three governorates.
3. The Nutrition activity supports national efforts in controlling iodine deficiency disorders, Vitamin A deficiency, and in promoting good breastfeeding practices.

II. Purpose, Objectives, and Methods of the Assessment[2]

Purposes:

1. Assess the performance of the prime contractor (John Snow, Inc.) in implementing the contract. If satisfactory, the assessment will be a determinant in recommending that the Mission exercise the option period and thus extend the JSI contact for an additional three and a half years.
2. Determine the feasibility of extending the HM/HC Results Package to other governorates if the program strategy and methodology are still valid.
3. Confirm that tasks and activities under JSI's option period are in accordance with SO 20's objectives
4. Review the approaches and process of UNICEF's grant and advise those activities that should be given consideration for future funding.
5. Answer the following questions:
   - Should the Mission exercise its option to extend the JSI contract by 3-1/2 years, i.e., to March 14, 2005?
   - If the JSI contract is extended, what modifications ought to be considered to enhance the success and sustainability of the activities?
   - Assuming that the UNICEF grant is not planned for extension, should JSI's option period expand to other districts which were not covered by UNICEF during the life of the grant in their three Governorates (Minia, Assuit & Sohag)?

Three Objectives:

1. Examine the extent to which the HM/HC RP, particularly through the JSI contract, is addressing the following:
   - Reaching the most vulnerable with good quality health care
   - Building the capacity of local institutions to plan and manage interventions
   - Including a community component and promoting NGO participation
   - Promoting and providing customer satisfaction with health services
   - Promoting and increasing cooperation and collaboration with the private sector

[2] Taken from the USAID/Egypt Scope of Work for the Assessment Consultant

- Promoting teamwork with partners and donors

2. Review the status and progress of the JSI contract and UNICEF grant:
   - Deliverables through June 2000
   - Deliverables remaining through September 2001
   - Key issues affecting timely delivery of results by the end of 2001
3. Generate findings and recommendations on:
   - Progress toward achieving the contract's tasks and milestones
   - Internal and/or external constraints on the achievement of milestones
   - Whether the HM/HC strategy and implementation structure is working as planned
   - The adequacy and appropriateness of JSI's management of the contract, including communication and coordination with USAID, MOHP, and others
   - The adequacy and appropriateness of JSI's human, material and financial resources to achieve the contract performance results
   - Ending and/or consolidating certain tasks with other SO20 activities in the option period
   - Comparing the effectiveness of UNICEF and JSI models and techniques in achieving project objectives
   - Lessons learned from the UNICEF grant which might be shared with JSI
   - Major and minor successes achieved by UNICEF and JSI in their respective focus districts
   - Modifications in targets needed
   - Which districts/facilities/activities seem to be more on track in terms of accomplishment of objectives

Assessment Methodology:

The assessment team reviewed relevant documents, reports, and other key materials and held orientation meetings and briefings with USAID, MOHP, JSI, and UNICEF. Site visits were made to 5 governorates and to observe activities. Discussions and interviews were conducted with JSI, UNICEF, MOHP, and USAID staff at central and local levels, as well as clients and NGOs. Several interviews were made with key collaborating partners. Debriefings were held with USAID, MOHP and JSI. The team consisted of Professor Dr. Mervat El Rafei, Cairo University Faculty of Medicine, Department of Public Health; Dr. Miriam Labbok, Chief, Nutrition and Maternal-Infant Health Division, PHN, Global Bureau, USAID/W; and Mellen Tanamly, Health and Nutrition Consultant, Team Leader.

III. JSI Contract Assessment

III.A. JSI Role in Project Accomplishments

III.A.1. Introduction

JSI was the recipient of a competitively awarded cost-plus-fixed-fee completion (performance-based) contract for the period March 15, 1998 through September 15, 2001 with an option period of September 16, 2001 through March 14, 2005 in support of the MOHP Healthy Mother/Healthy Children initiative. It is also expected to complement the Health Policy Support Program (HPSP) of USAID/Egypt designed to improve the environment to plan, manage, and finance sustained maternal and child health systems, and the ongoing Reduced Fertility package. This setting calls for considerable collaboration and frequent organizational interchange. Clearly, accomplishments may reflect the work of more than one partner. In this assessment, an effort is made to specifically assess the accomplishments of JSI in this setting.

III.A.2.General

Findings:

The JSI contract team has produced more than promised and has overcome numerous obstacles in a creative manner. There is a clear impact on service quality in the areas completed, as evidenced by data and by informal interview of personnel of all levels. Milestones have been achieved according to schedule with few exceptions. A highlight of this evaluation is the strong management and monitoring and evaluation system of the contractor. In general, during the first two years of operation the contractor team has performed well and has overcome numerous obstacles in a creative manner, leading to important contributions to HM/HC objectives.

Conclusions and Recommendations:

Given the pressure of a performance-based contract, now is a good time to reassess, reconsider and regroup to ensure optimal outcomes and sustainability. It may be necessary to extend some aspects that had been considered for closure, re-examine cross-task and cross-partner input and collaboration, and to agree to milestones to allow for review and modifications at this time. Specifically, some areas are well planned, developed and implemented, and should continue with ongoing and strengthened supervision to ensure continued progress: training in EOC, curriculum development, clinical supervisor activities, equipment of maternity and newborn centers, formation of teams at governorate, district and community levels, IEC, and strengthening and/or maximizing effectiveness of NGO and *raidayats*. Additional areas may merit more attention at this time. These include operations research, maternal mortality surveys and surveillance, and integration and consistency across all materials and services. Given this time of reassessment, it may be necessary for USAID to be flexible in the milestone content to allow for review and modification.

Specific examples and recommendations are given below under relevant task areas.

III.A.3. Serving the more vulnerable and disadvantaged to reduce disparities in the provision of services

Findings:

The Maternal Mortality Survey of 1992 revealed that MMR for Upper Egypt was 217 for Upper Egypt, and as high as 544 in Assiut, while Lower Egypt was below 150. Further, the infant and child mortality rates are twice as high in Upper Egypt. Therefore, the selection of Upper Egypt is a valid approach to reducing disparities. Additional decisions that will reduce disparities include:
* The MOHP and JSI are increasing access to quality services in disadvantaged communities by a strategy to provide sufficient service capacity to meet the needs of 100% of women according to WHO standards. This means upgrading district hospitals as referral centers for Comprehensive Essential Obstetrical Care (CEOC) and creating capability in selected PHC units in all catchment areas for Basic Essential Obstetrical Care (BEOC).
*The decision to have a strong concentration on community awareness and basic Antenatal Care (ANC) and healthy delivery care made sense, since the Maternal Mortality Survey had revealed that much of the mortality country wide was due to delay in seeking services and the quality of the services, and

*Given the relative compactness of the population around the Nile basin and sufficient resources, the decision to attempt nearly full coverage of high-risk regions remains a reasonable approach to decreasing disparities.
* The EOC (including CEOC and BEOC)/*dayas*/community approach addresses reducing mortality as a multi-factorial event, as revealed in the Maternal Mortality Survey

Conclusions and Recommendations:

The approach taken is based on sound decision-making given that the project impact indicator is reduced mortality, a multi-factorial event. A strategy such as this -- to create governorate-wide attention to the issue, to decentralize, and to create multi-level changes -- should be continued, as affordable, pending impact results.

III.A.4. Building the capacity of local institutions to plan and manage interventions

Findings:

The JSI effort concentrates on decentralizing management with the development of a network within the health structure to ensure ongoing internal feedback and support for the upgraded services and community interaction. In the 5 governorates, a sufficient number of facilities will be upgraded and personnel educated to allow for improved interchange on proper client care and services. Within these governorates the approach taken for underserved areas was to create a service that would be available to the entire population. Clearly, the targeted institutions are benefiting from the renovations and the training of clinical personnel as well as the strengthening and support for the management and community outreach networks. When significant up front investment such as is called for under this contract is used to jump-start positive action, the question always remains concerning sustainability. This issue is further explored below.

Highlights of the JSI approach include "on-the job" supervision (OJT) by specialists from university or related settings. This allows both for competency assurance and ongoing skills strengthening, as well as ready feedback on progress. Other highlights include the excellent standard protocols that have been widely disseminated, allowing consistent care in all situations, a data collection system that supports the MOPH needs, and management team development at every level to ensure oversight. There is a felt need among these supervisors that they need assistance in staying abreast of new clinical research and findings relevant to the protocols, so that they may do their jobs optimally.

The state of the health care system within the target governorates demanded the project rebuild service capacity in the system as a whole. Since the project is reasonably well funded, JSI was able to make significant up front investment complementary to the GOE targeted investments that were used to jump-start positive action. This approach, while extremely effective, leaves questions of sustainability on many fronts after the project period. Support for sustaining the service improvements needs to come from both the Curative Sector for the hospitals and Primary Care for the primary care units.

Conclusions and Recommendations:

Issues that still need active consideration in the JSI approach include issues of sustainability, complete integration into MOPH function, per diem payments to committees that cannot be continued, personnel transfers resulting in *in situ* skills reduction and potential breakdown of systems, and expansion into the remaining areas of targeted governorates. While nearly all of these are already being considered

and/or actions are underway to address them, it may be necessary to allow, or add, milestones to ensure that there can be adequate attention paid under a performance -based contractual agreement.

The poor state of the health care infrastructure in some areas demanded that the project virtually re-build service capacity in the system as a whole in order to ensure adequate attention, referral, and services for pregnant women. It is important to recognize this in any assessment of cost-impact on the less served populations.

Having strengthened basic protocols in EOC, the need remains to have a mechanism, preferably in the MOHP, to allow for ongoing updating. Whether this is accomplished via Medline access or some other form of assistance is a subject that the MOHP with advice from the TA agencies, will have to consider.

III.A.5. Including a community component and promoting NGO participation

Findings:

The community component was started after the other components and is adding a needed dimension to the activity. Given the decision to have a major focus on facility level intervention, the importance of community support for attendance at the facilities increases.

Another aspect of community involvement is the recognition and cooperation with the local *dayas*. This is an especially delicate and essential issue, as most *dayas* have little formal training and assessments of their practices have shown potentially harmful practices. The inclusion of the *daya* as part of the medical team should lead to better practices, increased referrals, and increased recognition by the community that the health system wishes to reach out more to the community interests.

The development and promotion of NGO competencies is another important aspect of the health system-community partnership. While NGOs seem to be a relatively small aspect of community health at the moment, the small grants "readiness" training will support many NGOs to consider including health promotion in their activities, well beyond the 100 or so that will receive the grants.

It is important to note that at this time the JSI small grants program is the only source of USAID-funded grants in the health sector and is thus filling an important gap in Upper Egypt.

Conclusions and Recommendations:

1. The feedback of community findings into training, IEC, management planning, and monitoring is really just beginning, however, all efforts to date have apparently improved the other tasks. This effort could be continued and expanded in terms of impact on clinical protocols and discharge order content. (see customer section below)

2. While the NGO health promotion activities in any given village will reach all women in the community, the numbers are still small under these grants. However, the training in planning and grantsmanship may have far-reaching benefits for the development of sustainable community work in this region. This effort should continue, with active linkage to other donors and funding sources at the earliest possible juncture.

III.A.6. Promoting and providing customer satisfaction with service interventions

Findings:

The health system as customer has expressed a great deal of satisfaction with the JSI work. While there is promotion of client as customer satisfaction through the media campaign that emphasizes the positive aspects of using the services, actual assessment of customer satisfaction and /or consumer acceptance has not been implemented.

Under the MotherCare assessments, the client's, i.e., women of reproductive age, knowledge and practices were assessed. Subsequently efforts have been made to respond to her preferences regarding preventive health care, social and cultural constraints. One example is the inclusion of both ethics and counseling in the EOC manual for physicians. Initial increases in use of the renovated facilities is worthy of note in this regard.

Conclusions and Recommendations:

1. JSI is planning to begin more work in this area. Customer satisfaction, including that of both health infrastructure personnel and individuals in the community, merits increased attention. This should manifest itself in both protocol and competencies modifications as well as increased utilization of services at every level.

2. JSI work on increasing the self-responsibility of health personnel is another manner to ensure quality of care and client satisfaction. This area should be completed, even if it means extending IEC efforts. As noted by JSI, increased attention to these areas is warranted. Work on client and provider behaviors and motivations is beginning and findings will and should be incorporated into all protocols and IEC.

III.A.7. Promoting and increasing cooperation with the private sector

Findings:

There are at least at least 5 sets of activities that directly address this issue: Training for private sector doctors and pharmacists, *daya* training, NGO grants, and community involvement activities of the Community Health Committees (CHC), as well as IEC efforts with the private sector. All of these activities increase interface and discussion between these sectors.

Private sector providers: Clearly, the outreach to the private sector is appreciated with high attendance at MD, nursing, pharmacist, and *daya* trainings. The content of each training curriculum is adjusted to ensure complementary messages and practices among all service providers in the community. All involved seem extremely grateful for the update and attention. Whether or not it will lead to increased referral and improved practices remains to be assessed, however, pre- and post-testing is reported as being gratifying in this regard.

NGO Grants: To date, these grants have focussed on bringing health messages to the community and promoting use of health services. One potential strength of NGOs that could be more fully exploited is their role as behavior change agents, e.g. encouraging women to attend antenatal clinics thus promoting links with the health units.

CHCs: This stimulating approach is built upon the cultural norm of meetings as a modus for protest and for initiating change. The CHCs observed exhibited lively interchanges among important local individuals.

One finding -- that virtually all private sector doctors and nurses are also public sector -- simplified some of the issues concerning use and training in standard protocols for treatment and referral. However, there is little hope of gaining access to data from the private practitioners.

Conclusions and Recommendations:

1. While all activities in this area are active and impactful, issues of sustainability are a very real question. Immediate attention should be given to mechanisms for ensuring ongoing interchange. This may include approaching these groups themselves for suggestions concerning self-sustainment, immediate active inclusion of the local Medical Syndicates in a leadership role that can continue after the project period, initiation of a seminar series, or similar function, given by the public sector physicians and health teams under the sponsorship of the MOHP MCH office, for attendance by all health-related personnel in the area, and/or other actions as determined by the JSI team.

III.A.8. Promoting teamwork with partners and donors

Findings:

JSI is a dynamic change agent in the HM/HC program, functioning under the pressure of a performance-based contact. As such, JSI is constantly functioning under deadlines that may or may not be in synch with those of its partners. Teamwork is always a very difficult task as all parties involved have differing motivations and modus operandi. In this case, UNICEF and JSI took different approaches to reduce maternal mortality. This assessment discusses the two approaches and the lessons learned in these two models. UNICEF worked in the three governorates where they had considerable prior experience in other aspects of health.

Nonetheless, MOHP, governorate level, district level health public sector personnel all express general satisfaction with JSI efforts in this arena. The MOHP in Cairo expressed satisfaction with JSI performance. UNICEF noted that interchange was generally good and that communications might be better, but recognized that there were geographic and process constraints, in addition to the normal personality and timeline issues. UNICEF also noted some unexpected but very useful teamwork advantages, such as the JSI offer of IEC materials to be used in UNICEF areas, etc. JSI has worked well with other USAID funded programs, including the Partnerships for Health Reform team, the Development Training 2 group, Healthy Egyptian 2010 Initiative, and others.

Conclusions and Recommendations:

The HMHC project is designed to support the MOHP efforts in MCH. As such, it is vital that all efforts be seen as bilateral support, but in support and as TA to the MOHP. Teamwork is a difficult task -- differing motivations and modus operandi -- JSI is a dynamic change agent with pressures of performance-based contract, and should continue and increase its efforts to be seen as a team member, supporting MOHP activities.

It is not clear that the HMHC partners view themselves as a unit, trying to share responsibility in support of the MOHP towards the same goal. This has, perhaps, been exacerbated by the decision to

have the geographic, rather than sector-based, division of responsibilities. USAID may wish to consider reallocation of responsibility after this project period, with UNICEF concentrating more on nutrition, including children and youth, and child health aspects, and JSI interfacing much more actively in the ANC/maternal/neonatal/postpartum activities and MHIS standardization, interpretation and use at all levels. This would mean that both groups would be present in some of the same geographic areas of project activity, a situation that should promote coordination in site visits and would demand increase coordination of the actual service and community activities.

Other donor initiatives, such as the EC family doctor work and family data system vs the MCH data system with EOC, have potentially duplicative and/or conflictual elements. USAID staff are well aware of the situation and are discussing how best to handle this. The assessment team encourages all parties, especially USAID in support of the MOHP, to support the MOHP in taking this situation under careful consideration to ensure that the various activities serve to complement and support each other. This may be an area where the Donor Subgroup on Health can play a role.

III.B. JSI's role and contribution toward project task areas

III.B. Task 1: Basic Benefits Package Established and Standards Defined

Findings:
One of the first and most important steps taken toward improving the quality and use of essential maternal, perinatal and child health services was the definition of the MCH Package of Essential Services (PES). A consensus meeting was held in 1999 with the MOHP and other key partners to reach an agreement on the most cost-effective services to be included in the MCH package to be addressed in the project. Clinical protocols and service standards were then defined to ensure delivery of quality of care. The HM/HC MCHPES includes ten elements, including Essential Obstetrical Care (EOC), nutrition, breastfeeding promotion, and 40th day integrated visit for mother and newborn. Most are preventive activities and some clinical services. JSI is responsible for supporting only certain elements of the package, and other partners have taken the lead in other areas. Thus, within the package, the primary focus has been on EOC and neonatal care in keeping with the stated targets of the project.

The next step was to develop training programs for physicians and nurses in the districts of UE in the new service standards and protocols. JSI chose a competency-based training approach, linked to a strong supervisory support system. This has involved developing and delivering competency-based curricula, modules and resources for staff of designated anchor facilities. Master trainers and clinical supervisors followed up with trainees in their own facilities to strengthen their mastery of skills and help ensure adoption of the new protocols and standards in the facilities. In the area of EOC, 18 well-qualified master trainers make bi-monthly 3-day visit to the same facility to work with obstetric, emergency room and operating teams in assessing progress and solving problems in the critical standards of care. Out of physicians in the target facilities, 205 have completed the nine-day EOC course and are in various stages of achieving competency. Thirty-four have achieved basic competency and 24 have achieved mastery of EOC. Twenty were chosen to be lead trainers and supervisors. Ninety-one nurses received on-the-job training in obstetric care and 73 in infection control. Similar on-the-job support is provided in the neonatal care area. A Quality Assurance monitoring system has been developed as a supervisory tool to assess compliance to service standards and effectiveness of interventions. This has resulted in strengthened supervision and quality assurance monitoring in upgraded facilities.

The strategy for increasing access to quality service in all districts is to provide sufficient service capacity to ensure 100% of women have access to basic maternal care and comprehensive essential obstetric care for women with complications. Based on the WHO guidelines, there is a need for one health unit providing basic obstetric services for every 100,000 people; accordingly HM/HC is establishing or upgrading at least one health center to provide basic obstetric care. In every district the district hospital is being upgraded to provide care for complicated cases. Each district hospital serves a population of about 500,000. The selected facilities are termed anchor facilities. In addition, the Obstetrics and Gynecology Department and Neonatal Unit of the General Hospital in each governorate are being upgraded.

In 1998, health providers attended 66% of births for urban women and 33% of rural women and 73% took place at home. The MotherCare assessment survey showed that despite having an adequate number of PHC facilities, obstetric services were limited as many units had no place for delivery, beds and equipment. To date, new delivery services were provided in 19 rural health facilities with no service beds previously – but with an average of about 57,000 people per Basic Essential Obstetrical Care (BEOC) facility, this means an additional 1-2 million rural people will have close access to safe basic obstetric care and referral when necessary. In some districts, integrated rural hospitals have been designated as anchor facilities and are offering basic normal delivery service for the first time. For example the assessment team visited the Bayadeya District Hospital in Luxor, which in 1998 did not provide any delivery services due to lack of equipment. This hospital serves an area where 5,000 births take place annually. Currently, the trained team in its upgraded facility is performing 70 normal deliveries and managing 12-15 complicated cases monthly.

Facilities designated as "anchor facilities" in the 25 target districts have been upgraded and teams have been provided with equipment and supplies for essential services. Facility improvements have been made in 95 obstetric units; 32 facilities brought into compliance with EOC service standards. Improvements are underway in 62 additional anchor facilities. These efforts are increasing supply and improving quality of EOC and neonatal care in 20 (25 by 9/15/2001) districts of 5 target governorates, serving 8 million Egyptians living in the highest risk areas of the country. To date, 83% of the expected 15% of deliveries with life-threatening complications have reached care and been treated by the established system in the completed areas of Luxor and Aswan.

With respect to other parts of the basic package of services the following are noted:

Antenatal care: Increasing the proportion of women who receive regular antennal care (four or more visits) is a key goal of the MOHP's maternal health program. The quality and effectiveness of ANC need to be improved as well. All upgraded facilities in 25 districts provided antenatal care and tetanus toxoid. There is an increase in the number of women coming for ANC visits for the first time (IEC) and for repeated visits (quality of care). MOHP data show a reduction of cases of reported tetanus in all but one target governaorate from 1998 to 1999.

Postpartum and Newborn Care: According to MOHP standards, visits by health personnel are to occur within 12th hour, 4th day, 7th day and 15th day; this will prevent 39% of maternal mortality in postpartum period. Health workers and *dayas* might play role and postpartum and care of normal newborns can be part of NGO activities. There is a need for an IEC campaign to promote postpartum examination and 40th day visit and family planning.

40th Day Integrated Exam for Mother and Child: Work has been initiated on defining the 40th day visit as part of Postpartum Care in cooperation with the Population Sector and the USAID Family Planning

contractor. This part is included in HM/HC training program implemented since 1998 - MOHP now is introducing in all upgraded facilities. Postpartum care visits are present in records but quality of care is not detected from these records. A plan for training in HM/HC on priority basis is scheduled in Luxor and Aswan during August. Birth preparedness campaign will increase this utilization. Coordination with family planning to use mobile units can increase this activity (this was observed in Daraw). Postpartum guide and training curricula are available.

Nutrition Services: Iron supplementation for children and vitamin A are available through the MOHP system. In January 2000 a national program started for distributing iron supplements to pregnant women; iron is given if hemoglobin is less than 11gm./100ml. Data on hemoglobin levels is registered in all health facilities visited – a monthly report is given for these levels in each visit. Accuracy of this detection was found to be lacking (very small percentage of anemic mothers). This service is covered within PHC centers (some had problems in supply) and was corrected by DMT and GMT – possible shortage results from underestimation of women with low hemoglobin level (observed in HIS of facilities). IEC, CHC, *Raiyidat* workers and committees are of help is solving this problem. The MOHP began a national Vitamin A program in January 2000. All women, irrespective of the place of ddelivery, are to be given a vitamin A capsule (200,000 IU) within 4 weeks of delivery. Women who deliver in an MOHP facility will receive the capsule prior to discharge. For those delivering at home and private clinics, capsules will be distributed during home visits by health facility nursed who wil be informed of the birth when the birth is registered at the health office.For children, vitamin A is given with vaccination at age of 9 and18 months. This is now well established in the national EPI program.

Breastfeeding Counseling: Baseline training is present from previous Baby Friendly and Wellstart activities. This is now implemented in all 5 governorates (25 districts) through training in EOC courses and basic HM/HC package, also NGO training and home visiting as well as activities of dayas in some districts -some of NGOs working received JSI grants.
The high turn over of PHC providers results in gaps in trained staff. Some were trained a long time ago and there is a need for more training. Some training materials were found (brochures) but many materials produced by Wellstart were not found (perhaps due to a delay in production).
The fact that it is planned to make all upgraded hospitals and facilities baby friendly, there is a need to assess present situation. The assessment team found that there is a good knowledge of breastfeeding at the service level but some deficient skills, e.g. nurses may not be proactive in helping mothers who are struggling to initiate breastfeeding. .

Challenges to quality remain in terms of regular supervision, and high turnover of staff in primary health care units. The costs of ensuring regular supervision need to be budgeted by the MOHP to continue assessing quality of care and providing support for staff in upgraded facilities.

To maximize impact, there needs to be increased attention to the continuum of preventive care, with curative as needed, throughout the pre-pregnancy, pregnancy, post-partum/neonatal, and early childhood periods. This "care-chain" is not as evident as one might wish in either the JSI or the UNICEF approaches. It could be easily enhanced by consideration of the steps in this process, and review of the competencies and protocols to ensure that each step considers healthy progress to the next.

Conclusions and Recommendations:

1. It is recommended that the MOHP commit to ensuring a reasonable period of stay of trained providers, particularly for lead trainers. This will allow time for lead trainers in facilities to train others and for protocols to be internalized in hospital practice.
2. Experiment with options to provide continuing education and updates for trained providers.
3. Continue intensive involvement of clinical supervisors on site in following up application of clinical protocols. This is one feature of the JSI strategy that has shown unequivocal results and should be continued in the option period.
4. More emphasis is needed on routine use of quality assurance checklists on all levels.
5. More attention is needed to the continuum of care, i.e. the linkages between ANC and postpartum care and family planning, IMCI, and preventive programs. Breastfeeding should be included in the JSI protocols for mothers as well as babies.

III.B. Task 2: Training in Standards included in Medical and Nursing Curricula plus Clinical Practice in Pre/In-service Training System Designed to Disseminate Standards to Public and Private Providers

Findings:

Task 2 is the central task in ensuring the quality and effectiveness of Essential Obstetric Care (EOC) and life-saving skills in Egypt. This project includes training of many cadres and includes both in-service and pre-service aspects. This has resulted in; 205 EOC trained MDs, 56 trained in anesthesia, 187 trained nurses, and 20 trained clinical supervisors working in 7 districts. Subsequent to ongoing assessments, anesthesia supervisors and referral trainings have been added -- management training for teams and NGOs, health educators under Tasks 7 & 9, ad hoc under Research, other.

The first major milestone under this task -- lead trainers trained and basic health package implemented in 5 districts -- has been completed. In fact, the training has gone well beyond the EOC training, and has included not only training of those who provide Obstetric/Gynecology services and neonatal services, but also has included BEOC training for those attending normal deliveries at basic facilities, training of private sector service providers and *dayas* (that fall under Tasks 6 and 7, respectively), and the commencement of pro-active referral training. (NB There are many other training components of this project, including management training for teams and for NGOs, training of health educators under Tasks 7 and 9, as well as more ad hoc trainings under Research and other Tasks).

Another major milestone in the contractual document is the modification of training materials. This is, perhaps, the greatest strength of this contract's performance. The process utilized has resulted in strong and defensible protocols: MotherCare situational analysis led to the identification of 19 critical standards of care that were then addressed by expert teams of Egyptian professors and specialists. The development of agreed upon standards of care and protocols to carry them out are the heart of the changes that have occurred in patient care practices. While some revision and cross-material consistency is now called for, the manner in which this task has been carried out may very well be invaluable in the future of maternal/child facility-based care for Egypt.

Institutionalizing technical competencies into the medical and nursing schools undergraduate curricula is also a primary aim of this Task. The medical school curriculum development has not, however, progressed as rapidly as the in-service training, primarily due to external constraints, although memoranda of understanding with five Universities to take on this issue have been negotiated. The plan was to establish curriculum development committees within each school to integrate the new materials into several levels of training, especially targeted to house officers and residents, and to train

faculty in the competency -based methodology. Progress has been good in some universities and slower in others, perhaps due to the leadership in the individual schools. There appears to be variation in plans for further expanding the competency-based approach to other aspects of the curricula and concern for sustainability. Some professors seem to feel that training house officers and residents in classroom sessions is not part of their current jobs and they would need additional incentives to add this to their already heavy load. It appears that the Ministry of Higher Education is not flexible at this time with respect to cost recovery in its hospitals, precluding a source of revenue for maintaining/replacing anatomical models and audiovisual equipment. These constraints need to be more fully considered before going forward with this program, particularly with the Obstetrical Departments. On the other hand, the work in Secondary Nursing Schools has only begun and it currently only covers one school in each of the five governorates.

Special trainings for private sector physicians and pharmacists have been implemented.

One unexpected outcome has been the success of the Supervisory Master Trainers in creating real change in the facilities where they are assessing skills, well beyond the specific individuals they are sent to assess. It is part of the long term plan to maintain a cadre of master trainers both in facilities and in universities, and to establish model clinical training sites, initially as anchor facilities in target districts, but eventually for replication country wide. At Luxor General Hospital, despite limited renovation of a decrepit facility, the trained, enthusiastic and busy staff has improved the quality of care in very limited conditions with support from their on the job supervisors and the leadership of the facility's own lead trainer.

The long-term strategy includes consensus building with partners to integrate MOHP officially issued protocols and standards and approaches into national certification/accreditation programs in both the public and private sectors. In discussions with the Executive Director for HM/HC, the preference is to introduce the standards and protocols for new MOHP physicians during the six-week pre-service training all PHC doctors receive at the governorate level.

Constraints have included issues of creating collaboration between universities, public and private sectors, and within facility acceptance of the approach. It is not clear if MOHP involvement has helped pave the way with individuals who have maintained dated practices for long periods of time. Increased MOHP presence in JSI-supported activities has been actively solicited and should be increased if possible. However, the active collaboration in the creation of the protocols and standards has allowed wide acceptance and use. All in all, this activity has worked well within the HMHC structure and has been an area of generally very positive JSI management and communications/ coordination with others. This has demanded considerable JSI human material, and financial resources, but this is appropriate to the importance of this Task area.

In comparing the JSI and UNICEF approaches to training, there are important lessons on both sides. JSI developed its competency-based materials in consultation with those in the facilities, but also included considerable international expert input. UNICEF, on the other hand, may have increased buy-in by using only local expertise, but may have missed some local practices that could have benefited from outside review, such as the current use of routine episiotomy in primiparas that is reinforced in UNICEF training. The JSI products concentrate on the duties at each level of personnel, while the UNICEF materials concentrate on readiness for referral to the next level of care. In general, it seems that there is nearly complete complementarity.