Expanded Coverage of Essential Health Services in Djibouti

Final Report

Project final report : May, 1st 2004 – September 30th, 2008

End of Project best practices conference June, 5th 2008

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Acronyms

BCC	Behavior Change Communication
CA	Cooperating Agency
CHC	Community Health Center
CME	Continuing Medical Education
CMH	Centre Medico Hospitalier (District Hospital)
COP	Chief of Party
CS	Child Survival
CTO	Cognizant Technical Officer
DEPCI	Direction of Studies, Planning, and International Cooperation
DHMT	District Health Management Team
EOC	Emergency Obstetrical Care
EPI	Extended Program of Immunization
FHI	Family Health International
FP	Family Planning
HGP	Pelletier General Hospital
HIS	Health Information System
HIV	Human Immuno-deficiency virus
HMIS	Health Management and Information System
HP	Health Post
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IST	In-service Training
JSI	John Snow, Inc.
MCH	Maternal and Child Health
MHC	Medical Hospital Center
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-governmental Organization
PECSE	Projet d'Extension de la Couverture des Soins de Santé Essentiels (Expanded Coverage of Essential Health Services Project)
PMP	Performance Monitoring Plan
PY	Project Year
QA	Quality Assurance
RH	Reproductive Health
RMT	Regional Management Team
STIs	Sexually Transmitted Diseases
TA	Technical Assistance
UGP	Project Management Unit of the Ministry of Health
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The Expanded Coverage of Essential Health Services Project, or PECSE, was awarded in late April 2004. Initially financed by USAID for three years and implemented by John Snow, Incorporated (JSI*),* PECSE is the first health sector project funded by USAID in Djibouti. In 2007, the Project was granted a 15 month no-cost extension in order to promote sustainability, complete remaining activities including a few new requests, and evaluate the impact of the project. The Project was planned to end in July 2008 after an independent end-of-project evaluation report commissioned by USAID. In 2008, JSI requested a second no-cost extension for a two-month period for administrative close-out.

The vision of the project is to support Djibouti health reform, and to expand coverage of essential health services with a focus on rural areas. The Project Special Objective at the beginning in May 2004 was to achieve "Expanded Coverage of Essential Health Services" in order to address several of the conditions which contribute to Djibouti's high infant, child and maternal morbidity and mortality. The contract stipulated the following anticipated results for the three-year implementation period:

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

To expand coverage of essential health services, was funded by USAID to assist the Djibouti MOH in:

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

The official launch of the project took place at the Sheraton Hotel on January 23rd, 2005. Numerous participants attended including the US Ambassador, USAID

Representative, His Excellencies the Ministers of Health and of International Cooperation, and others including ambassadors, UN bodies' representatives, French Cooperation, international and local NGO representatives, members of Djiboutian civil society, MOH officials and District Hospital physicians.

During the four years of the Expanded Coverage of Essential Health Services in Djibouti Project (PECSE), the Project has made significant contributions towards improving health indicators in rural areas of Djibouti, meeting and often surpassing project indicators. Major contributions to national health systems development, especially the health management information system, community mobilization and health infrastructures refurbishment were achieved.

Major Achievements of the project implementation include the following:

- The project office established, Work plan developed jointly with the Djibouti MOH and approved by both MOH and USAID and launching ceremony held on January, 23rd 2005.
- Twenty three health posts have been rehabilitated, equipped, and furnished with solar electricity and an improved water source.
- All 23 health posts received support and training and the nurses supervised by MOH representatives and PECSE staff (including the social mobilization team and the Monitoring and Evaluation Officer).
- All health posts and district hospitals have been improved in using the data collection and management tools designed with the MOH and provided by the Project, sending their data monthly to the MOH, and actively tracking their progress towards goals.
- Community mobilization has been tested and scaled up to all the sites. Educational and promotional materials were developed and distributed to community health workers, and ceremonies were held in Champion Community sites to celebrate the work of the community (particularly the health volunteers) improving health indicators.
- In partnership with the MOH and health partners, the Project contributed to create and organize the health partners meetings, the immunization campaign, cholera outbreak management, etc.
- An End of Project Conference (EOPC) has been held in 2008 for best practices dissemination with the participation of MOH staff and health committee members from many communities. Documentation of major initiatives and successes was completed with various partners, and a final Project Brochure summarizing achievements was distributed.
- Project Evaluated by external USAID team. An external USAID MCH Program evaluation team visited Djibouti from May 26th 2008 to June 6th 2008. This evaluation was commissioned by the United States Agency for International Development's (USAID) Mission to Djibouti and USAID/East Africa in Nairobi to review USAID/Djibouti's health program achievements in improving maternal and child health (MCH) care mainly through the Expanded Coverage of Essential Health Services Project [Projet D'Extension de la Couverture de Services de Santé Essentials (PECSE Project)]. "Based on the findings, the Evaluation Team concludes that USAID assistance achieved its overall objectives and surpassed the magnitude of positive change that would have been expected in a 4-year period. The rapid progress made in the access to and use of MCH services contributed to an acceleration in the decline in child mortality.

- Close-out procedures were completed without many delays, including material property transfer, staff severance payment and other administrative tasks completed. Banking procedures were completed, and required deposits reclaimed although this activity required more human resource allocation than originally planned. Final administrative close-out, bank account closure, and reporting with be done by JSI/Boston staff including the out-going COP.

First health coordination meeting held on February 2004 with the Project support

Dikhil District Health Management Team training
(January 2008)

Project and MOH staff met in 2004 with the rural community
(Goubetto 2005)

1. INTRODUCTION INCLUDING MAJOR HIGHLIGHTS

The Republic of Djibouti is a small nation of roughly 700,000 located in the Horn of Africa. Upwards of two-thirds of the population have settled in the capital city recently, while the rest remain nomadic herders or occupy small traditional villages near watering holes or pasture lands. There is still a significant seasonal migration out of the capital city during the hot season each year, with many moving to the cooler highlands or adjacent countries where they have family ties. Life expectancy reflects the harshness of the climate- estimated at 43-55 years- and maternal mortality is about 740 per 1000,000 live births- one of the highest in the world. Malnutrition, malaria, diarrhea, pneumonia and tuberculosis are common.

USAID has funded a number of partners working in broad maternal and child health including UNICEF and WHO for more than a decade but significantly increased its investment in the health sector beginning in 2002. In 2003, JSI was awarded the contract for Djibouti "Expanded Coverage of Essential Health Services" (ECEH Project) in April 2004. Initially funded for three years, the Project was extended until September 2008. The contract stipulated a number of anticipated results including:

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

Intermediate Results (IR):

1: Increased Supply of Essential Health Services;

2: Improved Quality of Services;

3: Enhanced Local Capacity to Sustain Health Services.

At project onset, mortality and morbidity rates were high, and weak infrastructure ranged from decrepit health posts and district hospitals to bombed out facilities in the north that were partially or fully destroyed during civil conflict. Equipment was out-dated, broken, or non-existent. Staff in health posts normally consisted of a medic and aide with no formal training and who received no regular supervision; qualified personnel outside of district hospitals were a rarity. Each district had 1-2 physicians primarily concerned with the district hospital and mobile clinic services. The Ministry of Health (MOH) had unreliable health statistics, and very limited human resources to address any of these issues. While there were active multi-lateral and bilateral donors in the health sector, much of the effort was focused on big hospitals and the capital city.

The Ministry of Health's Health Sector Reform Strategy aims to increase access to health care through decentralization, prevention, and primary care. In addition, the MOH committed to investing USAID project resources in rural and peri-urban areas where conditions were the worst. Training of health workers including nurses and midwives was being modernized, and a new strategy for recruiting students from rural areas where they were likely to return to work later was instituted. At the community level, there was poor health knowledge and no systematic linkage of the health facility to community members. Unlike for other areas of health sector reform, however, the MOH was not interested in pursuing community involvement in health sector support.

The basic package of services supported by the Project included:

- Preventive care for pregnant women including anti-malarial drugs, iron pills and tetanus immunization
- Child growth monitoring and breast feeding
- IMCI including diarrhea, Acute respiratory infection and immunization
- Treatment for common infections such as malaria and common injuries
- IEC and Behavior Change Communications
- Counseling for HIV/AIDS prevention and STI treatment
- Community-based services

The Project was designed to focus on all four rural districts including twenty-three health posts and the four district hospitals, most of which required major renovations

and work on water supply. In addition, the Project was to assist with specific actions at the central level with the MOH, including development of a BCC package and establishment of the district component of a national health information system (HMIS).

JSI was awarded the TASC II contract for Djibouti "Expanded Coverage of Essential Health Services" in late April 2004. This report covers progress during the 4 years of the project implementation from May 2004 through September 30th 2008.

Each of the IRs were measured by project benchmarks, and was finalized and included in the Performance Monitoring Plan (PMP). This PMP was developed during the PY 01, and was revised in early 2006 after the visit of Dr. Vathani from USAID's regional office and according to additional comments by Mr. Tom Hall, CTO.

In early 2006, USAID informed JSI that the following four indicators are the main foci for USAID work in the health sector:

1. DPT3 Coverage;
2. Percentage of health facilities linked to community health committees with both male and female representation;
3. Percentage of health posts rehabilitated with a water system;
4. Number of training modules implemented.

In the fall of 2006, after USAID formalized their new system of Operational Plans and released books of indicators, PECSE worked with USAID/Djibouti to select three indicators from the options indicated for "investing in people." These indicators were to be analyzed each year, and superseded those included in the PMP for the purposes of USAID reporting. They were:

1. Number of child diarrhea cases treated;
2. Number of antenatal visits by a skilled attendant;
3. Number of people trained in child health and nutrition.

In August 2007, USAID informed JSI that the indicators listed in the table below were the main focus for USAID work in the health sector to reflect the OP goal of "investing in people." Following this request, the targets and performance indicators were desegregated by year (they were no longer cumulative). Some targets in PY04 were also reduced since the MOH withdrew the Project Training Officer and there was difficulty finding a replacement. The MOH also changed all the rural nurses and did not wish for them to participate in needed trainings. By end of 2007 the MOH also delayed the training and TA missions until end of the project.

Indicators	Activities/ Mode of calculation of the indicator	Source of the data / Baseline / Target	Annual PY Targets From May to April			
			Year 1	Year 2	Year 3	Year 4
DPT3 Coverage : Proportion of children aged 12-23 months who received the full series of immunizations for Diphtheria, Pertussis & Tetanus before age 12 months nationally	Numerator: # of children immunized by 12 months with DPT3 in a specified calendar year Denominator: Total # of infants less than 12 months of age the specified year	***Routine Data*** Baseline :11 % Target:10 % annual increase N= 23 health posts	11%	13%	15%	22%
Number/Percentage of health posts, rehabilitated and equipped, providing a basic package of essential health services in USAID assisted areas	Numerator: Number of rehabilitated health posts in Project areas that have essential equipment and provide a basic package of essential health services Denominator: Number of health posts in Project areas (Total facilities = 23)	***Routine Data*** Baseline : 0 Target: 19 annual increase N= 23 health posts	3	7	9	4
Number/Percentage of health posts linked to functional community health committees	Numerator: Number of health facilities in the Project assisted areas that are formally linked to a functional community health committee Denominator: Total number of health facilities assisted by the Project (total health facilities = 23)	***Routine Data*** Baseline: 61% Target: 16 N= 23 health posts	5	6	3	10
Number**/**Percentage of communities with trained community health workers	Numerator: Total number of communities with at least one trained community health aide Denominator: Total number of communities within the USAID assisted areas (total = 23)	***Routine Data*** Baseline : 0 Target: 87 % N= 23 health posts	0	5	10	10
Number of trained health workers in the Health Project assisted areas	Number of health workers (including community health workers and community health committee members) trained according to job/position specific service delivery guidelines, protocols and mandates. Service delivery guidelines and protocols are on file	***Routine Data*** Baseline: 0 N= 23 health posts	150	250	300	100[1]
Number/Percentage of health posts rehabilitated, including a water system	Numerator: Total number of rehabilitated health posts in the Project assisted areas Denominator: Total number of health posts in the Project assisted areas that need to be rehabilitated (as per PECSEI assessment = 16).	***Routine Data*** Baseline : 0 Target: 16 N= 23 health posts	3	7	6	0
Percentage of Health Posts supervised according to MOH guidelines for supervision and management	Numerator: Total number of health posts in health Project assisted areas that are routinely supervised (at least once every three months) , Denominator: Total number of health posts in Project assisted areas (total number = 23)	***Routine Data*** Baseline: 0 Target: 100% annual increase N= 23 health	50%	35%	45%	50%
Number of child diarrhea	Number of under-five child diarrhea	***Routine Data***				

[1] The fourth year target has been reduced to take into consideration the fact that the MOH withdrew both the project's Training and Social Mobilisation Specialists. In addition the MOH also postponed or cancelled planned trainings and supervision of the health providers.

Indicators	Activities/ Mode of calculation of the indicator	Source of the data / Baseline / Target	Annual PY Targets From May to April			
			Year 1	Year 2	Year 3	Year 4
cases treated with a) ORT and b) Zinc supplements	cases treated with ORT and Zinc supplement in the Project sites [2]	Baseline 2006: 1200 target: 10 - 15% annual increase N= 23 health posts	NA	NA	1400	1600
Number of training modules implemented	The number of training modules, developed by PECSE, implemented in the Health Project target districts	***Routine Data*** Baseline: 3 in 2007 and the total target:18 N= 23 health	5	10	3	0[3]
Number of people trained in child health and nutrition through USG supported programs	Number of people trained (health professionals, primary health care workers, non health personnel) in child health and nutrition conducted by the Project	***Routine Data*** Baseline = 131 Target : 150 by year	NA	NA	150	200
Number of people trained in treatment and care of infectious diseases	Number of people trained (health professionals, primary health care workers, non health personnel) in care of infectious disease conducted by the Project	***Routine Data*** Baseline = 131 is the PECSE year 2 performance Target : 150 by year	NA	NA	150	150
Number of people trained in maternal/newborn health through USG supported programs	Number of people trained (health professionals, primary health care workers, non health personnel) in child health care and child nutrition conducted by the Project	***Routine Data*** Baseline = 150 is the PECSE year 2 performance Target :160 by year	NA	NA	160	160
Number of health promotion and disease prevention messages delivered through the media which include print, radio and TV	Number of health promotion and disease prevention messages delivered through the media which include print, radio and TV	***Project reports*** Baseline = 7 radio spots in year 2 performance Target : 16 all media	2	5	7 radio spot	16 all media

[2] Given that the ORS protocol in Djibouti does not include Zinc for ORT (Oral Rehydration Therapy), only cases treated with ORS will be recorded.

[3] In the extension phase, it is not planned to develop new modules, but to use the existing modules to train or provide refresher training to the newly appointed nurses and district teams.

2. CONTEXT

Estimates of Djibouti's population range from 500,000 to 700,000 (for political reasons, a national census has not been conducted in decades). It is estimated that 80 per cent of the total population of Djibouti lives in or just outside the capital city. Overall, 83 per cent live in urban areas (the capital and other cities – e.g. Ali Sabieh, Arta, Dikhil, Obock and Tadjoura), and approximately 15 per cent of the total population is composed of refugees from Somalia and Ethiopia. Djibouti's poverty, high unemployment and chronic humanitarian and social needs make it susceptible to instability and social and economic collapse (based on information from USAID/Djibouti in 2005). The physical environment is challenging and average temperatures from May to September are over 40 degrees Celsius. In addition, there is significant population movement out of Djiboutiville and some secondary cities during this annual hot season, to both rural areas and to Somalia, Ethiopia, Eritrea and Yemen.

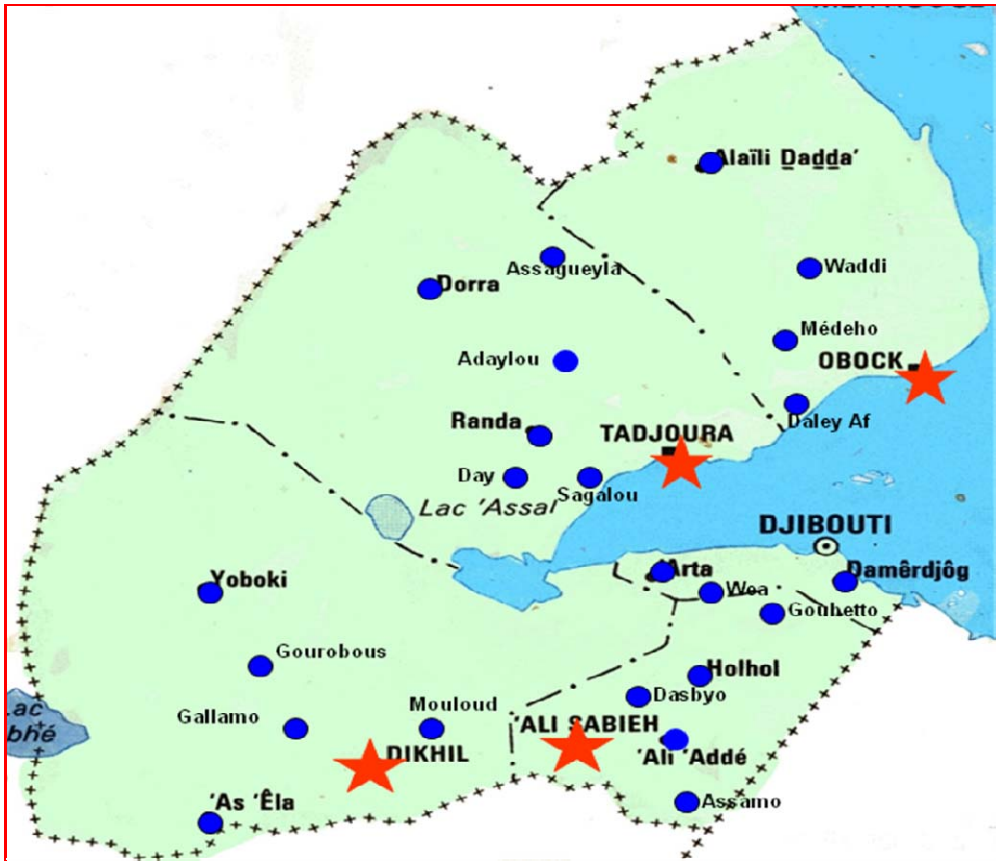
Djibouti's relatively high per-capita income of US $900 (World Bank 2003) compared to the average Sub-Saharan African country, and the high proportion of its population living in urban areas, are belied by its poor health indicators, including high rates of infant, child and maternal mortality, total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

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

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

The Ministry of Health struggles with low levels of trained staff, a historical concentration of physicians and other trained staff in tertiary care facilities in Djiboutiville, and little success in implementing primary health care measures throughout the country. The Government of the Republic of Djibouti (GORD) is well aware of these challenges and has undertaken a health reform program which emphasizes a decentralized management system, rationalized use of existing personnel, and an increased emphasis on prevention and primary care throughout the system. Success in assigning newly graduated nurses to rural areas, and implementation of strategies to train more health professionals ready to return to rural areas, show recent commitment to improving health throughout the country.

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



PECSE Project has targeted 23 rural health posts

3. COMPLETED ACTIVITIES DURING THE FIVE YEARS

IR 1: Increased Supply of Essential Health Services

PECSE has an ambitious program of actions to increase health service supply, and many of the activities under this IR are prerequisites for improved quality of care (IR 2). Many of the activities under this indicator have focused on improving the physical condition of health facilities. The project has worked to ensure that every targeted community has access to a health facility that is clean, hygienic, and well equipped (which includes having access to an adequate supply of clean water). PECSE has also prioritized the establishment at each health post of a core set of essential health services that are available to the community. The essential health package identified by PECSE in collaboration with USAID and the MOH includes:

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

Achievements of the five years include:

Rehabilitation of Health Posts

All targeted health posts (23) have been equipped and/or rehabilitated. While the majority of the 19 health posts work had been completed by then end of PY 3, Additional renovations for 4 clinics were also added at the request of the MOH and USAID, which were originally planned to be refurbished with African Bank funds.

Solar pumps and photovoltaic equipment were installed in all the sites. In addition, the project was able to respond to USAID/MOH requests to equip additional health posts not included in the original workplan. In total, 23 posts have been either updated or completely rehabilitated through the Project, and three health posts that were rehabilitated by other partners have been equipped by the PECSE Project.

Health Post in rural Djibouti, before and after rehabilitation

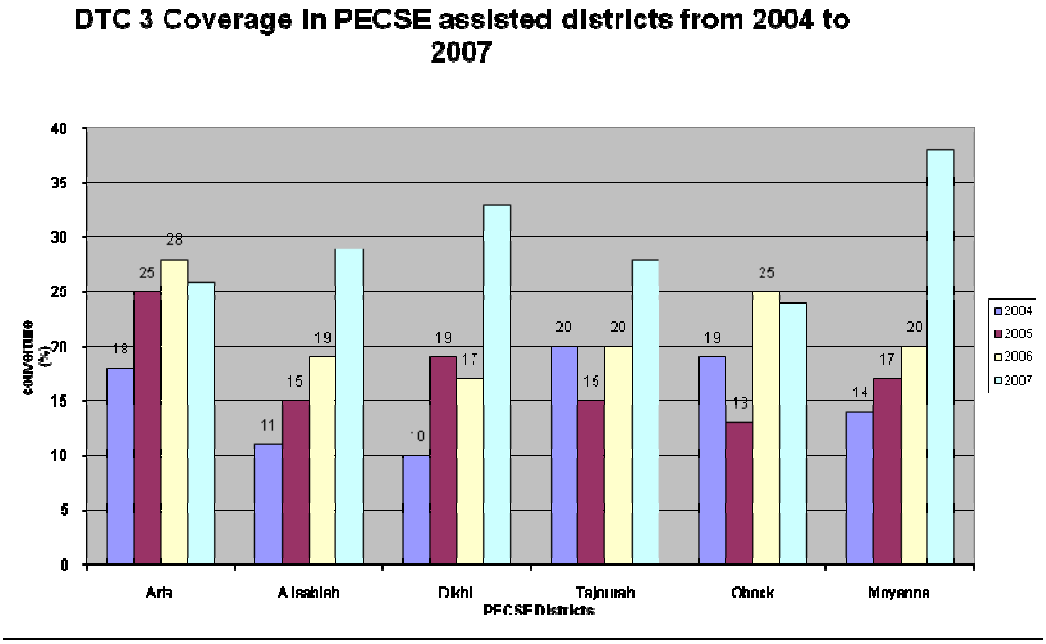
Water supply to the hardest-to-reach health posts had been developed and implemented. In partnership with the US military team, a well has been drilled to one site and equipped with solar pumps to provide water to the health post. The project also improved existing shallow wells at Medeho and Alaili-dada and used a local firm to replace the Dorra diesel water pump with a solar one and install solar pumps in Medeho, Alaili-Dada and Daley Aff wells. Only Assagueyla could not be provided with a solar pump since there would not be enough water in the shallow well even when deepened. In addition, the Project has been informed that UNICEF was working in Assagueyla to reinforce the shallow well.

In addition to the original equipment planned for each site, the Project worked with the MOH and the Ministry of Agriculture to provide special freezers to support the central Avian flu task force activities and water distillation systems to the districts hospital, as well as the Djibouti main hospital (Peltier). Many of these systems take advantage of the newly installed solar-powered generators provided by the Project. In addition to equipping the sites, training was provided to local health workers and volunteers in how to properly use and maintain the equipment.

A major radio communication procurement requested by the MOH and approved by USAID required long discussions with different national, regional and US experts. Difficulties in obtaining required permission from the government, questions of what frequencies could be assigned and who would pay for the frequencies and several requests from the MOH for changes in system design and insufficient time to complete the procurement and installation process led to the cancellation of this procurement.
*The project contributed to the immunization campaign*s covered through out the country. The project also funded the rehabilitation of 3 cold chains before helping UNICEF to provide solar cold chain to all the rural health posts.
Guidelines for health providers on basic services and supervision were also developed.

Water issue is a great concern in Djibouti mainly in rural area where thirsty animals are dying (Photos in Obock District July 2008

With the project support, water systems have been reinforced and equipped with solar pumps. Here the Medeho rural population is proud to show that water is now available daily from the shallow reinforced well of the village.



Assamo solar pump installation with the community participation

Dorra solar panels provide the pump with energy

Solar lighting and fans in a rural health post.

IR 2: Improved Quality of Services

Activities under this IR focused on human resource development and improvement of support to rural service providers including increased supportive supervision. Key achievements include:

Informing Policy and Practice with Reliable Health Data

During his life, the project took several steps to improve national capacity to gather, manage, analyze, and make use of health data. Urban centers were equipped with computers, printers, photocopiers and other equipment. The users were also trained an a training workshop took place in May 2007 facilitated by Dr. Abdou Mounkaila (MEASURE/Evaluation) and Dr. Michel Othepa (USAID/Immunization Basics) focused on the utilization of statistical health data for decision making. Participants included representatives from the MOH and health providers from both urban and rural areas.

All health providers in both rural and urban areas nationwide have now been trained in data entry and analysis and have access to the data collection tools developed by the Project. While information is recorded in PECSE-designed paper registers at health posts, district hospitals now enter their monitoring data directly into a user-friendly Microsoft Access database that was created by technical consultants from MEASURE/Evaluation. MOH staff accompanied the PECSE Monitoring and Evaluation Officer on supervisory visits to health posts and hospitals to ensure that data was being recorded regularly and appropriately. They have also worked together to review the quality of data at the central level. The Project has also facilitated the ability of MOH staff to access and use data by installing the first LAN network at the MOH.

Trained Nurse in Tadjoura District collecting Data for the Monthly Report

Establishing a Well-Trained Cadre of Health Workers

Maintaining a highly trained cadre of health workers at the health post level has been a major challenge of the Project. At the beginning of the project implementation in 2004, the majority of the nurses and midwives were not trained and there was not any in service training activity organized. The Project worked jointly with the MOH with the help of consultants to develop training modules and use them to train the nurses and midwives.

The main difficulty was the fact that the nurses were shuffled around between health posts and other facilities very frequently, and Project-trained nurses are typically replaced with nurses who have not attended PECSE trainings. Training activities were on hiatus the last two years of the project implementation as the project Training Officer had to leave the project in order to take up a position with the Ministry of Health and because the MOH delayed scheduled training activities.

Despite these obstacles, the Project was able to go with planned trainings in STI management, HIV prevention, child immunization, mother and child health, nutrition, data collection, and use of data in decision-making. PECSE has also provided technical assistance to the District Health Management Team (DHMT) to build their capacity to act as trainers and supervisors. However, the MOH cancelled or delayed all training activities scheduled for the end of the project (2007-2008).

Au total, 18 training modules were developed and used to train 845 health workers (including community health workers).

District health management teams (DHMT) and urban health providers training (December 2007)

Establishing a Network at the central MOH

With the PECSE Project support, a LAN network has been installed at the MOH offices to allow better information sharing between the MOH departments. This system allows the HMIS (Health Management Information System) to share the health information for the utilisation and decision making.

Central MOH Servers installed and functioning thanks to USAID

Mr. Knight, Director of the East African Affairs Office of the State Department interested in the PECSE work in support of the MOH LAN network (April 2008)

IR 3: Enhanced Local Capacity to Sustain Health Services

Social Mobilization: Empowering Communities to Improve Health

Following the study tour to Madagascar and Ethiopia in 2005 to share the social mobilisation experiences developed in these countries by JSI, MOH interest in social mobilisation increased. This experience helped the MOH to work closely with the PECSE Project team in order to develop National Strategy for Social Mobilisation. The framework of this strategy was proposed by PECSE, and the MOH invited all other health partners to approve this new approach. PECSE's community mobilization specialist found far more enthusiasm for education and mobilization at the community level itself, although in remote areas concerns for basic survival were foremost for the population due to the years of severe drought conditions that have followed years of minimum survival among the semi-nomadic tribes.

During the five year of implementation, the Project achieved complete coverage of all health posts with social mobilization activities. All sites (23 rural sites and 10 urban/peri urban sites) now have functioning health committees with both male and female members as well as at least four project-trained community health workers, at

Training for Community Volunteers' Work Plan Development

One of the challenges for the development of community mobilization at the beginning of the project was the lack of a MOH department in charge of social mobilisation, but after three years of implementation, the MOH created a Department in charge of the social mobilization activities and the project then helped the MOH unit to extend the social mobilization activities in three non project sites. In addition to their advisory and advocacy roles, the health committees are leading efforts to set up cost-recovery programs at several sites. The project organized supervisory and support visit to each health post. This includes both the 23 rural sites originally targeted for this activity, three non-project health posts and the 10 additional urban and peri-urban sites that were added at the request of USAID and the MOH upon seeing the positive impact of social mobilization activities in rural settings. During these visits, the PECSE team helped community health workers to develop monthly Activity Plans for outreach and educational activities, distributed promotional and educational materials (such as flip charts, posters, and t-shirts) as well as mosquito

bed nets and met with health committees. These educational materials produced by the Project were also distributed nationwide to project partners working in health or education.

The PECSE Project has also implemented and extended the Community Champion strategy implementation in selected sites, with 10 sites selected with two in each district. Unfortunately, Arta District could not participate for a variety of reasons, and withdrew from the program. PECSE launched a major education outreach campaign in December 2007 that involved reinforcing the BCC activities of community health workers with theatre, song, and dance embedded with health education messages. In the final months of the last year, ceremonies were held at Champion Community sites to honor community health worker volunteers and health committee members and to celebrate the community's work in improving health indicators. These ceremonies received the highest level of support from local and regional authorities, as evidenced by the attendance of figures such as the Sultan of the Afar, the President of the Regional Development Committee and local members of Parliament. Communities responded enthusiastically to the ceremonies, even creating new songs and dances for the occasion.

A Mobilization/education outreach campaign took place during the Project life to reinforce the BCC activities of the community health workers with plays, poetry, songs and dances imbedded with health education messages by some of the most renowned Djiboutian singers and comedians.

Community Champion dedication celebration in Daley Aff health post (April 2008)

A *major communication outreach campaign (December 2007)*

Upon seeing the success of PECSE's social mobilization strategy, the MOH has adopted aspects of the strategy to be implemented in upcoming years. Specifically, the MOH has decided to formally train and hire community health workers based at each health post, and has selected many of the PECSE-affiliated community health workers to participate in this program. Additionally, with the installation of maternity wards at the health post and growing demand for these services, the Ministry trained a cohort of aide midwives to staff the health posts following their expected graduation in the summer of 2008. Finally, as mentioned above, PECSE expanded social mobilization activities (specifically the training of community health workers, the creation of health committees and educational and promotional materials were developed and distributed to community health workers) to include not only the originally targeted rural areas, but also urban and peri-urban areas around the country. Joint teams from the Project and the MOH have conducted training and support visits in these newly targeted areas. These changes in policy represent a major achievement for the Project and reflect the success, and significant local and national support, of the PECSE social mobilization activities.

Developing Materials for Community Education

The series of flip charts were finalized after extensive revisions linked to pre-testing results. The series of flip charts were finalized, duplicated and distributed throughout the country.

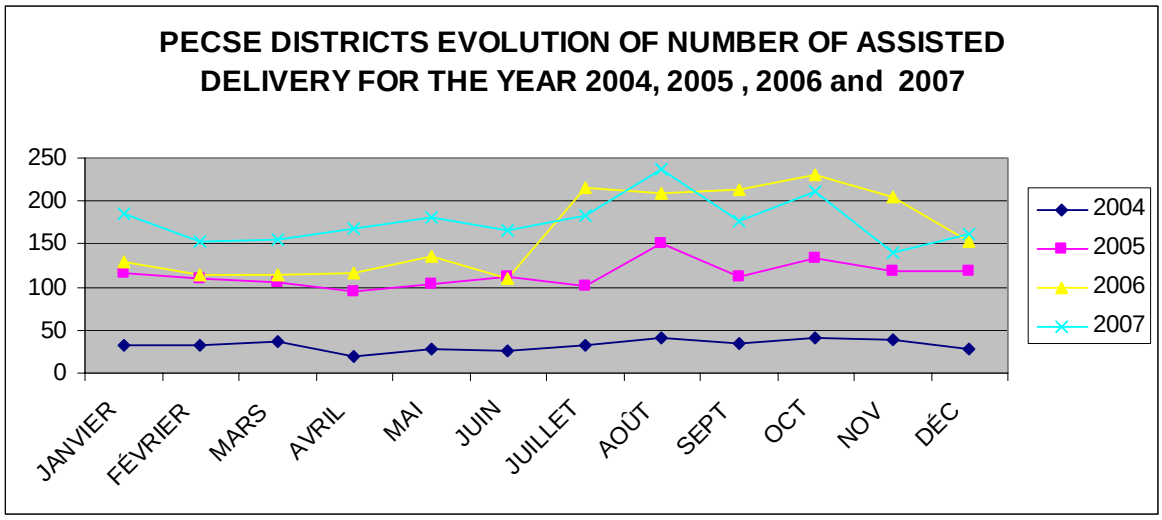
Radio spots that were developed during the Project Year 2 were broadcasted until the end of the Project in the three local languages on the following themes and broadcast:

- Pregnancy risk prevention;
- Diarrhea management and dehydration prevention;
- STI/HIV prevention;
- Malaria-in-Pregnancy prevention;
- Acute Respiratory Infections management;
- Child immunization;
- Breast feeding;
- Tetanus prevention in pregnant women;
- Nutrition and child growth monitoring.

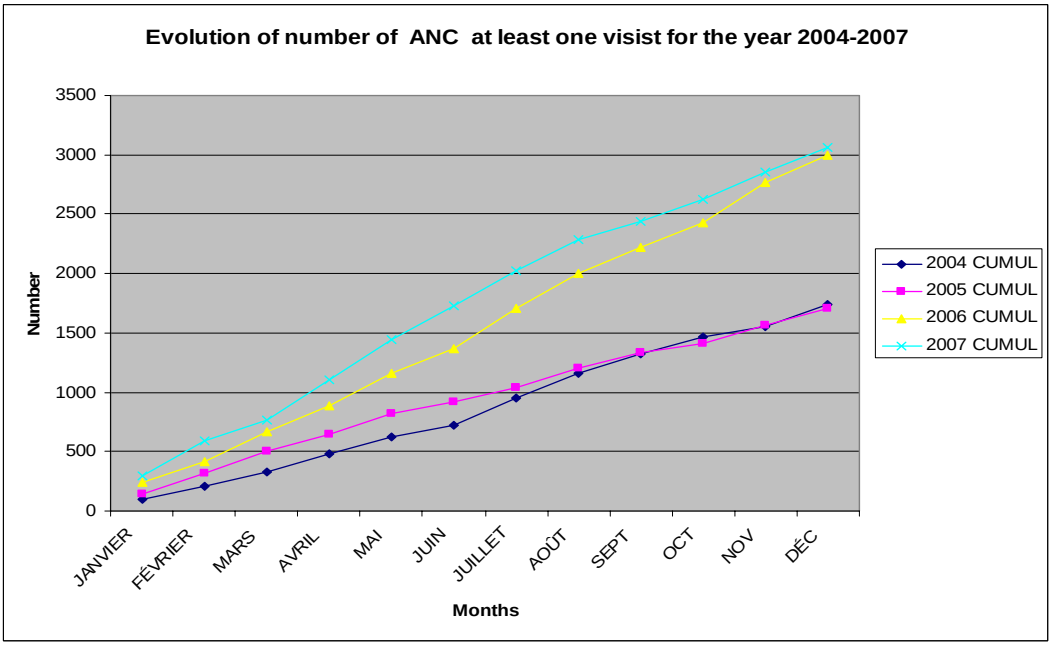
PECSE COP Welcoming the President of Djibouti, the Minister of Health and Distinguished Guests at the PECSE Project Exhibition Stand. April 2006

4. PROJECT FINAL RESULTS

ANNUAL Indicator 2: Number/percent of health facilities targeted by PECSE and equipped that provide the basic package of services



PECSE succeeded in linking facilities with health committees at each of the 23 targeted health posts by the end of Project Year 3 and has continued to provide these committees with support and supervision. At the request of the MOH and USAID, the Project has expanded the target to include the creation of 10 additional committees in urban and peri-urban areas (one in each district capital and another five in Djibouti City) during this year. These additional committees were trained in quarter 3 of Project Year 4.



ANNUAL Indicator 3*: Number/percentage of health facilities linked to community health committees with both male and female representation*

PECSE succeeded in linking facilities with health committees at each of the 23 targeted health posts by the end of Project Year 3 and has continued to provide these committees with support and supervision. At the request of the MOH and USAID, the Project has expanded the target to include the creation of 10 additional committees in urban and peri-urban areas (one in each district capital and another five in Djibouti City).

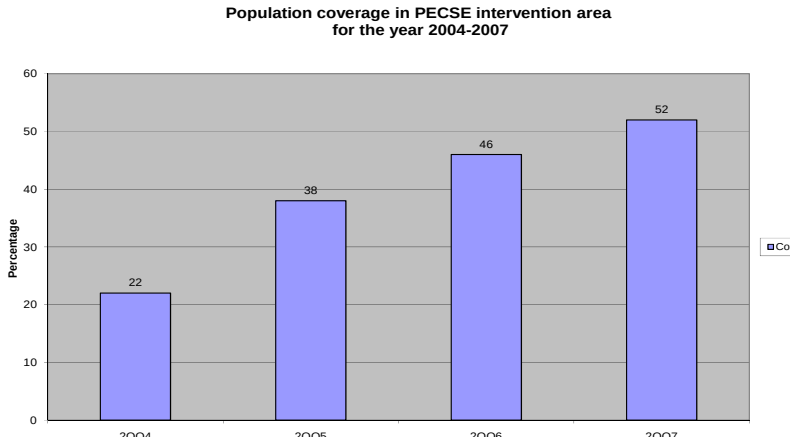
ANNUAL **Indicator 4:** Number/percent of communities with trained community health workers:
All target communities have trained community health workers, achieving 100% coverage. 128 workers from more than 23 villages were trained.

These indicators are recorded quarterly, and are organized under their respective Intermediate Result.

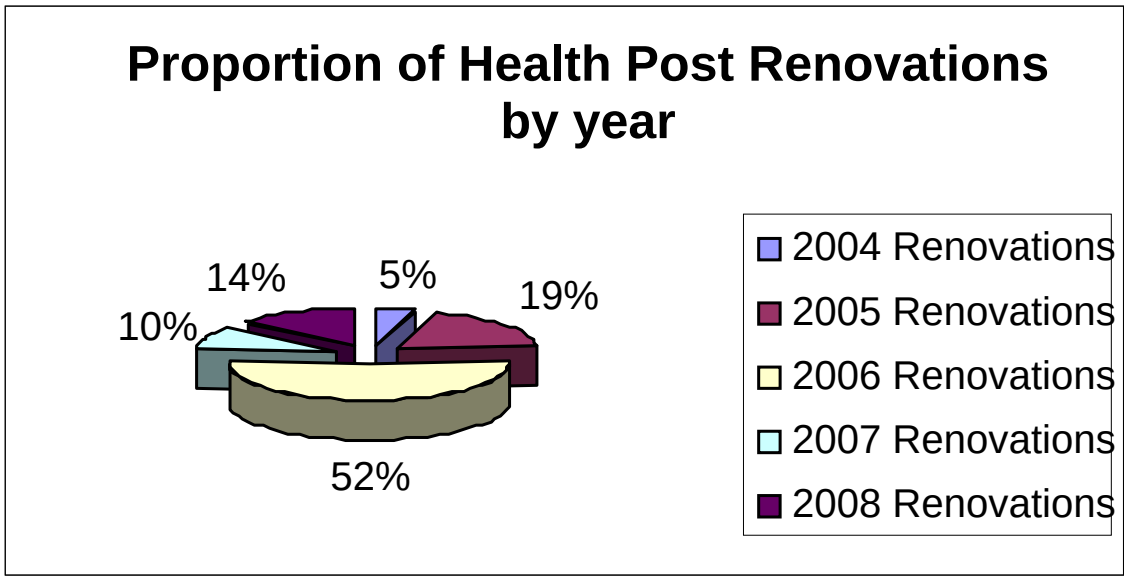
IR 1: Increased Supply of Essential Health Services

- IR 1.1 Population Coverage rates:

Coverage is difficult to calculate in Djibouti due to the lack of reliable demographic data in the country. It is also difficult to estimate the impact on coverage rates of a large nomadic population and recent influx of Somali refugees. PECSE calculates coverage rates using district-level population estimates from WHO; these figures were revised in 2007. The population coverage rate reached 52% at the end of 2007.



- IR-1.5 Number/Percentage of health posts rehabilitated, including a water system storage, by PECSE. The following chart provides a summary of status of rehabilitation and water supply.



As described earlier, all health posts have been rehabilitated: the 19 originally targeted and the 4 additional sites by request of the MOH and USAID. Water sources and storage systems have been improved at each site. Additional health posts rehabilitation (requested by MOH and approved by USAID) work have been completed.

IR 2: Improved Quality of Services

- IR 1.2 Number of training modules implemented:

During PY 4, the project had planned to conduct follow-up trainings using previously developed curricula as many of the original participants in the trainings have been replaced at the health posts and district hospitals. Refresher trainings were held on certain topics in the first quarter of PY 4, but most of the planned trainings for the year were delayed indefinitely by the MOH.

- IR:1.3 Number/Percentage of trained health workers (including community health workers and community health committee members) in the Project Area: 574

- IR1.4 Percentage of health posts supervised according to MOH guidelines for supervision and management: 100%

  All health posts in rural area (100%) received supervisory visits during this year

IR 3: Enhanced Local Capacity to Sustain Health Services

- Number/percentage of health facilities linked to community health committees with both male and female representation (see SO Indicator 3).

- Number/percentage of communities with trained community health workers (see SO Indicator 4).

5. COLLABORATION, COST-SHARING, AND COST CONTROL

Regular meetings and routine sharing of information and issues has reinforced positive coordination with USAID. PECSE enjoyed excellent technical and administrative support from USAID in Djibouti and USAID/REDSO in Nairobi. In 2005, USAID's long-term Senior Health Advisor arrived in Djibouti and soon became PECSE's CTO, adding to available support and coordination with the MOH.

One of the Project mandate is to help the MOH to establish a donor coordination mechanism, despite MOH resistance. Due to USAID and the PECSE COP, the health partners' meetings became a reality. USAID has been identified to be in responsible of the secretary of this Group and the COP was charged by USAID representative to be the secretariat of the partner coordination group. The first meeting resulted in a frank discussion between the MOH and the donors about the issues of human resources, and mechanisms for partner coordination. Regular meetings were held during project life with PECSE project support and two technical ad hoc groups have been created; one on the Millennium Objectives and the other on the health human resources development. Overall, donor and partner enthusiasm for the coordination meetings has been high.

The Project has also coordinated efforts with the USAID-funded EQUIPE I/AIDE project in the education sector. PECSE and the EQUIPE I/AIDE project coordinate in improving health messages in school curricula and in developing new ways to integrate specialized messages into primary school classrooms. Posters and a work book for elementary school students have been developed and printed.

The PECSE Project works closely with other donors in the health sector, sharing information and coordinating efforts whenever possible. PECSE also coordinates with WHO, World Food Program (on food distribution), the US and French Armies (on renovations and assessments), and other groups as possible.

Unexpected health crises required PECSE intervention. With both human and avian H5N1 bird influenza cases reported in Project year 3 as well as a deadly cholera epidemic in Djibouti, the Project was involved in several actions of the MOH to better curb and control these diseases. In addition, PECSE assisted communities and rural health post staff in preparedness for avian influenza.

The Project, following the MOH and USAID request, has given technical expertise to the MOH, in the health system reform and basic health reinforcement. The COP was

an active member of several core groups of the MOH who are in charge of these aspects.

Long-Term Planning for Health

Several PECSE staff, including the COP, were active and key participants in meetings and workshops to develop the Ministry of Health's national five-year plan. In addition to serving an advisory role in the process, PECSE contributed funding for a national meeting of stakeholders to discuss progress towards goals from previous plans and priorities for the future.

Support for ongoing MOH Programming

Besides the myriad actions laid out of PECSE in its Work Plan, PECSE was also flexible and responsive to MOH needs. During Project Year 1 to Year 4, PECSE supported several maternal and child health activities of the MOH, including working with WHO and UNICEF for the National Immunization Campaign, International AIDS Day or World Health Day, and the organisation of the large regional conference on the fight against Female Genital Mutilation which took place or health regional conference.

PECSE has landed technical expertise and other support to a variety of MOH programs. The project has assisted in the development of a nutrition program, a "Djibouti health map," and guidelines for health providers on basic services, including clinical algorithms. In addition, the project has provided the MOH with all of its training modules and materials for use by MOH trainers as needed. The Project provided TA for district health management team (DHMT) training. The concept of DHMT (District Health Management Team) is neither known nor applied in Djibouti and the project worked for the definition of minimum activities for the DHMT, the only alternative to ensure a better supervision system of health posts.
In summary, PECSE and the MOH have developed very satisfactory working relationships on several levels and throughout the country, leading to significant joint activities including planning, human resource development, renovation oversight and problem-solving. This is a real partnership, and is appreciated by both the MOH and USAID.

Immunization Campaigns: A Joint Effort

In order to support routine immunization (EPI) services, a joint program for EPI has been developed in collaboration with WHO, UNICEF and the Ministry of Health. Its implementation contributed to the effective coordination of the capacity building for EPI implementation. Expert technical support to EPI has been obtained from ImmunizationBASICS, a centrally funded USAID project implemented by JSI, and began in PY2. PECSE continued to be a major partner in nationwide annual immunization campaigns, partnering with the MOH, UNICEF, and WHO.

Sharing with the Global Health Community

Finally, during the first quarter of year 4, the Chief of Party and the Monitoring and Evaluation Officer participated in the JSI biannual International Division Meeting in Washington, DC. The theme of the meeting was "Monitoring and Evaluation of Projects" and was an opportunity to learn about best practices in impact evaluation and ongoing monitoring systems from other programs worldwide.

In the last year, an abstract sent by the Project Chief of Party and the Senior advisor to the Global Health Council held annually in Washington for an advocacy to sustain the community mobilization policy in Djibouti was accepted. Due to major activity in tha Djibouti Project, only the senior advisor attended the conference in May 2008 to Washington for this activity.

Coordination with USAID and the US Military:

Regular meetings and routine sharing of information and issues has reinforced on-going positive coordination with USAID. PECSE continues to enjoy excellent technical and administrative support from USAID in Djibouti and USAID's Regional Office in Nairobi.
The PECSE Project works closely with the US Military in Djibouti, sharing information and coordinating efforts whenever possible. In particular, the Project has partnered with the US Military to rehabilitate several health posts.

USAID and PECSE staff with the US Military team in the Project office (Sept 2007)

Distinguished Guests visited the project sites during the third implementation yea.
Here the discovery channel team with the Gallamo Community (Dikhil district)

COST CONTROL AND COSTS SAVINGS

The PECSE Project always used all available means to provide good value to the US Government and quality services to the population of Djibouti. The JSI management philosophy, applied to PECSE, is to both control costs and to seek ways to reduce costs whenever possible. A number of actions have been taken to contain costs.

1. Leveraging: Whenever possible, PECSE shared funding for activities with the MOH and other donors or projects. For example, cost-sharing for training activities initiated by ImmunizationBASICS were co-funded by WHO. National Immunization activities continued to be funded by multiple partners including PECSE. PECSE has also contributed to the commemoration of World Health Days in Djibouti with other partners (UNICEF, WHO, et al).

2. Identifying Best Local Technical Support: While there are limited numbers of trained technicians in Djibouti, PECSE has gone beyond the usual channels to find qualified people to perform technical oversight on renovations and other tasks. This usually has led to significant cost savings when compared to the responses to local requests for quotes on work. In one case, the resulting costs were less than one-half of what the lowest bidder has quoted.

3. Identifying Best Local Value: When finalizing arrangements for the purchase of materials and equipment, PECSE went outside of the usual suppliers to find additional options, saving the project funds and often obtaining better products at a lower price.

4. Using Local Government Resources: Although the PECSE contract stipulated use of outside experts for engineering and architectural work on clinic rehabilitation, PECSE identified qualified experts within the MOH to do some of the work,

reducing costs, increasing MOH ownership of the activities and increasing internal expertise within the MOH.

5. Identifying Appropriate Resources: Whenever possible, PECSE uses experts internal to JSI to provide needed technical support. Some of these experts come from other USAID-funded projects, such as MEASURE/Evaluation and Immunization Basics thus using US government resources whenever possible. PECSE has also utilized experts from other JSI projects overseas, who have first hand knowledge of similar conditions (Madagascar, Ethiopia). In both these cases, costs are usually lower that hiring independent consultants and results have been excellent to date.

6. Order the equipments and medical materials through JSI head quarters in the US had double advantages; in one hand, to get the materials using international procurement process rapidly, and on the other, to benefit from their technical expertise to make sure the quality reliability of the materials. This zone of the Horn of Africa, inundated by products from India and Pakistan, it is very important that the technical instruments be in good quality in order to resist several cycles of sterilization as well as the solar equipements.

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

Tree Planting by the Minister of Health and the US Ambassador after a health post dedication ceremony (2008))

6. CHALLENGES AND LESSONS LEARNED

Over the course of the four years of implementation, JSI's implementation team for PECSE has faced challenges and learned lessons about how to best work with partners in Djibouti.

Human Resources:

Human resource issues have been a constant challenge over the life of the project. During the first year of the project, it proved difficult to find qualified local staff to fill key positions. At the start of PY 4, two critical members of the PECSE team, the Social Mobilization Officer and the Training Officer, were recalled to positions in the Ministry of Health, and PECSE was forced to seek replacements for them. While the Project eventually succeeded in identifying a new Social Mobilization Officer, it was necessary to use an outside Consultant for training.

Regular supervision and follow-up trainings have proven to be essential to maintaining the quality of services at health posts, particularly because the rate of staff turnover is extremely high. The constant replacement of Project-trained nurses at health posts has made continual training essential. The MOH does not have a standard policy for longevity at post or transfers.

The MOH continues to express the need for a health system management model, including using statistical data for planning, monitoring and evaluating programs, and the organization of the district management and supervision teams. However, District Health Management Teams (DHMTs) have not been organized nor tasks delineated within the structure of the overall GORD plan for decentralization. The District Health Officers have undergone nearly constant change, and often believe their role is only limited to the curative activities, neglecting the preventive and management aspects; they often believe that district coordination, monitoring and supervision is up to the central level MOH administrators.

Future plans of the MOH will require well-performing DHMT to ensure an effective functioning of the decentralised health system, conducting trainings and supportive supervision of health posts' nurses, and performing key public health management tasks. As already mentioned, the regular re-assignment of the staff in charge of districts is a big concern, as is the low skill level of many staff in Health Posts. The MOH promised to assign additional staff, particularly Midwife Assistants to health posts in 2009. While waiting, the MOH recruited "Community Health Workers" from the Project "community volunteers" and trained them to be paid as nurse assistants in the rural area. The impact of these new health workers is not know; they are currently completing their formal training before returning to begin work in health posts and centers throughout the country.

Maintenance procedures and capacities:

One major concern in the MOH is the weakness of maintenance procedure and capacity. The need for more maintenance expertise required through USAID investments in solar materials, well pumps, solar refrigerators, intranet system, HMIS

database, etc, The MOH needs to be supported to put in place a functional maintenance system; while JSI provided basic repair and maintenance training to health post staff, staff changes and long-term needs require a more general approach to reinforcing MOH capacity.

Health Management and Information System (HMIS):

Four years of PECSE Project support to the HMIS (Health Management Information System) including specialized help from the JSI-implemented MEASURE Evaluation Project has enabled the district and national health staff to provide statistical data with a rate of completeness and promptness close to 100%. This was facilitated by the development of a customized database for the data collection and analysis of statistical indicators. Before the Project end, a senior staff from Measure Evaluation will conduct a technical assistance to the HMIS central unit in the comprehension of the database exploitation and utilisation. Key to the success of this work has been close collaboration from the start with MOH stake holders and other health sector partners.

Reinforcement of Community Mobilization:

All the communities around health posts have been mobilized; they put in place their health committees, as well as identifying community health workers who were then trained. The supervision of these community workers has been conducted as well as the distribution of the flip chart sets. PECSE implemented and supervised the Champion Community Initiative. These actions need to be reinforced in the future and sustain by all the health partners in an effort to support the MOH as they continue to implement their new community mobilization and partnership activities. In addition, peri-urban and urban health posts and clinics need adapted models of community mobilization, and the MOH requires more technical support to be able to extend and support these activities and Health Committees.

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Finally, when the MOH recruited “Health Promotion Workers” among the volunteer community health workers to assist the nurses mainly in the rural areas, a number of communities were plunged into conflict as some volunteers were recruited for these paid positions and some were not. For example, educational requirements eliminated some volunteers, and the MOH could only recruit two people per site. PECSE staff attempted to quell the issues and re-unify communities around support to the health facility. While PECSE expects that this policy will reinforce the MOH staff in rural areas and integrate women as health providers for the first time, there will be a need for regular supportive supervision that the MOH has not provided without partner prompting in the past.

Food Security:

The malnutrition situation for children in Djibouti appears to be a priority for the MOH. Between 2002 and 2006, rates for various malnutrition indicators among children increased (see Figure 6). Drought, high food prices and limited economic options exacerbate the problem.

The continued poor food security situation in parts of Djibouti, including a number of PECSE Project zones, has made efforts at community mobilization flawed. Communities with serious food and water shortages are more concerned with basic survival than with preventive health measures.

The Project assisted sites nurses are trained to identify and address malnutrition with scales provided by the Project as well as a small supply of food stocks. The food-aid largely comes from the World Food Program but they have frequently empty or near-empty storerooms.

Many children suffer from malnutrition, and PECSE has been involved in assisting the MOH to respond to this problem. In co-ordination with the MOH, PECSE included the renovation or creation of a space for nutrition education and the recovery of malnourished children in health posts rehabilitation plans when possible. PECSE also supplied cooking materials for 33 health nutrition centres in rural areas as well as in District health centres. In addition, arrangements have been made at many health posts to prepare and secure areas for storage of food aide.

According to experts on the region, the food insecurity in Djibouti is permanent and cyclical, and more sustainable solutions need to be identified than provision of food aide. With the growing violence in Somalia and beginnings of renewed exodus of refugees into Djibouti from Somalia, limited community resources will be stretched and the need for outside food aide will grow.

Access to Safe Water:

Resolving the potable water issues for health posts and the surrounding communities is complicated and fundamentally different at almost every site. The well drilling technical challenges and the procurement process required highly specialized technical staff. Djibouti does not have local firms with drilling rigs for well drilling or specialized providers of solar pumps, and this caused difficulties. Coordination with the US military on water supply issues was done in good faith; frequent turn-over of military staff led to delays, as did changing technical assessments by military teams and lack of clear coordination with the MOH and Ministry of Agriculture. For example, on several occasions planned water improvement work was scheduled only to find that another development partners was also scheduled to do the same work. During PY 4, a major change in technical assessment by the military led to a change in plan and budget as there was a new determination that only one well could be drilled instead of the three planned.

Gender:

Concerning the gender approach, PECSE Project staff consists of both women and men in both technical and administrative functions. PECSE also worked with the Ministry for the Promotion of Women and with the UNFD (National Union of Djiboutian Women) to create a Task Force in social mobilization and to train community health volunteers, who are both male and female. In addition, PECSE provided information and lobbied for the creation of a White Ribbon Alliance affiliate in Djibouti to provide public education and advocacy for maternal mortality reduction; to date, no chapter has been formed.

Environment:

An environmental impact assessment completed by USAID early in PY 2 raised a number of concerns, many being addressed directly by PECSE. PECSE has adjusted its plans to meet suggested actions, and is supporting the creation of incinerators in the health posts per USAID guidelines. In addition, PECSE is working with USAID to prioritize actions to improve access to potable water for health posts. The environment in Djibouti is particular by the almost absence of trees. Therefore, the Project distributed small trees to rehabilitated health posts during two years (PY 3 and PY 4) to fight against this harsh environment; some health posts have also modest planted gardens within the new fenced perimeters which keep out goats and other herbivores. Those small trees grew well in certain sites (Dalley Aff, Sagalou, Gallamo, etc) and both the MOH and the beneficiary population are invested in the effort.

Border conflict between Eritrea and Djibouti in 2008 made the north part of the country insecure.

Radio Communications:

A major radio communication procurement required long discussions for the needs assessment and the technical specifications preparation, requiring national, regional and US experts. The local laws are not clear on parameters for this type of activity, and this should be clearly expressed in the Project documents during the evaluation period. Since radio communication can be considered a national security issue, broader discussions about how to better improve MOH communications especially as related to emergency evacuation requests and epidemics should be established.

Partnership:

Partnership among bilateral and multi-lateral health institutions and the Ministry of Health was fundamental to the Project. Continued dialogue, joint planning, sharing of objectives and results, joint missions, and division of tasks created larger changes in Djibouti's health sector in four years than any one partner alone could have achieved. The success of the MOH in myriad areas is recognized by all, as are the continuing challenges to maintaining gains and continuing to reduce levels of morbidity and mortality.

JSI, the PECSE implementing institution, held a New Year party for key health partners

7. WORTH NOTING

USAID Representative, Madame Janet Schulman and JSI's Chief of Party Dr. Stanislas Paul Nebie received at the end of the Project (May and July 2008) the highest recognition a non-citizen can receive from the Government of Djibouti: National Order of June, 27th (Chevalier de l'Ordre National du 27 Juin). Mme Schulman and Dr Nebie were recognized as having played a vital role in helping to revitalize the collapsed health system in Djibouti, with focus on the rural areas; Both have served in this position during the past 5 years. They were decorated by the Djibouti Prime Minister as Knight of the National Order of June, 27th by the Djibouti Prime Minister in the Prime Minister office, in presence of the USAID staff and many MOH and USAID staff members.

USAID Representative knighted by the Prime Minister

Knighted JSI's Chief Of Party congratulated by the Minister of Health

8. PECSE Project Success stories:

<u>Success story</u>: A New Breed of Community Organizer: Saida of Daley Af Obock District, Republic of Djibouti

> "Sometimes I walk a long way to visit with women in their camps, but they don't always want to listen and sometimes they don't have time to talk. But I keep going- now we know things we didn't know before and we can be healthier."
>
> Saida, January 2006

Selected by her community to help prevent common illnesses and increase the use of health services, Saida works with a community of several hundred people, including several scattered encampments of traditionally nomadic families. For the first time, community mobilization is taking place in rural districts of Djibouti, as a result of the USAID funded initiative "The Expanded Coverage of Essential Health Services Project." For outreach workers like Saida, this is an opportunity to be a community resource—in addition to improving their own knowledge and health practices, they assist clinic-based nurses in linking those in need with available services.

Women rarely play visible public roles in rural Djiboutian society, and are virtually absent from the health care system. Consequently, the predominantly male cadre of nurses working in the countryside is often unable to be an effective resource for communities since women do not feel comfortable speaking with men about health issues. Female outreach workers such as Saida are helping women access health services and prevent illness, as well as overcome traditional beliefs about both sickness and prevention and women's role in civil society.

The Expanded Coverage of Essential Health Services Project, implemented by John Snow, Inc, aims to provide populations in rural districts with better access quality health services. Its objective is to reduce morbidity and mortality rates among women and children, and promote full community participation in health service delivery. In rural areas, the Project is working with communities to organize and train village health committees, select and train health workers like Saida and renovate, equip and update training for nurses. JSI provides materials, supplies and support to community workers, reinforces linkages between village health workers, the health committee and clinic health providers and provides support for the three parts of the local system.

Saida speaks with confidence about her role as an educator and motivator in a recent polio eradication campaign, and how it enabled her and other community organizers to feel self-assured about their community assessment skills. They now know where children and women in high-risk groups live, even among scattered

camps in a radius of several kilometers. Saida worries about the high level of anemia in women, which she

"Saida listens as people in the community talk about their health needs."

can now recognize from physical symptoms, and the commonness of diarrhea among
young children, and hopes to help change things. She refers potentially anemic women to the clinic, encourages pre-natal visits and teaches mothers how to rehydrate their children at home and when it is serious enough to seek help from the clinic.

“Before I was an animator, I wasn’t sure what to do,” Saida says. “Now I know—even though the work is hard sometimes, I like it and will keep doing it.”

SUCCESS STORY
Health Management Information System (HMIS) Improved in Djibouti

Djibouti suffers from a lack of reliable health statistics, mainly due to an inconsistent reporting system. In many remote health posts throughout Djibouti, data collection was either inexistent or insufficient as recently as 2006.

The USAID PECSE Project reinforced the system, working with health post nurses and supervising physicians to design and field test new Health Management Information System tools to register patients, collect and analyze data for decision making

On-going work by USAID's PECSE Project and the Ministry of Health has reinforced improved data collection in renovated health posts by providing training, supervision and tools to perform routine health data collection and analysis for all priority health areas

District hospitals, home to District Health Management Teams, and the Central Ministry of Health have been provided with a computer and software package and training for the Health Management Information System. Now data is available in each health post, collected and consolidated at the District, and used nationally. The Ministry's Information System is regularly supervised and more complete than it has ever been

***BEFORE*:**

Poor data collection in health posts

The USAID PECSE Project provided data collection tools to the entire country

AFTER:
Trained health agents analyze health data for decision making

The USAID PECSE Project computerized the system and trained health providers to collect, analyze and use data for decision making