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INTEGRATING COMMUNITIES INTO THE HEALTH SYSTEM

THE TAKAMOL PROJECT SUMMARY REVIEW

PARTNERS

Takamol is funded by USAID and is a collaboration between Pathfinder International, the government of Egypt, and a consortium of partners that includes John Snow Inc., Johns Hopkins Bloomberg School of Public Health Center for Communications Program, Meridian Group International, American Manufacturers Export Group, and Egypt-based Health Care International.

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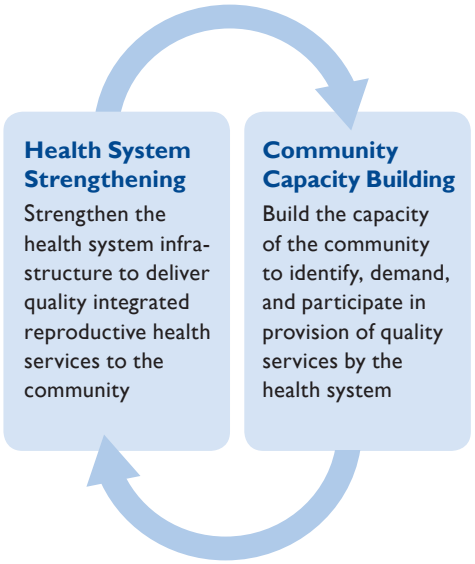
PROJECT CONTEXT & STRATEGY

In recent years the Egyptian Ministry of Health and Population (MOHP) and its partners have made great progress toward reducing maternal mortality in the country, lowering the rate from 84 per 100,000 births in 2000 to 55 per 100,000 births in 2007. As the UNDP reports, Egypt appears to be on target to meet its Millennium Development Goal for maternal mortality.[1] Still, recent indicators demonstrate that the need for quality, timely, well-designed, and well-delivered reproductive health (RH) services remains high for the majority of low income and rural Egyptian women. Poor women are still 2.5 times more likely to have a child die before the age of five than wealthy women. 57.4% of rural women do not regularly access maternity services during pregnancy, and 87% of all under-five child deaths in Egypt occur during the first year—and often within the first month—of life.[2]

PHOTO ON COVER AND ABOVE: COURTESY OF PATHFINDER-EGYPT



Recognizing the persistent need for quality RH services in Egypt, and with the support of USAID, in 2006 Pathfinder International partnered with the Egyptian MOHP and a consortium of partner organizations to launch the five-year Integrated Reproductive Health Service Project (Takamol). Takamol, which means "integration" in Arabic, was designed to build upon the advances of the Egyptian government's Health Sector Reform Program of the 1990s, which aimed to shift the Egyptian health sector from vertical programming to an integrated, lower cost model for delivery of care.[3] In line with this focus, Takamol sought to enable delivery of quality integrated RH services by strengthening two core areas: the health system and the communities served by the health system.

The Takamol strategy employed a two-pronged approach of health system strengthening and community capacity building to address the full breadth of the RH service delivery value chain, from supplier to user. On the supplier side (primary health care centers, hospitals, and individual providers and managers), Takamol's health system strengthening activities were designed

to ensure that the Egyptian health sector was able to deliver, maintain, and sustain integrated RH services. On the user side (patients), Takamol employed the socio-ecological model to address the individual, social, and structural factors that influence women's ability to identify, demand, and participate in quality reproductive health service delivery.

SITE SELECTION

Takamol identified health facility intervention sites based on a core set of criteria that included district-level health indicators such as contraceptive prevalence rates and antenatal care utilization rates. Selection also took into account MOHP facility renovation plans and performance assessments.

Each health facility's catchment population served as a community intervention site. In the less densely populated region of Upper Egypt, 131 primary health centers (PHC) were selected, amounting to a catchment population of over 1.9 million. In Lower Egypt, 44 rural health clinics and 4 urban clinics were selected, in addition to the obstetric, gynecological, and neonatal departments of 21 hospitals—amounting to a catchment population of over 755,000. The total 179 clinics and 21 hospitals targeted by Takamol encompassed a community catchment population of over 2.6 million people.

HEALTH SYSTEM STRENGTHENING

Takamol health system strengthening efforts targeted individual providers and their team members, and the institutional structures in which they worked.

PROVIDER STRENGTHENING

Takamol's provider strengthening activities focused on building providers' and team members' knowledge and practice of core RH areas. After assessing each intervention site's clinical knowledge and self-identified training needs, Takamol adapted curricula to address each site's technical needs. Across intervention sites, common training needs included: core competencies; counseling skills; topics specific to maternal and child health (MCH), family planning (FP), and RH; team-building for integrated service delivery; use of the Egyptian Maternal Mortality Surveillance System; management; and clinic–hospital referral systems. Takamol's training activities also included an on-the-job training program, which combined classroom teaching of best practices with practicum-like observed practice to maximize providers' understanding and effective application of the concepts learned in the classroom.

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INSTITUTIONAL & STRUCTURAL STRENGTHENING

MOHP technical assistance

Takamol provided technical support to the MOHP, using technology transfer and change management principles to develop trainings designed to enable national MOHP leaders to adopt the management, supervision, and business processes best suited to maximizing the effects of existing health reforms. To strengthen the MOHP's ability to guide, monitor, and support Egyptian health facilities, trainings targeted all levels of the ministry and emphasized strategic planning skills and integrated supervision practices. Using an inclusive revision process, Takamol also worked with the MOHP to revise relevant national practice guidelines.

Facility Renovations

At the facility level, Takamol's institutional strengthening began with full renovation of intervention facilities. Renovations included improvements to electrical and plumbing systems, painting and structural renovation, and furnishing of up-to-date medical equipment including ultrasound machines. Construction took place at the same time as provider training, so that staff were able to return to work as soon as facilities re-opened.

Board reformations

Clinic and hospital boards of directors (BOD) were historically composed of seven medical and government appointees, who were minimally involved in service delivery, and two community members, whose voices were often marginalized due to their small number. At the request of the MOHP, Takamol undertook efforts to establish democratic election processes for facilities' BODs. Efforts focused on increasing BODs' community representation (including women) as

well as on building their skills sets. BODs were trained in board management practices, financial and supervisory training, and technical support. Many lacked the financial skills and procedural abilities required to utilize service-improvement funds critical to meeting facility needs. In response, Takamol worked with the MOHP and the Ministry of Finance (MOF) to authorize bank accounts for BODs and train board members to manage service improvement funds in line with MOF protocol. Finally, all newly revised hospital BODs received training to establish Safe Motherhood Committees (SMC). Composed of the heads of all departments involved in MCH service delivery, SMCs were created to regularly review hospital maternal and neonatal morbidities and mortalities, identifying facility error and improving quality of care. SMCs linked obstetric and neonatal departments under one monitoring body and created a forum for addressing unresolved issues, thus strengthening the hospital's system for performance monitoring.

Combined community capacity building and health system strengthening activities maximized providers' ability to deliver quality services, and patients' ability to engage meaningfully with service provision.

COMMUNITY CAPACITY BUILDING

Takamol applied the socio-ecological model for behavior change to organize its community capacity building efforts. At the individual level, Takamol worked to ensure that women had the personal knowledge and skills to care for themselves, and to determine whether and when to seek care. Integrated health and literacy classes aided in educating women about the basics of RH while they simultaneously learned to read and write.

At the social level, community capacity building activities created networks of knowledgeable and supportive peers and family members to enable women's improved RH outcomes. Takamol trained volunteer outreach workers from the community in child and adolescent health, lifecycle phase-appropriate topics such as FP and pregnancy danger signs, and topics related to gender, such as early marriage and gender-based violence. Outreach workers conducted home visits to married women to provide one-on-one support, and couples communication courses aided in creating supportive home environments in which spouses enabled women to access care.

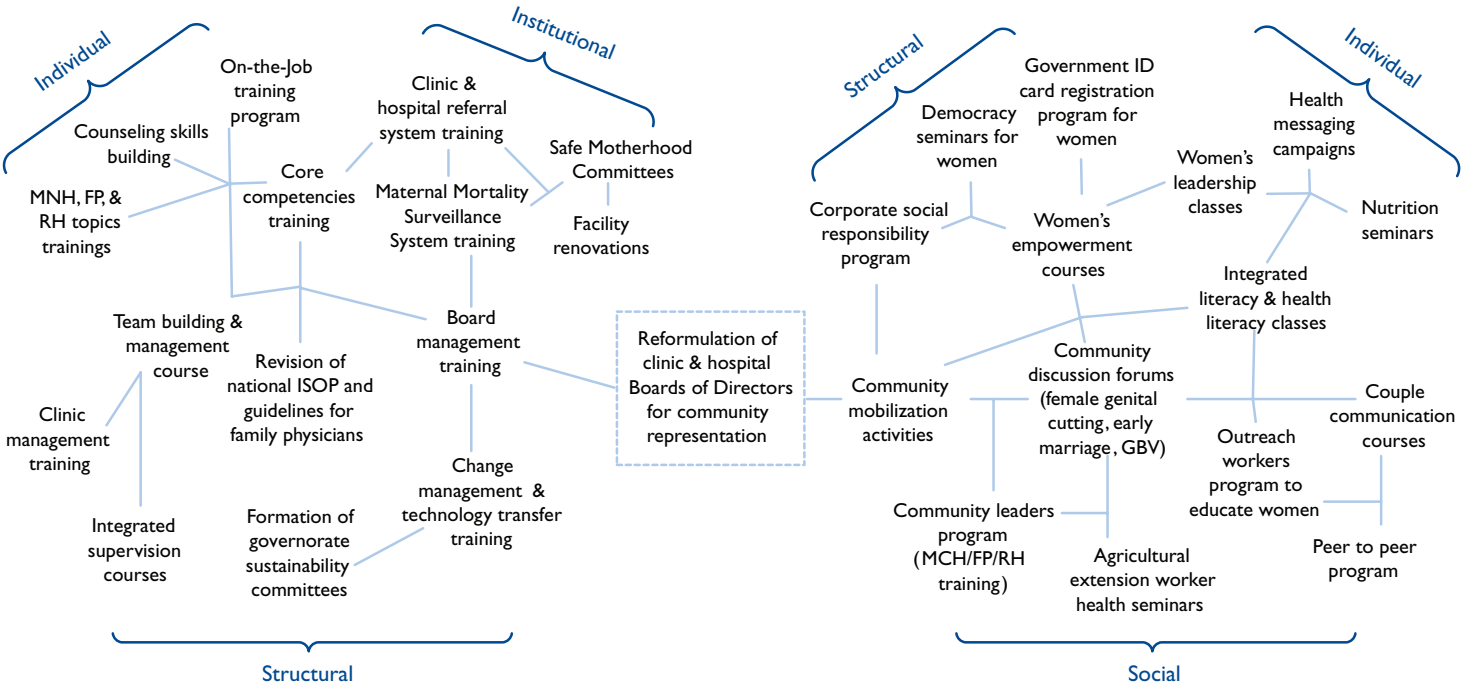
To influence social factors outside the home, Takamol identified Community Development Associations (CDA) to engage community leaders in support of the project. Takamol identified religious leaders, literacy facilitators, and agricultural extension workers to receive community leader training and serve as community mobilizers. Community leaders educated the community, encouraging men and women to identify and address social barriers to care, and increasing demand for services. Community discussion forums similarly created space for active communitywide debate on social topics relevant to RH.

Finally, Takamol conducted civic and corporate engagement activities in its structural-level work. Democracy seminars educated women on the basics of democracy, from voting to community organizing, thereby supporting them to advocate for themselves at the political level. To address food security and other structure-related health needs, Takamol helped women register with the government, issuing identification cards that proved necessary for voting and to participate in government assistance programs. Finally, to ensure that economic status was not a barrier to accessing services, Takamol implemented a corporate social responsibility (CSR) program. The CSR program served to encourage public-private partnerships and to leverage corporate s upport to generate donations to Takamol programs and services.

TAKAMOL'S REINFORCING ACTIVITY SYSTEM

Takamol's health system strengthening and community capacity building activities were designed to reinforce each other, leveraging the strengths of the existing health system and assets of communities to generate improved RH outcomes. On the community end of the spectrum, capacity building activities increased intervention communities' ability to engage in and claim ownership of health improvement

FIGURE 1: TAKAMOL'S REINFORCING ACTIVITY SYSTEM



efforts, and to mitigate the social barriers to their improved RH outcomes. Classes and home visits increased women's and family members' understanding of MCH, FP, and RH issues, and thus their ability to follow preventive health practices in their daily lives. For unpreventable conditions, skills-based trainings equipped women to better advocate for their needs in their social and political environments, and in interaction with their health facilities. When these activities were accompanied by community- and family-level education efforts to support women's health-seeking behavior, they fostered an environment supportive of women's positive health outcomes at all social and political levels.

At the same time, health system strengthening activities supported clinic and hospital staff to overcome existing impediments to integrating and delivering quality MCH, FP, and RH services to women, while increasing capacity to identify and understand community need. Takamol trainings helped providers and their teams to increase their technical knowledge and improve their service delivery and client-counseling skills. Clinic renovations improved the physical environment in which providers delivered services, and Takamol's technical assistance on procedures, guidelines, and managerial and business practices reshaped facilities' policy environments to enable providers' effective delivery of integrated care.

As Figure 1 demonstrates, the restructuring of health facility BODs was the lynchpin between Takamol's community capacity building and health system strengthening activity systems. Reformed BODs played an integral role in uniting health systems with the communities they serve, allowing facility leadership to directly represent the communities, and supporting facility leadership and delivery teams to more easily and effectively identify and meet their clients' needs.

By addressing both the provider (health system) and user (community) sides of the service delivery value chain, Takamol employed a holistic approach to the drivers of women's and children's poor RH outcomes. At the individual, social, and institutional levels, combined community capacity building and health system strengthening activities maximized providers' ability to deliver

quality services, and patients' ability to engage meaningfully with service delivery. At the structural level, combined health system strengthening and community capacity building activities created enabling environments at the social and political levels to support the Egyptian health system and the people it serves to improve RH outcomes.

M&E FRAMEWORK

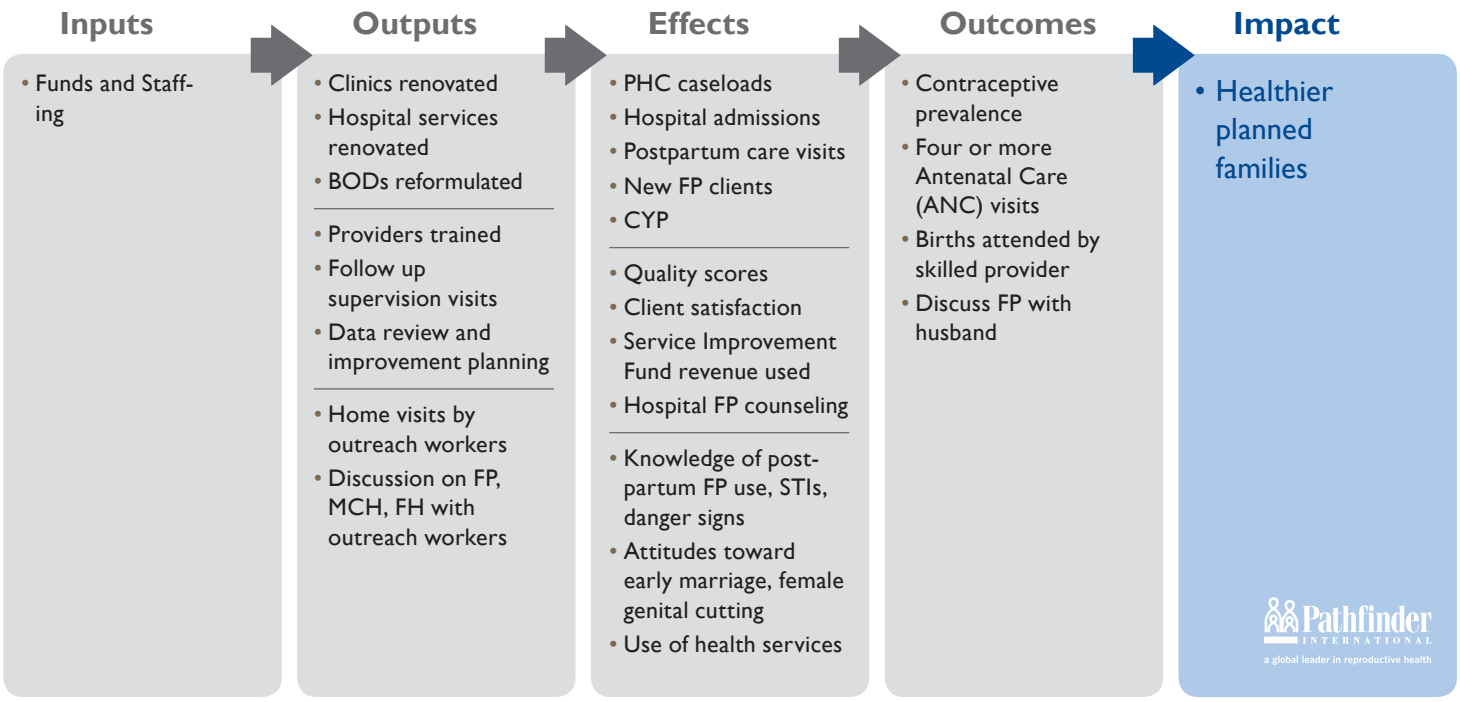
The project used a logical framework to identify indicators that describe how project activities are expected to effect change at the facility and community levels, as evidenced by increases in service caseloads, standards of quality and client satisfaction, and changes in health knowledge and service usage at the community level.

RESULTS

Takamol's five-year effort has yielded encouraging results. The program successfully renovated 179 PHCs and, in Lower Egypt, 21 hospital obstetric and gynecological departments. PHC caseloads increased from approximately 700 clients per month in the first month after re-opening to over 1100 per month by the end of the first year. Service statistics show that postpartum home visits per delivered woman rose from an average of 2.8 visits in the first month post-intervention to 3.5 visits by the end of the first year. In Lower Egypt, where Takamol focused additional efforts on improving neonatal care in hospitals, admissions to the neonatal intensive care unit showed an increase of 40% as compared to pre-intervention. Indicating the project's impact on service integration, in Lower Egypt 74% of women in household surveys reported having received multiple services during their last visit, up from 61.9% pre-intervention. In Upper Egypt, 66.7% reported the same, as opposed to 55.5% pre-intervention.

Overall, PHC quality scores, as measured by monthly quality monitoring checklists based on Egyptian MOHP standards of care, rose in both Upper and Lower Egypt intervention sites. In Lower Egypt, scores rose from 78% in the second quarter of the program to 95% 12 months following clinic re-opening. In Upper Egypt, scores rose from 79% in the first month after re-opening to 92% at twelve months after re-opening. Finally, client response to services reflected an overall improvement in patient perspectives on service delivery. In Lower Egypt, two-thirds of clients reported they had spent enough time with their providers and that all of their questions had been answered. In Upper Egypt, 80% of all clients reported that

FIGURE 2: M&E FRAMEWORK



all their questions were answered during their visit and 77% said they had spent enough time with their providers.

From a community capacity building perspective, Takamol also made achievements in increasing knowledge of and changing attitudes toward issues relevant to women and children's health outcomes. More than 50% more women in Upper Egypt and 31% more in Lower Egypt could report two or more pregnancy danger signs post-intervention than before interventions began. Post-intervention, almost three-quarters of women knew that early marriage is harmful to health and named the appropriate age at marriage as 18 years or over. Both regions saw significant increases in women reporting the best age to marry as 18 or over: from 75% to 92% in Lower Egypt and from 64% to 92% in Upper Egypt. Post-intervention, 50% more women respondents in Lower Egypt and almost 40% more in Upper Egypt could also name the important reasons why female genital cutting is harmful, including risk of bleeding, infection, and nervous shock.

Overall, the core components of Takamol's community capacity building approach were effective. Outreach workers successfully reached a majority of women in their catchment areas with essential messages about maternal and neonatal health, as well as FP, HIV prevention, and other practices harmful to women and girls. Women's participation in community activities such as literacy and empowerment classes increased dramatically.

Of particular importance to Takamol's reinforcing activity system, reconfiguration of facility BODs was a resounding success. In clinic BODs, Takamol nearly doubled community representation, increasing the number of community directors from 2 out of 7 to 5 out of 11. Community representation in hospital BODs increased from 3 out of 9 to 5 out of 11, nearly a 50/50 split between community and clinic BOD members. Women's representation on BODs also increased from 30% to 38%, a significant shift in Upper Egypt as women rarely served on BODs due to social norms.

Finally, Takamol met each of its objectives. Discussion of FP between women and their spouses, an outcome indicator that correlated to an observed increase in use of FP methods, rose between pre- and post-intervention across the regions. Regularity of antenatal care visits also increased significantly, as did deliveries attended by a skilled birth attendant.

TABLE 1: EXCERPT, TAKAMOL EVALUATION FINDINGS

Health System Strengthening Results			
Increased average clinic caseload		59%	
Increased new antenatal care users		8%	
Increased new FP users		19%	
Increased couple years protection (CYP)		18%	
Increased neonatal admissions (approximate)		40%	
Community Capacity Building Results		**Prior**	**Post**
Use of primary health services by any household member	*Lower Egypt*	83.0%	96.8%
	Upper Egypt	68.7%	99.5%
Women who received visit from outreach worker in past six months	*Lower Egypt*	37.8%	78.6%
	Upper Egypt	20.5%	86.8%
Women who participated in community development activity	*Lower Egypt*	3.0%	31.0%
	Upper Egypt	3.4%	46.1%
Women aware mother and neonate require care within first 24 hours	*Lower Egypt*	49.7%	88.4%
	Upper Egypt	44.0%	81.1%
Overall Program Outcomes		**Prior**	**Post**
Discussed family planning with spouse	*Lower Egypt*	46%	60%
	Upper Egypt	48%	69%
Current contraceptive use	*Lower Egypt*	75.3%	78.7%
	Upper Egypt	62.7%	68.7%
Four or more antenatal visits	*Lower Egypt*	22%	71%
	Upper Egypt	6%	74%
Last birth attended by skilled provider	*Lower Egypt*	62%	98%
	Upper Egypt	51%	99%

RECOMMENDATIONS & LESSONS LEARNED

During its five-year tenure, Takamol learned important lessons. In the interest of sharing this knowledge with the greater field of programmers and policy makers, lessons learned from the lifetime of the project are outlined below.

WORKING WITH THE GOVERNMENT

Working within existing MOHP rules and regulations during program implementation helped build government capacity to manage and "own" the program, and aided in reevaluating outdated procedures. Revising existing structures allowed MOHP staff to see that they could increase their productivity using regulations already in place, which in turn fueled investment in the program and a willingness to think critically about the need for potential additional MOHP procedural revisions.

COLLABORATION & PUBLIC PRIVATE PARTNERSHIPS

When addressing implementation constraints and public–private partnerships, "win-win scenarios" helped stakeholders both large and small to see the future benefits and rewards of engagement with the program. For example, corporate contributions to funding for community activities helped solve facilities' financial deficiencies, thusly improving service quality and increasing patient satisfaction, while giving donors the community recognition that they desired. In addition, the program enjoyed support from a diverse set of public and private sector organizations in large part due to its focus on health education (as opposed to a strictly health services focus). Such connections between the community and health sector evidently appeal to a broad array of less traditional supporters of health programming.

Participants of a Takamol women's empowerment course engage in debate over MCH, RH, and FP issues. PHOTO COURTESY OF PATHFINDER-EGYPT

WORKING WITH CLINICS AND HOSPITALS

Facility renovations attracted clients and contributed to higher utilization rates. Nevertheless, renovations should not be considered sufficient in and of themselves. Improvement of service quality is a critical counterpart to physical renovation and proved essential to meeting clients' expectations, which had been elevated by program outreach and capacity building activities. In the same vein, theoretical training for staff of renovated facilities must be coupled with well-structured on-the-job training programs if they are to yield upgraded skills and outcomes. This also proved true with district supervisors trained in integrated supervision. They too required observed practice training time to ensure proper functioning as a team, to draw up plans, and to put the plans in motion.

Takamol found that encouraging collaboration between university professors and MOHP practitioners to update clinical protocols increased time efficiency. In turn, the collaboration created a feeling of ownership among both partners, leading to the adoption of evidence-based standardized practices in the MOHP as well as in university hospitals.

Takamol's collaborative relationship with the MOHP also helped the project create an environment that encouraged analytical thinking and continuing education within its hospital sites.

Takamol's relationships with the MOHP and intervention hospitals proved mutually supportive to program goals, and led to important innovation. A prime example of this is the Safe Motherhood Committees, which exemplify the application of new knowledge in the hospital setting, made possible by support from the MOHP.

BOARDS

As part of Takamol's BOD reconfiguration efforts, it created a Board Exchange Program, aimed at gathering the most successful boards so they could exchange experiences. This practice was highly effective in inspiring them to step up their efforts. Given its success in boosting the change-management process within facilities, efforts like the Board Exchange Program should be introduced early in program efforts and conducted at a large scale across intervention areas.

Board reconfiguration efforts were a critical juncture between Takamol's health system strengthening and community capacity building approaches. BOD efforts proved an effective tool to introduce transparent supervision within facilities, and to increase facilities' accountability to the community. More than that, reconfigured BODs engendered widespread community support and enthusiasm for the program, which in turn helped to keep community health workers and other partners motivated and committed to the work at hand. In this way, BOD reconfiguration contributed to value generation across the program as a whole.

COMMUNITY & COMMUNITY LEADERS

The involvement of religious and community leaders in health activities in Egypt is not a new phenomenon and is often cited as a reason why FP programs have enjoyed such broad-based support and acceptance. Takamol, however, took this involvement a step further by connecting the community religious and traditional leaders directly with adjacent health facility staff in a way that benefited them both. Facility staff saw an increase in utilization of clinic services and a stronger sense of ownership by community members as a result of community leaders' involvement. They were also insulated from criticism in part because respected community leaders viewed them as providing a valuable service. In turn, community leaders gained a sense of satisfaction and empowerment in seeing members of their community achieving important progress on health issues as a result of their involvement in Takamol.

The use of health-based literacy curricula is also a highly effective practice that helped to retain the interest and engagement of adult literacy class students. The relevance of the texts prompted many students to use the literacy materials as reference books for their families and neighbors, which enabled Takamol health messages to "go viral" and maximize impact beyond the classroom.

MANAGEMENT & LEADERSHIP

Strengthening the role of MOHP middle managers (e.g. district supervisors) transformed them into strong leaders and active participants in the sustained delivery of quality MCH/FP/RH health services. The involvement of government supervisors from the earliest stages of implementation in their district was essential for transferring activities to other clinics. Unfortunately, in remote rural districts the turnover of district teams was problematic. To ensure that such instability does not impede project progress, it is essential that programs enlist and engage equivalent government representatives to assist in replacing teams.

ENDNOTES

1 UNDP, MOED. *Egypt's progress towards achieving the Millennium Development Goals 2010.* Accessed February 15, 2011.

2 El-Zanaty F, Way A. *Egypt Demographic and Health Survey.* Cairo: Ministry of Health, 2009. Accessed February 15, 2011. http://www.measuredhs.com/pubs/pdf/FR220/FR220.pdf.3 Gaumer G, Rafeh N. *Strengthening Egypt's Health Sector Reform Program: Pilot Activities in Suez.* Bethesda: Abt Associates. Accessed February 15, 2011. http://www.abtassociates.com/reports/ES _egypt_health_reform_suez_1005.pdf.

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523
Tel: (202) 712-0000
Fax: (202) 216-3524
www.usaid.gov