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REVITALIZING PUBLIC HEALTH CLINICS AND THEIR BOARDS OF DIRECTORS

THE TAKAMOL MODEL IN EGYPT

Caseload at the renovated El Awamia clinic in Bander, Luxor, increased from 450 to 900 visits per month. The clinic has become a major community resource and information center.

PHOTO: JENNIFER WILDER/ PATHFINDER INTERNATIONAL

The five-year USAID-funded *Reproductive Health Services Project (Takamol)* was launched in 2006 as an integrated model to help the Egyptian Ministry of Health improve family planning use and the overall health status of women and young children. *Takamol* is an international consortium, led by Pathfinder International with partners John Snow International, Johns Hopkins Bloomberg School of Public Health Center for Communications Program, Meridian Group International, and local partner, Health Care International. The program has been implemented in 179 primary health care clinics and 21 hospitals in 11 Upper and Lower Egypt governorates, and selected urban poor areas.

On the cover: **The revitalization of Boards of Directors of Primary Health Care Clinics, with members elected from both clinic staff and the community, has strengthened clinic management and clinic responsiveness to community needs.**

PHOTO: TAKAMOL STAFF

BACKGROUND

In the last two decades, Egypt has made significant progress improving health care with major reductions in maternal and child mortality, increases in immunization, and an increase in contraceptive use from 22.8 percent in 1980 to 60 percent in 2008.[1] However, great disparities continue to exist between the quality and utilization of health services in major urban areas, and that of more remote and poor communities. Despite a national abundance of trained physicians, more than 26 percent of women receive no antenatal care, and more than 28 percent deliver their children at home.[2]

Data on the maternal and child health/family planning/reproductive health (MCH/FP/RH) status of women and children shows the stark contrast between the poorest 20 percent and the richest 20 percent of Egyptians.[3]

As an essential part of improving services to the poorest and hardest to reach, the Ministry of Health (MOH) is working to transform community level primary health care (PHC) clinics into the primary service contact point for their Family Health Model (FHM) that integrates MCH/FP/RH.

1 Egypt Demographic and Health Survey, 2008.
2 Ibid.
3 USAID/Egypt, 2009: USAID/Egypt Population & Health Overview; History and Results.

THE TAKAMOL PROJECT

In 2006, the USAID-funded *Integrated Reproductive Health Services Project (Takamol)* was launched to implement a model for the sustainable integration of MCH/FP/RH services at the community level. *Takamol* works closely with the MOH to reduce fertility and improve health outcomes for mothers and newborns. The project focuses on achieving the following results: 1) increased use of quality integrated MCH/FP/RH services at the PHC level; 2) increased use of the same services at the hospital level; 3) positive behavior change in communities; and 4) improved capacity of MOH national, governorate, and district management teams, and health facility teams to sustain the performance of integrated MCH/FP/RH services.

REVITALIZING PRIMARY HEALTH CARE CLINICS

PHC clinics in Egypt's poor and hard-to-reach regions have long been under-utilized. Poor management, dilapidated facilities, inadequately-trained and indifferent providers, and insufficient supplies and drugs discourage clinic use by all but the neediest families.

One of the *Takamol* goals is to improve both the quality of care provided by PHC clinics and the level of demand for services. Working in 11 of 29 Egyptian governorates, *Takamol* has revitalized 179 PHC clinics to improve MCH/FP/RH services in the country's poorest and hardest-to-reach areas. *Takamol* has garnered the support of the MOH and key governors, which proved invaluable.

Facility improvements: A phased approach to clinic revitalization began with a comprehensive clinic assessment and selection process. Entire clinics have been renovated to conform to FHM standards. As of March 2010, 90 of the 147 intervention clinics (61%) have received FHM accreditation. While clinic renovation is essential to the improvement of quality services, it is also an important signal of *Takamol*'s commitment to the community. Renovated clinics have been reopened with considerable fanfare and major dignitaries in attendance. The publicity of these re-openings heightens local confidence, attracting new clients and sparking interest in replication in neighboring communities.

Strengthening Clinic Staff: To upgrade service quality, physicians and nurses receive nine days of didactic instruction in integrated MCH/FP/RH, taught from the *Integrated Standards of Practice* (ISOP) manual, which was updated by *Takamol*. Providers learn client-centered counseling skills to overcome client distrust and hostility, replacing it with quality communication and health prevention messages.

Clinic staff also attend management training to learn how to work collaboratively and use the necessary tools for continuous quality improvement. The management curriculum's results-focused management techniques, work planning, and monitoring skills have promoted an unprecedented sense of staff ownership over quality of care. District and governorate supervisors are included in these trainings as an essential first step in helping them realize the extent and value of the changes being made and this knowledge consequently leads them to provide the necessary support for continued sustenance of quality services.

TABLE 1: HEALTH INDICATORS BY WEALTH

	Poorest 20%	Richest 20%
Total fertility rate	3.6%	2.6 %
Contraceptive Prevalence Rate	53%	63%
Infant mortality rate/100,000	59	23
Under-five mortality	75	25

REVITALIZING CLINIC BOARDS OF DIRECTORS

PHC clinics in Egypt have long had boards of directors comprised of clinic staff and a few community representatives, but their role was weak and ill-defined. Token community membership failed to give voice to community concerns, which generally resulted in public indifference. In addition, the boards' weak spending authority over clinic funds significantly limited the clinics' ability to purchase equipment and supplies necessary for the long-term sustainability of clinic maintenance.

To revitalize the clinic boards and transform them into bodies of positive leadership, *Takamol* facilitated the democratic election of new board members, strengthened their procedures and financial management skills, and created a process for supportive supervision.

CLINIC BOARD ELECTIONS

Takamol has established democratically-elected boards of directors, with equal representation from clinic staff and the local community. Ten members are elected to each board—five from among all clinic staff and five from representative community groups (e.g., women's associations, religious leaders, agricultural groups, teachers, and community outreach workers). Female candidates are encouraged. The board is chaired by the clinic physician. Community representation is essential to overcoming local distrust and persuading families to drop their resistance to using the clinics. Board members must be local residents, age 30 to 50, with the time

Left: **Community members hold an excited discussion during election of their board members in Kafr-El-Sheikh.** *Right:* **A *Takamol* representative demonstrates the tallying of votes in the election of community board members.** PHOTOS: TAKAMOL STAFF

and commitment necessary to assume this important role. The election process, like board proceedings, is transparent to public observation and comment.

The open election process has significantly diversified board membership. More nurses are being chosen on the staff side and concerned community members, such as pharmacists, professionals, housewives and university students are replacing institutional community leaders, such as local council members. This shift reflects significant devolution of authority from public officials to community members.

CLINIC BOARD PROCEDURES

New boards elect their officers, including a secretary and treasurer. They follow transparent procedures for scheduling meetings, developing agendas, and keeping minutes, which are posted for public review. This is a great departure from previous board procedures, where meetings were sporadic, disorganized, outside of public scrutiny, and largely ineffective.

FINANCIAL MANAGEMENT

The management and spending of clinic revenues, including client visit fees, co-payments, and donations, all of which are placed in the Service Improvement Fund (SIF), is a principle responsibility of all clinic boards. *Takamol* trains the physician/board chair and bookkeeper in bookkeeping and management of a bank account, and revenues and expenses are posted for public scrutiny.

Takamol also trains clinic board members to manage current income, generate additional revenue, and oversee expenditures, ensuring that they fulfill clinic needs. While SIF funds were always collected, they are only now being effectively accessed and used for the purchase of new equipment, renovations and maintenance, and hiring new personnel. Clinic staff present their needs for equipment and improvements, and community members give voice to concerns about services, facilities and clinic operations, and the board decides how to allocate funds. With solid knowledge about facility needs, community board members can make credible appeals to their constituents for donations (e.g., fans, carpets, an EKG machine, a dentist's chair). With this information and a trusting relationship, community members generously donate funds, labor, and material.

Over the course of the project, the 138 boards in project clinics have increased the average monthly SIF revenues they raised from $89 to $235. Nineteen percent of these

Covered seating areas, like the one shown here in a clinic in Luxor, are often the result of clinic board fundraising efforts. PHOTO: TAKAMOL STAFF

donations have been made in cash and 81 percent in kind (construction improvements, furniture, painting, and repairs). Average monthly expenditures of these funds for individual clinics have increased from $27 to $76 for syringes, infection control materials, and other medical equipment. The Salem Mekki Clinic in Luxor District increased their funds available for drugs from LE 4,000 to more than $711 to $1,049 in one year, and their income from individual client fees increased from $142 to $284 in only three months during 2008.

As trusted neighbors and local leaders, board members have become vital communicators of health messages on the importance of MCH/FP/RH care. A growing number of religious leaders on boards now play critical roles in overcoming religious taboos against FP and discouraging harmful traditional practices.

CLINIC BOARD SUPERVISION

After the original development of the clinic board model, *Takamol* recognized the need for sustained oversight, support, and management of boards that are sometimes weakened by limited skills and high member turnover. In project intervention areas, district teams were trained to supervise between 10 and 40 clinics each. After observing clinic board trainings and the changes that can be achieved, teams attended a five-day Integrated Supervision Training on supportive, on-the-job (OTJ) team-building supervision. For six to nine months, the teams were coached through OTJ training, while they provided managerial and financial supervision to clinic boards under their responsibility. Reversing the traditional vertical, punitive manager's role, team members supported staff in sharing the process of performance analysis. More independent, self-monitoring clinics now function on their own; district team presence was very hands-on at the beginning, but tapered off as board strength increased.

REPLICATING THE CLINIC BOARD MODEL

To ensure sustainability, more than 80 percent of district team members have been trained to lead additional clinic boards through a replication process without *Takamol* assistance. By the end of 2009, teams had trained 244 non-project boards. Taking advantage of the enthusiasm that engages clinics undergoing change, teams initiated new programs in neighboring clinics for modeling and inspiration.

District team members are valuable intermediaries, breaking down initial opposition in new areas. Their coaching and mentoring strengthens clinic board members who may lack the experience or confidence to make suggestions or decisions of consequence. Some boards go through a dormant phase due to changes in member priorities, but district teams can encourage new elections and replacement of members who do not attend.

RESULTS

As of the end of March 2010, the 179 clinics where *Takamol* has intervened showed a 72.1 percent increase in caseload above baseline assessments (858,083 pre intervention and 1,477,053 post intervention).

Nationwide, clinic boards are no lon-

An MOH outreach worker and board member of the El Toud Clinic in Luxor Governorate, this woman has seen community members become more trustful of the clinic. A religious leader and a physician accompany her to community gatherings to help community members (especially men) be more open to FP and RH.

PHOTO: JENNIFER WILDER/PATHFINDER INTERNATIONAL

As an NGO worker, this board member does community outreach. "The people are hungry for information, but traditional beliefs are difficult to change. If the villages in Upper Egypt change, it will improve all of Egypt in terms of beliefs. We are seeing a 60 percent commitment to change."

PHOTO: JENNIFER WILDER/PATHFINDER INTERNATIONAL

THE TAKAMOL TRAINING MODEL

A corporate training and management methodology was adapted for developing and sustaining quality management teams from governorate to district to clinic levels. The training model addresses rigid hierarchies, inefficiencies, and lack of ownership that have long constrained Egyptian health services. Through group workshop sessions focused on individual engagement, sustainable team building, and collaborative problem solving, hundreds of formerly dormant and ineffectual boards have become vital links between clinic and community, providing leadership and financial stewardship responsive to public needs.

Dr. Amal Adel is the El Zinia District district manager. "Things have changed at all levels. We now have political support at the top and from the community. People never used to understand the difference between what they thought they wanted and what was possible to get at the clinic. Now they know. I have worked with the Takamol team to replicate this process in one other clinic in Zeniya and then in two additional clinics without Takamol. They have been very supportive in helping me get government approval of the results."

PHOTO: JENNIFER WILDER/PATHFINDER INTERNATIONAL

ger dismissed as useless. Their successful community engagement draws families to accept the value of the family health model. Beyond improvements achieved through financial and in-kind contributions, men and women now respect the information they receive at the clinics, which translates into better health care decisions and behavior at every level.

LESSONS LEARNED AND ONGOING CHALLENGES

BOARD MEMBERSHIP

Religious leaders are invaluable board members. Their respected positions and credibility make them key advocates for behavior change and acceptance of health care interventions. This is especially true for acceptance of FP, but their sanction is also often needed by husbands simply to allow their wives to attend a clinic. Most trained religious leaders are deeply committed to project goals, as they see healthcare as an important area in which they can provide leadership.

BOARD DEVELOPMENT AND TRAINING

- Clinic board members come from very different backgrounds, and trainers must allow ample time to reconcile perceived conflicts of interest between clinic and community members. While training unites members around goals, it takes time for them to let go of their differences. *Takamol* introduced a clinic board exchange program that brings diverse board members together to share experiences and ideas, which has stimulated members to expand their horizons.
- The experiential nature of the management training process makes it difficult to find knowledgeable Egyptian trainers comfortable with this approach. In addition, most qualified trainers come from a university environment or professional organizations and are unfamiliar with working with the government. As a result, training of trainers requires a considerable investment of time.
- The support of the MOH at every level is essential to sustainability and long-term systemic changes. *Takamol* finds it useful to include a co-trainer from the central MOH office for all trainings, which helped ensure MOH cooperation and support. Replication of the clinic board model in new districts is markedly easier if local health authorities are vocal in their support.

TABLE 2: INCREASES IN SERVICE DELIVERY

	Pre-intervention	Post-intervention	
	Clients	New clients	% average increase
Antenatal care visits	12,032	15,428	28
FP new clients (any method)	13,296	16,946	27.5

The Governor of Luxor, Dr. Samir Farag, during the inauguration of El Hebeil PHC clinic, July 2009. PHOTO: TAKAMOL STAFF

SUSTAINABILITY AND REPLICATION

- To promote acceptance and replication of the clinic board management model in districts outside project areas, *Takamol* invited central MOH leaders to observe the model, participate in the implementation of its components, and experience the impact and value of the changes taking place. Their understanding and enthusiastic support has been key to scaling up in new communities.

- District teams are more effective in replicating clinic board improvements in areas where at least 50 percent of the clinics in the area are participating in this process. Where only one or two boards are involved, they lack the inspiration and clarification provided by a model.

- *Takamol* is bringing trained clinic boards together to exchange experiences and feedback on the replication process. Once follow-up and coaching has been done with two or three board members in a new district, the foundation is laid for the replication process. The key is local understanding and buy-in.

- Management and oversight of clinic boards places heavy demands on district teams. However, if their tasks are planned according to their own vision and priorities, teams become invaluable in assuring high quality standards of care.

CONCLUSION

Takamol's comprehensive upgrading and revitalization of Egyptian PHC clinics demonstrates the vital importance of combining improved services with increased demand. By upgrading the quality of facilities, as well as clinical and management skills, the facilities now rival or exceed services offered at a higher cost in the private sector. And the innovative restructuring and strengthening of clinic boards has introduced the community oversight of clinics that USAID has long sought as a sustainable approach to creating demand and making healthcare services responsive to client needs.

The *Takamol* approach to providing MCH/FP/RH services has raised community and facility expectations for quality and responsiveness. Because the process is owned and improved by these stakeholders, as well as their supervisors up through the levels of the MOH, there is every reason to expect this approach to be replicated and improved over time.

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