HANAN QUARTERLY NARRATIVE REPORT
Reporting Period: July through September 2005

Introduction

This section provides the Executive Summary of this report. More detail is provided in the subsequent sections. In addition to this report, a number of longer technical documents are mentioned in the text, most of which were either created by project staff, or were commissioned by the project. These are available upon request.

I. Overview of Progress and Accomplishments

This quarter was focused almost entirely on preparing to launch the Project's implementation steps, on establishing the Project's satellite offices, and on beginning to lay the ground work for the Project's Sustainability Strategy.

As those familiar with the Project will recall, the first and second quarters of the Hanan Project were focused on organization and management, on creating the M&E system, on staffing, and—especially—on fact-finding, strategic development, and establishing relationships with key stakeholders.

The third quarter was taken up with the detailing of interventions, tools and methods, and the identification of human resource development arrangements. This pre-implementation period also involved finalizing the choice of participating communities, associated PHC clinics, and implementation partners. One highlight was the completion of the in-depth health facility assessments of participating clinics and the initiation of the capacity building process. The assessment of community capacity was also initiated.

One major and crucial effort was devoted to developing a strategy for maximizing sustainability for two key aspects of the Project:

1) The clinic supervisory function; and,
2) The community mobilization function.

This undertaking is discussed in the following paragraphs

The highlights of this quarter are summarized below:

A. Sustainability Strategy

The strategy for maximizing sustainability involved two key aspects of the Project:

1. The clinic supervisory function; and,
2. The community mobilization function.

The logic behind aspect one was that, in the absence of continued and effective supervision at the clinic level, the improvements established by Hanan would quickly evaporate. Given that the Project will work primarily with MOH clinics, it was necessary to seek arrangements wherein the MOH would at least begin to take responsibility for the clinic supervisory function. Although arrangements are not finalized, we are pleased to report that the MOH has been most sympathetic.

To implement the above, staff are working with MOH officials to hire two Public Health Officers for the Satellite Teams in WB. The agreement is that these two staff will be paid by the Project at roughly the Government rate, and will become MOH staff members at the end of the project. For Gaza, there is agreement, in principle, to have the MOH "second" already hired public health doctors to the two Satellite teams. The MOH will fully cover the salaries and benefits for these "seconded" staff, while Hanan will train them and will provide logistics support. In keeping with USAID regulations, no direct cash funding will be provided to any MOH staff.

A second part of the Project's sustainability strategy is to outsource the two staff of the Community sub-team in each Satellite Team, to a qualified NGO. Although these staff will be jointly recruited, they will be paid for by the Project, and will be regular staff of the NGO. The intention is that these staff will remain with the NGO following the Project, to enhance its capacity and to contribute to the sustainability of Project's Community activities. Present arrangements call for all Community activities in WB to be outsourced to a leading NGO (Palestine Medical Relief Society), and in Gaza to be divided between two NGOs (Near East Council of Churches, and Ard al Insan). In all cases, Hanan is developing the modality for joint supervision of these MOH and NGO staff, ensuring that Hanan will retain the control it needs to assure accountability.

We would here like to express our thanks to ANERA for its flexibility over the past months as regards precisely which Satellite staff would be outsourced, be dedicated to MOH, or be hired by ANERA. It is not too much to acknowledge that ANERA played an important role in allowing these developments to take place.

B. Satellite Teams

Two of the four Satellite Teams—in Hebron and in Gaza City--are now housed, staffed (except for the seconded and outsourced personnel), and are beginning to function. Active recruitment for the remaining two Team Leaders (for Jenin and Khan Younis) has been underway for some time. Given the unusual qualifications required and the rigorous screening by the Project, it has proven difficult to staff these positions. A crucial need of the Teams is to develop the

full armamentarium of tools and methods each team will need to conduct their clinic and community interventions. Equally important is for the Project as a whole to be able to coordinate visits of staff to each field site so as to support the Team's efforts, and to communicate with team counterparts, without overwhelming the Teams. Finally, as noted, it is essential to develop the modalities of joint supervision of Team staff and of field level activities in a way that meets the needs of all concerned. The process for developing the myriad of tools and methods and procedures is well underway and will be completed by middle of October, well in advance of the onset of full operations.

C. Most Vulnerable Clinics and Associated Communities

It is fair to say that Project staff had little appreciation of what a long and difficult process would be needed to complete this process successfully using the evidence based and thorough approach we deemed necessary. The benefit of the process was that Project staff learned a great deal about the dynamics of "vulnerability," and what drives health seeking behavior and access to services. In some ways, the most difficult aspect of the process was interfacing evidence-based findings with the "political realities" of the various stakeholders. With this process now behind us, and feeling confident of our choices, we are able to move ahead to build upon the assessments and informal discussions already done at the community, clinic levels and MOH-NGO partner levels. In retrospect, one of the most valuable steps in identifying partner communities and clinics was the Field Validation Visit. A great deal was learned which surely helped to make the final choices as well informed as possible.

D. Capacity Building

Perhaps of all the interventions being undertaken by the Project, Capacity Building is the most complex and determinative of impact. In order to target Project inputs into clinics and communities as much as possible, it was first necessary to determine the current status and needs of each, using as a reference the capacities needed to meet Hanan MCHN goals for its target population. This reality compelled the Project to carry out a series of assessments, based upon which the capacity development plans for each clinic-community would be based. These assessments – immediately following the completion of the FVVs - included the health facility assessment for participating clinics, the household baseline surveys in each participating cluster, formative research for communication and marketing interventions, and the community capacity assessment in each designated community. A training plan, based on the information generated, and in support of the overall CB program was finalized and training began during this reporting period. It will continue for at least the next 18 months.

Another area of significant progress was the decision to emphasize job aids, based on but much simpler to use than the Protocols. The development of these

job aids is now underway, and the training and supervision programs will help to ensure their adoption and use.

E. Communication and Marketing

All preparations for conducting formative research, using focus group methodology, for developing the communication and marketing strategies have been completed. This exercise has already started in Gaza and Hebron. Focus groups are being carried out with mothers, and grandmother and mothers-in-law at selected Hanan clusters in both WB/G. This activity will provide information about prevailing practices in ANC, PNC, breastfeeding, family planning, childhood illnesses and barriers to changing existing practices. It will also provide information needed to empower caregivers. Additionally it explores the perceived role of health providers, brochures and pamphlets, in-clinic educational videos and posters; and, media, including magazines, radio, TV, theater, billboards, posters and handouts as sources of information.

F. Household Baseline Survey

Currently Project teams are working closely with the contractor to ensure that the quality of the work meets scientific standards and Hanan's expectations. Using the Lot Quality Assurance Sampling (LQAS) methodology, Hanan completed the data collection for the baseline household survey in WB/G. This baseline survey will identify high and low "performers" on specific MCHN indicators between all geographic intervention clusters, and will establish project-wide baseline measures on specific MCHN indicators for Hanan interventions. This will allow the estimation of results achieved by Hanan (progress on health outcomes). It is expected that the preliminary data analysis and a draft report will be completed by October, 2005. Hanan is the first project to introduce the LQAS sampling design in WB/G, a cost-effective, easily manageable sampling methodology that allows decision makers to track and make prompt and informed decisions.

G. The Project Steering Committee

This committee is now fully functioning, and has proved to be a lively forum for sharing information with key stakeholders, and getting feedback. The meetings are now being held simultaneously in WB and GS, chaired by the MOH DG for International Cooperation in Gaza City. One issue that Hanan would like to raise is whether the Committee would benefit from a somewhat expanded membership, for example from the private sector and additional NGOs.

II. Constraints

A. Clinic Selection

The selection of clinics associated with MVP communities, and which could meet many other rigorous Hanan criteria, was seriously delayed and complicated by concerns and agendas of a number of stakeholders. Particularly crippling in this regard is the inability of the Project to work with so-called "shuhada" clinics, that is, clinics which use the word "martyr" as part of their name. This restriction effectively reduces the Project choice of clinic sites by nearly half. Although this is to be expected, the sometimes competing agendas made finalization of the selection unusually complicated, and required a number of compromises on the part of the Project. Despite these difficulties, we are now confident that the Project has a set of first cohort clinics to work with which can produce the outputs expected. Moreover, because of the flexibility shown, we believe that we have generated better trust and support from crucial partners.

B. Restrictions on Staff Mobility

The inability of Palestinian staff to travel freely between the West Bank and Gaza Strip, or to Jerusalem and Tel Aviv, will continue to inhibit the project's ability to make good use of its staff resources, especially in the areas of maintaining communications, providing technical guidance and supervision, and coordinating our efforts. Although there is improvement in this regard, even staff members who have permits are often turned away from checkpoints, resulting in missed opportunities—not to mention the negative impact on morale. To overcome the travel and communication constraints, project decision-making has been progressively decentralized. This process will continue to minimize avoidable delays, while maintaining the integrity and unity of command within the project. Due to the settler evacuations during this quarter, the situation was especially destructive to staff morale and productivity.

A related issue is the deterioration of the security situation, especially in Gaza. A spate of kidnappings of aid workers and other foreigners has caused the cancellation of planned visits on several occasions.

Another problem is that Project staff are having difficulty in getting the needed permits. Frequently, staff have been told that they have permits based on information from USAID contact people, only to learn that this is not the case. Closer coordination with USAID is needed.

C. Salary Demands

For whatever reasons, USAID-funded projects have developed the reputation of paying salaries and consultant rates far above those provided by other development agencies. The Project is trying to hold the line on this, but has

suffered in its recruitment efforts as a consequence. It is not uncommon for a prospective consultant or staff member to demand double the amount justified by their income history. One prospective consultant recently demanded $880 per day, which was not only excessive in absolute terms, but had no relationship with her salary history. This problem continues, and helps to explain the inability of the Project to fill the Nutrition, PR, writer-editor, and Communications & Marketing Specialist positions, and even to secure ad hoc STTA for data analysis.

D. Difficulty in Finding Editor/writer and PR person

Although we have approached a number of people in an effort to secure skills in the areas of Technical Writer-Journalist and PR services, these recruitment efforts have so far been unsuccessful. However, we believe that this problem is solvable, and will continue to search for a competent, reliable, and affordable professional(s) with the requisite skills.

III. Major Achievements of the Period

July

- The field validation visits--to choose the communities and clinics for the first cohort--completed.
- Health Facility Assessment (HFA) tool developed.
- Organization capacity assessment tool (OCAT) developed.
- LQAS adopted as data collection approach and LQAS training completed in WB and GS.
- The final version of the PMP submitted to USAID, formal approval received.
- Community Capacity Assessment tool (CCA) developed, and community field visits initiated.

August

- The HFA was piloted in WB/G.
- Training plan was completed.
- Designated neighborhoods were mapped, population statistics gathered, and contact persons representing designated communities were identified.
- Success of Howwara MOH clinic and applicability to Hanan's proposed C&M efforts was assessed.
- 11 Hanan-designated clinics in all selected districts were visited to identify areas for high visibility improvements.
- Met with MOH Health Education department leaders in West Bank and Gaza; overall C&M plans were discussed.
- MHN and CHN materials, developed by various donors, for potential use in Hanan's C&M's efforts were short-listed and translated.

- Market research plan to conduct focus group interviews in selected Cohort I communities was finalized.

September

- Hanan's GIS indicators were approved and, as a result, the project began reporting on monthly performance indicators.
- The HFA was completed for all first cohort clinics: 11 clinics in Gaza Strip and in 14 clinics in the West Bank.
- Hanan Model Clinic characteristics paper was completed.
- Preliminary results from the HFA were generated as the basis for the CB interventions for each participating clinic, e.g., a training plan for the facilities, communities and NGO partners.
- Job aids are being developed, and 7 IMCI wall charts were developed.
- Supervisory tools and checklists were developed.
- The first training of clinic staff, and Satellite Team staff (in Infection Prevention and Control) was conducted; training included an orientation to the Hanan program and approaches.
- Moderator's guides and screeners to recruit participants to focus group interviews were developed and translated.
- Protocol for clinic exit Interviews were drafted.
- Planning for proposed high visibility improvements in first cohort clinics, based on field visits and preliminary HFA data, was initiated.
- Assessment of job aids for ANC and IMCI wall chart with first cohort clinics, Health Education department in MOH in WB/G, and NGO partners was initiated.
- Draft C&M strategy was developed and presented internally and to NGO partners.
- Community Mobilization Action Cycle model was developed; model was presented internally.
- Preparatory meeting to implement the Community Capacity Assessments (CCAs) in Jenin was conducted.

IV. Major Activities and Outputs

A. Programmatic & Technical Overview

The achievements of Hanan on programmatic and technical issues this quarter need to be understood in the unique intervention context of the Project. This quarter, more than any preceding one, technical refinements (detailing) were conducted with an eye to the operational constraints under which they will be implemented.

The public health problems facing WB/G for MCHN lie not so much with an imperfect PHC system, as they do with the arrested progress and even erosion

of a PHC system, despite some recognized achievements (i.e., immunization coverage which is universally high). An example of this erosion is the IMR which, while reasonably acceptable by LDC standards, has been increasing in recent years.[1]

None of the technical "health" problems addressed by the project are in themselves unique:

- Hanan is setting the stage for full implementation of IMCI, a national strategy for which to date only training has taken place. Implementation will include institutionalization of IMCI in the clinic systems, and creating operational links with its community mobilization strategy.
- Hanan will strengthen and concentrate on service delivery system for Maternal Health, with an emphasis on ANC and PNC, for which protocols already exist and some curricula are available.
- Perhaps more challenging will be how, and to what extent, the problem of safe childbirth and neonatal care can be improved, given that these areas of intervention are outside the Project's remit, and take place at a distance from the Project's work at the PHC level.
- Nutritional issues--mostly hidden malnutrition resulting from micronutrient deficiencies (iron and vitamin A)--are a problem given the state of development in WB/G, but are less so compared with many other developing countries.

What is unique to the project is that its mission is to help the health system deal with *all these issues* based on specific needs assessed at the local level, where vulnerability affects communities in different ways. This is quite different from dealing with a single public health problem (i.e., quality of ANC). This holistic approach places a heavy burden on efforts to build systems, and to institutionalize and standardize methods and tools at the clinic and community levels. The breadth of Hanan's interventions also imposes a certain pace to the Project's need to engage in a considerable amount of technical development.

The other major reality which affects the Project's technical and work planning is the scale of achievements expected by EOP. The Project expects to reach 170,000 WRAs and 140,000 children under five within its 36 month operational period. Working back from this impact, the Project has planned what strategies, tools and methods, personnel, stakeholder relationships, and capacity building have to be completed, and by when, to ensure this impact.

Capacity Building. Details are provided below on the progress made in the area of capacity building. These include the identification of training curricula for revision, and inauguration of the first training (infection prevention) which began towards end of this reporting period. Good progress has also been made in

[1] Hanan Child Health and Nutrition Technical Brief.

elaborating the clinic supervision strategy. The Project's clinic strategy may later include a number of innovations--including an original approach to cycles of quality improvement based on evidence, through the "clinic scorecard", the development of supervision tools, and the first draft of a basic toolkit for quality improvement. To ensure a more rapid and surer start-up, however, Hanan will take a simpler, already proven, approach to clinic supervision strategy, based largely on the use of approaches, tools and methods already in use by the best local providers such as NECC, UNRWA, and PMRS. As learning takes place, and needs become clearer, Hanan will seek to introduce appropriate best practice tools and methods based upon international experience.

MVPs. The Capacity Building team played a key role in the finalization of the list of most vulnerable communities and clinics ("clusters") where the Project will work during its first cohort period. This effort resulted in the submission of the final list of first cohort clusters, along with an updated estimate of first and second cohort beneficiaries. With the help of a consultant, project staff completed the first draft of a document which describes the Project's "Vulnerability Methodology," and which will be widely disseminated. The Project is planning an inter-agency forum on "Vulnerability" for November.

Community Mobilization and Communications & Marketing. Much groundwork has also taken place on the community side, through regular visits and identification of contact persons in village councils and municipalities, the development of essential tools such as the Focus Group Discussion (FGD) guide, and the plan for formative research on Communications and Marketing issues. The C&M and CM components have worked hand-in-hand to ensure consistency and complementarity. Both areas are on track for rapid startup based on the results of the baseline assessments being conducted.

While additional detailing and refinement is still needed, the assessments are underway and the capacity building stage will soon begin. Thus, the work done this quarter has placed Hanan on sound footing to start field implementation in the coming months.

Reflecting the emphasis of the Project to design and implement its interventions in a maximally integrated way, the following descriptions of Project activities were done in a way which seeks to illustrate that approach. This is in contrast to past practice, where Project reports simply presented each technical intervention as relatively free-standing, and one after the other.

1. Capacity Building—Clinical

The Capacity Building (CB) team finished the field validation visits and the first cohort clinics were chosen. Meanwhile the team was developing the Health Facility Assessment Tool (HFA) and the Organization Capacity Assessment Tool (OCAT). These were used to develop a comprehensive picture of the technical

and managerial needs of the clinics and local NGOs which Hanan will work with. These needs profiles are now being converted into customized capacity building plans which are the basis for this first round of CB, including training.

The HFA was completed for all first cohort clinics: 11 clinics in Gaza and 14 clinics In the West Bank. The data were compiled and preliminary results were generated. Based on the initial results of the HFA the CB team has developed a draft training plan for the facilities, communities and NGO partners.

A "first installment" of the CB program was the Quality Assurance (QA) training conducted for Hanan staff and the staff of key stakeholders in West Bank and Gaza. This training provided the idea to introduce the "Balanced Scorecards" and other QA approaches which may be introduced later in the Project. The team also participated in defining and creating the concept of the Hanan Model Clinic. A simple "model clinic" design was developed and used as the basis for determining what capacity a fully functional Hanan PHC clinic would need to deliver its ESP at an acceptable level of quality and access.

Drafts of 6 supervisory tools and checklists were developed by the end of the reporting period.

Training. Training activities began near the end of the reporting period. The initial course covered the Infection Prevention and Control protocols, and took place simultaneously in Gaza and West Bank. Each training session began with a thorough orientation about Hanan objectives and about the Satellite offices and their roles.

Neonatal Resuscitation Training. The Hanan Project is working with LDS Charities, the humanitarian arm of the Church of Jesus Christ of Latter-Day Saints, who wish to bring their Neonatal Resuscitation Training Program to the West Bank and Gaza. This training program has been provided to 25 countries, including Jordan.

In addition to the training, they provide textbooks and multiple training kits that include newborn mannequins and additional equipment, such as bag and mask kits to equip hospitals. Their goal is not so much to teach these clinicians but more to help organize this program and support it, to ensure sustainability.

A team of four headed by Dr. Edward Kimball arrived on September 15 in order to make initial assessment and develop the training program to be conducted in early 2006. It was agreed that Hanan will take the lead in arranging the proposed training in the West Bank and Gaza, and will work closely with the MOH to select participants and arrange for the schedule and logistics. The goal is to work in synergy with existing or planned programs related to neonatal resuscitation and the prevention of infant mortality.

For child health, the training will be based on the IMCI protocols, using MOH trainers to provide the training. To detail the IMCI services program, an inter-agency committee was formed, 7 IMCI-related wall charts were developed, and Project staff are exploring the need for other IMCI job aids such as booklets and desk calendars.

For ANC, the Project will use the UNFPA-developed curriculum and training materials when ready. In the meantime, the Project's Training Specialist is working with UNFPA on the design and preparation of these materials. In addition, Project staff are reviewing protocols and curricula covering postnatal care, nutrition, child spacing and family planning, counseling, and STIs. As needed, plans have been completed for printing and distributing the protocols and materials.

The first draft of the ANC job aid was developed by the Associate Director for Maternal Health. The job aid reflects WHO, as well as the national ANC, guidelines. The draft job aid was circulated among Hanan's technical staff for input, and was shared with the MOH women's heath department in the West Bank for their technical feedback. The next step will be to establish a working group from the MOH Primary Health Care departments in the West Bank and Gaza in order to get their technical input before proceeding with the layout and the design. This effort—as for all job aids—is being done in coordination with the Communication and Marketing Director.

2. Communications & Marketing

Eleven of the planned 24 clinics were visited in WB/G to assess availability and use of educational materials, clinic signage, and amenities in waiting areas. Findings from these visits were confirmed by preliminary data from the HFA which suggest that most MOH clinics have inadequate or no signage both outside and inside the facilities; educational materials are not displayed and accessible to clients in both MOH and NGO clinics (mostly due to lack of availability from the MOH and donors); and, the waiting areas in the MOH clinics are not client-friendly and welcoming.

The C&M team is developing a plan to undertake some quick "high visibility" improvements at all clinics, by installing appropriate signage at all clinics, display shelf for educational materials in all waiting areas, and a "suggestion box" to encourage patient feedback.

An Exit Interview protocol is being developed for use at the clinics. Once CB work at the clinics is underway, data will be gathered quarterly to measure the impact of C&M activities on the clinic's clients. In addition, the data will inform the CB and CM teams of areas that they may need to address.

Along with the CM team, meetings were held in Howwara with the municipality and MOH clinic to better understand the highly successful community mobilization and communications efforts linking communities with the facility funded by the Gates Foundation under the EMOC project. Detailed discussions with a cross-section of staff yielded valuable ideas that Hanan might incorporate as it begins developing C&M strategies for the communities.

The direction of the C&M efforts at the clinics and communities were discussed with Mr. Moeen El-Kariri (Health Education, MOH/Gaza) and Ms. Lubna Sadder (Health Education, MOH/West Bank). They will be involved in finalizing and supporting the implementation of the C&M plan through the MOH clinics.

The C&M strategy was drafted and presented internally and to NGO partners. In order to avoid creating demand prematurely, the C&M campaign will be implemented in a phased manner after the CB and CM work in first cohort facilities and communities are underway.

Maternal Health & Nutrition. The large volume of MHN educational materials, gathered in the previous quarter, were short-listed based on their applicability to Hanan's key interventions. These materials were translated. Ideas for how these messages may be incorporated into Hanan's proposed brochures and posters, for use at the clinic and community levels, were discussed internally.

A focus group moderator's guide was finalized and translated targeting women who have delivered within the past 9 months. Fourteen focus group interviews (two in each selected community) will be conducted in WB/G. The areas of interest include antenatal care; postpartum care; and, breastfeeding practices. In addition, twelve focus group interviews will also be conducted in WB/G with women in their role as mothers-in-law to better understand care provided to daughters-in-law during pregnancy and postpartum periods. Interviews are initially being conducted in Gaza and Hebron. Data will guide the development of Hanan's communications and marketing strategy.

The job aids for ANC, being developed by the CB team, will be assessed by a cross-section of providers drawn from among Cohort I clinics as well as a broad net of MOH and NGO partner clinics, and the Health Education departments at the MOH and NGOs. The intent is to understand the format most useful to providers so that the resultant tool will be used by them in the clinics. The job aids will be available for distribution broadly within the provider community.

Child Health & Nutrition. The "best" CHN educational materials, developed by various donors, were short-listed and translated; ideas for how these messages may be incorporated into Hanan's proposed brochures and posters for use at the clinic and community levels were discussed internally.

Twelve focus group interviews (two in each selected community) will be conducted in WB/G, targeting women in their role of grandmothers of children below 5 years of age. The moderator's guide was finalized and translated and covered specific areas of interest, i.e., diagnosis, home care and practices for ARI and diarrhea. Interviews are being conducted in Gaza and Hebron. Data gathered through this research will guide the development of Hanan's communications and marketing strategy.

The IMCI "wall chart" is being developed by the CB team for first cohort clinics as well as for use by a broad network of MOH and NGO partner clinics, the Health Education departments at the MOH and NGOs, and UNICEF. The chart will portray the topics and format most valued by providers so that it will be used by providers in the clinics.

3. Community Mobilization

The reports submitted by the local and international consultants contributed to—but did not provide--a fully useable framework for Hanan's CM intervention. Therefore, the CM team developed the Community Mobilization Action Cycle Model (CMAC), a model that it will use in the first cohort communities in WB/G.

The first step in the CMAC model is for the communities, NGO partners, and Hanan-designated facilities to arrive at a common understanding and language that will serve as the foundation on which Hanan's CM work will be built. To this end, the CM team visited each community at least twice. Community leaders are now aware of the Project's key interventions, the areas of support the project can provide, and the desired EOP outcomes sought in the community. For their part, each targeted community has nominated a primary contact person assigned to Hanan, provided neighborhood maps, and population statistics. Contact persons have assisted, when needed, the HBLS research team during the data collection process in their community.

The Community Capacity Assessment (CCA), a CM tool critical to the implementation of the CMAC model, was developed. A preparatory meeting to implement this tool was held in Jenin; similar meetings will be held in Hebron and Gaza. These meetings will serve as the genesis for the formation of (or identification of existing) Community Coalitions comprising community leaders from both, the formal and informal sectors, CBOs, other stakeholders, as well as the target populations, i.e., WRA, and other influential members of the household.

Individuals with the potential to work as community mobilizers and volunteers have been identified in Jenin by PMRS, Hanan's NGO partner in the WB. Once recruited, these mobilizers and volunteers will conduct meetings and focus groups to identify the main health problems and the appropriate interventions at the community and facility levels.

4. Programmatic Sub-Contracts

To date, sub-contracts have been used almost exclusively to procure research services. Particularly notable in this regard is the Household Baseline Survey (HBLS). While such contracts will recur, particularly for periodic HBLS updates and for market research, the more complicated, directly programmatic use of sub-contracts will be in support of the Project's training and CM programs. Specifically, we will enter into a few major sub-contracts with qualified NGOs as part of the Project's sustainability-driven strategy to outsource its CM activities.

Other agreement instruments will be used to document the Project's working agreements with communities and for MOH clinics. Although the approach to such agreements is not finalized, we envision something like a Letter of Agreement for both cases. These agreements—which will lack the force and formality of a contract—will stipulate the agreed upon program of work, the obligations of both parties, a work plan, and the expected end result with the indicators to be used to track progress.

Project management is committed to closely adhering to the vetting and other requirements established by USAID, and will seek to have USAID staff review all agreement instruments prior to their initiation, even those for which the Project is not obligated under current rules to secure prior agreement.

Contracting Manual. With input from Project staff, the Home Office is developing a contracting manual, including the forms and templates. JSI HQ expects to finalize the manual in the coming few weeks. The new Contracting / Procurement Manager will be responsible for managing and processing all the subcontracting and procurement activities.

B. Support Functions

1. Policy and Advocacy

During this quarter, the Project Director (PD) took the initial steps needed to implement this function. This step consisted of consultations with an internal and an external consultant to sketch out a Policy & Advocacy process for the project. In addition, the PD worked with these consultants and project staff to identify the list of stakeholders most likely to share the type of policy issues which Hanan will have. The next step was to initiate discussions with these stakeholders to learn which Hanan-relevant policy constraints are of greatest concern to them; what advocacy efforts they have undertaken or plan to; and, potential interest to collaborate with Hanan and other agencies which share a common policy concern. To date, a preliminary dialogue has been held with UNICEF and UNFPA. Staff are currently looking for a competent local advisor to help the PD to continue the process.

2. External Relations:

The Project has intensified its coordination and collaboration with the MOH at all levels, particularly: the Deputy Minister; the DG for International Cooperation; the DGs for PHC in WB and Gaza Strip; the District Health Officers for Hebron, Jenin, and Gaza; as well as many mid level technical staff in Education, QIP, IMCI, and Women's Health. A "communications channels" memo between Hanan and the various sections of MOH was agreed to.

A second PSC meeting was held, the main agenda items being a presentation of the Project's Vulnerability Methodology and a description of the Project's HFA tool and Baseline Survey approach.

Beyond these, the Project has developed a wide network of collaborative relationships across the broad spectrum of health related donor and development agencies, e.g., JICA, UNFPA, PMRS, NECC, Ard al Insan. Hanan actively engages with these groups directly via planning-coordination meetings, working group meetings, and by sharing materials and plans. In addition, Hanan staff have participated in joint field trips to enhance information sharing (e.g.,CARE), and have acted as the intermediary for MOH with CARE/EMAP to facilitate the PA's effort to procure health commodities. The Project has also facilitated the development, by the MOH, of their list of facilities most in need of assistance through the forthcoming Small Infrastructure Project.

Staff are also active in learning and sharing with others via Thematic Group membership and via participation in various fora, e.g., The Health Inforum, the USAID Roundtable, and via dissemination of its materials.

After a relatively long gestation period, the Hanan Web site was finalized, and after incorporating feedback, is now posted on the internet.

C. Monitoring and Evaluation (M&E)

During the third quarter, the M&E Unit carried out several activities. Advances were made in the following areas: 1) both the PMP and GIS indicators received approval allowing for monthly project reporting; 2) clinic and community level reporting requirements were determined; 3) an online database was constructed; 4) the M&E archival system was brought up to date; 5) the HBLS is well underway and is being managed by the selected research group (Alpha International); 6) the Research Working Group (RWG), now chaired by the M&E Director, finalized its SOW; and 7) the Unit supported the training of 35 researchers in LQAS methodology.

1. Performance Indicators and Reporting

During the month of July, Hanan's PMP received official approval from USAID. The PMP, which outlines the Project's desired outcomes (ten in total) in relation to IR 1 and IR 2, is further defined by 33 complementary outcome and performance indicators. Additionally, for each indicator, the PMP provides operational definitions, data sources, frequency of data collection and responsible parties for data collection, analysis and reporting. Once all baseline assessments have been completed, the PMP will also include target achievements to be reached by the end of project.

Indicators defined in the PMP will be reported according to specific time periods per indicator: monthly, quarterly, semi-annually, annually, end of first cohort and end of project. Data will be entered into the project's database, which includes a GIS. These GIS data will also be submitted to USAID on a monthly basis. The M&E Unit expects that the GIS indicators will be approved before the end of September as Hanan has committed to begin reporting to USAID as of this month.

2. Clinic and Community Level Reporting

While the PMP indicators provide information on project performance and outcomes achieved, data collected at the clinic and community level will also be undertaken. These data will help inform clinics and communities of their progress in relation to improvements made in maternal and child health and will serve as a warning signal, should performance drop, indicating the need for program adjustments. During the third quarter, reporting requirements for clinics and communities were defined. During the fourth quarter, reporting forms will be designed and entered onto hand held PCs so that satellite office field staff can collect and report data efficiently. It is anticipated that by the EOP, data collection and reporting on hand held PCs will be assumed by the clinics and communities.

3. Online M&E Database

For the last three months, the Hanan project has been in the process of developing a comprehensive database that will help store and manipulate data for the life of the project. The database is now ready with an online user-friendly interface that will allow Hanan field workers/staff to add data directly to the database. The database has 30 tables corresponding to the 33 indicators that require reporting. These tables will be interrelated through a unique code given to each community that Hanan will be working in. SQL-server 2000 was used in developing the database, making it compatible with Excel, Access and SPSS softwares. ASP platform and VP.net language were used to develop the online interface. Three training/ demonstration sessions were carried out in mid September to train Hanan staff on how to use the database.

4. M&E Archival System

The M&E Unit now has an active archive system containing several folders relevant to the monitoring and evaluation of MCHN. The first folder, entitled Assessment and Evaluation Instruments, contains files on instruments designed by Hanan for various assessment activities/studies as well as those designed by others. The second folder, GIS Information, includes files on maps, raw data and a selection of general information articles pertaining to GIS and public health tracking. Folder three, entitled M&E Training, holds information on materials used for M&E training, to date on the LQAS training provided by Hanan. The fourth folder, called Reports, is designed to hold both internal and outsourced reports, in both draft and final versions. Included in the fifth folder are files holding information on all TOR, SOW and RFAs relevant to M&E activities. The sixth folder include files pertaining to performance monitoring. These files can be accessed by all staff seeking information on Hanan's M&E activities and general information.

5. The Household Baseline Survey (HBLS)

Having responded to Hanan's RFA for the HBLS, *Alpha International*, the winning research group, began data collection, following Hanan supported training of their researchers in LQAS sampling. In Gaza, data collection started on the 4th of September and lasted until the end of September. Almost 56% (95 out of 171 points) of the targeted population has been covered, three clusters have been completed, and six are still underway. As for the West Bank, data collection started on the 10th of September and is expected to last until the 10th of October. In Hebron clusters, approximately 34% (51 out of the 152 points) of the total targeted population has been covered. As for the Jenin clusters, approximately 46% (79 out of the 171 points) of the targeted population has been covered. To date, spot checks carried out by Hanan M&E staff reveal that *Alpha* utilizes a rigorous quality assurance system. According to their contract with Hanan, the final report is due on or before the 15th of November 2005.

Based on the above progress:

- Data collection was finished.
- Dummy tables for both general analysis and LQAS are ready.
- Data editing, checking and coding are completed.
- Design of the data entry program is under way.

6. The Research Working Group (RWG)

The RWG has continued to meet in an effort to coordinate all Hanan research, assessments, evaluations and studies and to ensure technical team representation in research activities. Now meeting on a monthly basis, with a clear SOW, the RWG meets to provide an update on all ongoing research activities and to examine and prioritize upcoming research activities. During the

third quarter, the focus has been on the Household Baseline Survey (HBLS), the Health Facility Assessment (HFA), the Community Capacity Assessment (CCA) and Communication and Marketing focus group sessions.

7. Lot Quality Assurance Sampling (LQAS) Training

Hanan supported the delivery of LQAS training to research institutes and researchers associated with the MOH and NGOs in both the West Bank and Gaza. Hanan acquired the services of Mr. Babu Ram Devkota, a well known international consultant with expertise in LQAS, to design and deliver the training program (4 days each in Ramallah and Gaza City). In total 35 people received this training, the first of its kind in the West Bank and Gaza. While LQAS is often the sampling methodology of choice for public health projects, this methodology has not been used here in the past. The benefit of LQAS is that in addition to providing a baseline for project indicators, it also allows for cluster specific information to help inform proper decision making and program adjustments, as required. The Household Baseline Survey (HBLS) is being conducted using the LQAS sampling method.

C. **Finance--**Budget Versus Expenditure

The project is well within budget limitations for all of its budget line items. The total project expenditures so far are well within the obligated amount of $10,825,800.

For more details, please refer to the quarterly financial report for the quarter ended September 30, 2005 which was submitted to the USAID Mission in Tel Aviv on September 15, 2005.

E. Administration

1. Staffing

a) Personnel Changes During Quarter

- Ms. Hassna Dajani was appointed as the Director of Administration.
- Ms. Nadira Shibly was appointed as the Procurement and Contracting Manager.
- Mr. Majed Bakri was appointed as the IT manager for the West Bank offices.
- Ms. Rula Abu Nimreh was appointed as the Admin Assistant/Receptionist.
- Ms. Diane Abraham was appointed as the Team Leader for the Hebron Office.
- Ms. Sahar Mukhaimar was appointed as the Communications, Marketing and Community Mobilization Coordinator for Gaza.

- Ms. Sahar Abu Samra was appointed as the Team Leader for the Khan Yunis Office.
- Ms. Thara' Nasser was appointed as the bookkeeper for West Bank.

Efforts continue to hire the team leader for Jenin. The first round of interviews did not produce a strong candidate.

As part of the Project's sustainability strategy, staff are working with MOH officials to hire two Public Health Officers for the Satellite Teams in WB. The agreement is that these two staff will be paid by the Project at roughly the Government rate, and will become MOH staff members at the end of the project.

A second part of the Project's sustainability strategy is to outsource the two community positions at each Satellite Team to a qualified NGO. Although these staff will be jointly recruited, they will be paid for by the Project, and will be regular staff of the NGO. The intention is that these staff will remain with the NGO following the Project, to enhance its capacity and to contribute the sustainability of Project CM activities.

b) Level of Effort

Name	Position	Status	Employer	Office	Start Date on Project	Effort Level
Richard Moore	Project Director	FT Employee	JSI	Ramallah	January 2, 2005	100%
Eric Sarriot	Director of Public Health	FT Employee	JSI	Ramallah	February 28, 2005	100%
Nancy O'Rourke	Director of Monitoring and Evaluation	FT Employee	JSI	Ramallah	March 7, 2005	100%
Nadira Sansour	Training Specialist	FT Employee	JSI	Ramallah	January 13, 2005	100%
Bassam Abu Hamad	Deputy Chief of Party	PT Employee	ANERA	Gaza	January 18, 2005	80%
Bassam Abu Hamad	Deputy Chief of Party	FT Employee	ANERA	Gaza	March 1, 2005	100%
Rand Salman	Associate Director for Maternal & Reproductive Health and Director of Project Operations	FT Employee	ANERA	Ramallah	January 18, 2005	100%
Hassna Dajani	Director of Admin.	FT Employee	ANERA	Ramallah	January 25, 2005	100%
Mahmoud Abu Radaha	Capacity Building Specialist	FT Employee	EMG	Ramallah	January 28, 2005	100%
George Shoufani	Director of Finance	FT Employee	JSI	Ramallah	January 17, 2005	100%
Emad Khoury	Driver	FT Employee	JSI	Ramallah	February	100%

					1, 2005	
Hisham Al Haj	Driver	FT Employee	JSI	Gaza	February 6, 2005	100%
Maher Saqqa	Office Manager / Accountant	FT Employee	JSI	Gaza	March 23, 2005	100%
Sana Abu Mazyad	Administrative Assistant	FT Employee	JSI	Gaza	March 23, 2005	100%
Manal Issa*	Office Manager	FT Employee	JSI	Ramallah	March 20, 2005	100%
Rola Tahboub	Senior Accountant	FT Employee	JSI	Ramallah	April 11, 2005	100%
Ya'qoub Habash	Driver	FT Employee	JSI	Ramallah	April 1, 2005	100%
Tom Neu		PT Employee	ANERA	Ramallah & Gaza	January 2, 2005	20%
Joumana *Nassereddin	Procurement Officer	PT Employee	ANERA	Ramallah & Gaza	March 1, 2005	20%
Joumana Nassereddin*	Procurement / Subcontracts Officer	PT Employee	ANERA	Ramallah & Gaza	June 1, 2005	87.5%
Haya Musleh	Administrative Assistant	FT Employee	JSI	Ramallah	April 13, 2005	100%
Nuha Judeh	Cleaner	FT Employee	JSI	Ramallah	April 11, 2005	100%
Rania Khayyat*	Receptionist	FT Employee	JSI	Ramallah	April 11, 2005	100%
Muhannad Dodin*	Database Manager	FT Employee	JSI	Ramallah	May 18, 2005	100%
Kumkum Amin	Director of Community Mobilization & Marketing	STTA	JSI	Ramallah	April 1, 2005	50%
Kumkum Amin	Director of Community Mobilization & Marketing	FT Employee	JSI	Ramallah	July 15, 2005	100%
Wassef Al Wikheiri	Monitoring & Evaluation Specialist	FT Employee	JSI	Gaza	May 2, 2005	100%
Nisreen Abu Middaine	Public Health Specialist	FT Employee	JSI	Gaza	June 8, 2005	100%
Randa Bani Odeh	Associate Director for Community Mobilization	FT Employee	JSI	Ramallah	June 13, 2005	100%
Saeda Abu Ramadan	Receptionist/ Admin. Assistant	FT Employee	JSI	Gaza	June 15, 2005	100%
Jasem Hmeid	Training Specialist	FT Employee	JSI	Gaza	August 8, 2005	100%
Diane Abraham	Team Leader	FT Employee	ANERA	Hebron	August 18, 2005	100%
Nadira Shibly	Procurement / Contracting Manager	FT Employee	ANERA	Ramallah	September 12, 2005	100%
Tharaa Nasser	Bookkeeper	FT Employee	JSI	Ramallah	September 6, 2005	100%

Rula Abu Nimreh	Receptionist / Admin. Assistant	FT Employee	JSI	Ramallah	September 15, 2005	100%
Majed Al Bakri	IT Manager	FT Employee	JSI	Ramallah	August 1, 2006	100%
Abdallah Abu Dayyah	Capacity Building Specialist	FT Employee	EMG	Gaza	June 6, 2005	100%
Daoud Abdeen	Associate Director for Capacity Building	FT Employee	EMG	Ramallah	July 18, 2005	100%
Riham Al Faqih	M&E Specialist	FT Employee	JSI	Ramallah	July 11, 2005	100%
Sahar Mukhaimer	Team Leader	FT Employee	ANERA	Gaza	August 1, 2005	100%
Samar Sharif	Admin Assistant	PT Employee	ANERA	Hebron	August 1, 2005	50%

Rows marked with an asterisk indicate the employees who are no longer working on the Project.

2. Facilities and Equipment

The Hebron office is now fully operational, and is shared with ANERA. The office furniture and equipment is in place, and the IT network is established.

The Jenin office is now fully operational. Equipment and furniture has been provided, and the IT network is established. A contract was signed for one year.

The Ramallah and Gaza offices. All needed equipment is in place, including laptops, digital camera, video, TV, printers and photocopiers, and furniture. The video-conferencing system is fully operational.

Vehicles. The three new vehicles have arrived and have completed customs clearance and licensing with the help of ANERA. Two have been sent to Gaza Office, one to Hebron, and one will be sent to Jenin office after appointing the team leader.

3. Visitors and International Consultants

a) The Project hosted many visitors to the Ramallah and Gaza offices. These visitors represented the MOH, local NGOs, donor agencies, and projects engaged in activities related to MCHN.

b) International Consultants

The Project brought in only three international consultants during the reporting period:

- Mr. Davis Balestracci, who provided training on QA for three weeks in the West Bank and Gaza,

- Mr Babu Ram Devkota, who provided training in LQAS, and,
- Ms. Nancy Piet, who completed 5 consultancy working days in WB on the vulnerability paper, and Forum design. She continued the work from Jordan for 5 more days to finalize the report.

F. Major Deviations from Approved Workplan

Major deviations from the work plan occurred in two areas.

1. Delay in the recruitment of the four Satellite Teams

For the reasons noted in the opening section of the Report, it has proven difficult to quickly staff these all these positions. However, two team leaders are already hired (Gaza and Hebron) and the hiring of the other two is in an advanced stage. Predictably, significant delays resulted from the Project's efforts to link Satellite Team staffing to its sustainability strategy. Since the Public Health Officers will be hired either jointly with the MOH at salary rates offered at the MOH, or the Project will second MOH health professionals to work within Hanan's satellite teams, a great deal of discussion and negotiation with the MOH was needed. To complicate matters further, the same sustainability strategy required the two members of the Community sub-team be outsourced to NGOs, and of course this has slowed things down. As noted elsewhere in this document, very good progress has been made on both of these fronts.

Another delay occurred with finding qualified candidates for the Management & Systems Officer positions. We have settled on a solution to the problem which will permit immediate staffing of qualified persons, while effecting major cost savings. To deal with this problem the two HQ-based management specialists who are part of the CB team will be playing dual roles. In addition to their jobs of overseeing the management system capacity building for the project as a whole, these two staff members will operate as Management & Systems Officers on the Satellite Teams. As needed, we will supplement their time at the field level with part time management-admin persons based in the relevant sub regions.

2. Delay in contracting with local NGOs for hiring the community sub team and managing community interventions

Although it took longer than originally anticipated, the Project has identified potential NGOs partners who can fulfill the needed tasks. Contributing to the delay in selecting them, was the longer time taken to identify the final MVP communities, since these have a relationship with the capabilities and "reach" of potential NGO partners.

Final negotiations with the PMRS (in WB) and Ard al Insan and NECC (in Gaza) are well underway. These highly qualified NGOs have agreed in principle to play

the desired outsourcing role, and SOWs have been exchanged and discussed. Project staff are now detailing the SOWs, and will be receiving organizational and cost proposals from each NGO as the basis for their final sub-contracts. Receipt of these proposals will lead to the final round of negotiations and the initiation of recruitment.

V. Cumulative List of Tools, Methods, and Publications

Hanan clinic criteria for essential MCHN services

1. Health Facility Assessment, based on the clinic criteria
2. First draft of a clinic scorecard model, including
   - Purpose and method of data collection
   - List of indicators
   - Rapid data processing plan (from collection to reporting)
   - During the reporting period the model was streamlined, optimally matched with PMP needs, and tested in two clinics in Gaza.
3. Hanan clinic quality improvement plan template to be used during the clinic orientation and startup workshop
4. Hanan clinic quality improvement plan template to be used during the clinic orientation and startup workshop
5. M&E online database
6. Online Hanan document archiving
7. Searchable field visit online database
8. OCAT revised for Hanan use with CBOs (in addition to NGO version)
9. Community Capacity Assessment tool
10. Training Capacity Assessment Report
11. Training plan completed for technical and management areas. Revisions due to identified shortcomings (i.e. the ANC “curriculum” did not meet standards) were completed.
12. MVP methodology document.
13. MVP presentation
14. Basic Hanan Web Page
15. IMCI wall charts (in Arabic)
16. Strategic Framework and Work Plan
17. Technical Brief on Maternal Health and Nutrition
18. Technical Brief on Child Health and Nutrition
19. Review of Community Mobilization
20. Maternity Homes Assessment Report
21. Field Validation Visit Protocol

VI. Expected Highlights of the Next Reporting Period

Following is a list of the major highlights expected for the next reporting period:

October

1. Health Facility Assessment, based on the clinic criteria
2. Complete recruitment and orientation of the satellite teams.
2. Hold third PSC meeting.
3. Complete the detailed Quality Improvement plans for PHC clinics.
4. Continue discussion with stakeholders to identify major policy constraints.
5. Complete the household baseline survey report.
6. Conduct an assessment of commodity management, and possibly, an informational presentation to the MOH and USAID (and possibly others) on commodity security options for WB/G though STTA provided by the Deliver Project.
7. Develop the various technical job aids.
8. Continue technical training in the areas of Maternal, RH, CH, and Nutrition.
9. Finalize the subcontract with the local NGOs for the community mobilization activities in the WB & GS .
10. Train the community mobilizers on Community Capacity Assessment and implement.
11. Create a stand-alone database, applied to hand held PCs, and install in the satellite offices. Corresponding with the database located on the project server, the PCs will be used to collect data that can be automatically reported to the M&E Unit in Gaza and Ramallah.
12. Visitors from JSI HQ will conduct pre-audit and will work with staff to fine tune the procurement and contracting system.
13. Hold an internal workshop to refine the Organization and Management system, including the details of roles and responsibilities.
14. Form Communications & Marketing Committee comprising members of Hanan team, Health Education department at MOH, and NGO partners.
15. Hire firm to design ANC job aids and IMCI wall chart, if content is finalized on time.
16. Identify appropriate signage – external and internal - required for all Cohort I clinics.
17. Conduct focus group research in selected Cohort I clusters/communities.
18. Place advertisement in newspaper inviting advertising agencies to pre-qualify for future contracts, and short-list potential agencies.
19. Provide “creative brief” to short-listed advertising agencies.
20. Initiate procurement of clinic equipment for the first cohort.

November

1. Hold a Vulnerability Forum with the participation of stakeholders, donors, and interested parties.
2. Continue the technical training.
3. STTA provided by the international nutrition consultant backstopping the Project.

4. Implement the routine, ongoing on-the-job training, mentoring, and problem solving as part of the clinic and community supervision process.
5. Continue the community assessment and develop the community action plans.
6. Identify and prioritize the Project's initial list of policy change priorities, and identify joint advocacy ventures with other stakeholders.
7. Submit the HBLS final report, providing Hanan with a solid baseline. Using LQAS sampling, the HBLS provides a baseline for the project as a whole as well as cluster specific data.
8. Print ANC and IMCI wall chart.
9. Produce clinic signage.
10. Select advertising agency for Cohort I campaign.
11. Finalize report from focus group research.
12. Select market research firm for pre-testing Cohort I campaign.

December

1. Submit the financial report to the USAID, as well as the First Annual Report.
2. Implement the community action plans.
3. Update the Web Site.
4. Continue on-job training and supervision.
5. Connect the Project database system to GIS, providing the project with up-to-date maps on project progress and results achieved.
6. Distribute ANC and IMCI wall charts to first cohort clinics and more widely to include other MOH and NGO partner clinics, as well as UNICEF (wall chart only).
7. Install clinic signage.
8. Pre-test planned advertising campaign.
9. Finalize campaign based on pre-test results, and begin "production."

Richard Moore
20 September 2005