BENIN INTEGRATED FAMILY HEALTH PROJECT (PROSAF)

Annual Report

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EXECUTIVE SUMMARY

This report summarized the activities and results of the first year of PROSAF. The project's important mandate and success are predicated on close collaboration with and participation by our counterparts, health professionals and managers of the MOH in the Borgou, by other USAID-funded partners working in the health sector in Borgou,, by other donors, and by the communities, who are both beneficiaries and our partners. The project team has spent a large part of this first year on consolidating these relationships and on beginning to transfer knowledge about and commitment to quality management as an underpinning for the project's activities.

One of the key strategies to prepare the health sector for change and to begin to identify priority areas for intervention has been the management assessment. This intensive assessment brought together all actors in the health sector to jointly measure its performance. The change in attitude among health personnel and their enthusiasm for focused intervention has been remarkable. Concurrently, PROSAF has started the process of developing community participation by initiating a systematic process of self-analysis with the assistance of its network of community facilitators.

Other key accomplishments for the first year of the program include:

- The concept of "integrated family health services" was defined, and the degree of integration of services was assessed, in collaboration with public and private sector health care providers and clients.
- Three sub-prefectures were chosen for the intensive community level interventions. They are Sinendé, Bembéréké and Banikaora. These three sub-prefectures now constitute two health zones.
- ABPF community activities were expanded and integrated with PROSAF activities through the recruitment and training of eight community mobilization field agents for the three target sub-prefectures. Nine additional ABPF zone animators were hired to cover all other sub-prefectures for community-based services.
- Consensus was developed on the roles and responsibilities of the departmental IEC/BCC committee, and an IEC strategy was outlined
- Coordination and collaboration have increased significantly among USAID-funded health sector projects and other donor-funded health sector activities. For example, PRIME, DSF, DDSP/B, Projet Santé II BAD, and PROSAF collaborated to disseminate the policies, norms and standards of family health.
- The MOH has expressed its support for the implementation of quality assurance and quality management in Benin. They intend to make the Borgou an experimental laboratory for this new approach through PROSAF

Thanks to the significant efforts made by team members in 1999, PROSAF begins 2000 with the sound base of information necessary for the activities to be carried out during the year, as well as solid relationships with its MOH counterparts and health sector partners.

ACRONYMS

ABPF	*Association Béninoise pour la Promotion de la Famille*
AC	*Animatrice (Agent) Communautaire*
ACOODER	*Association Coopérative pour le Développement Rural*
ACOOMOR	*Association Coopérative pour la Modernisation Rurale*
AIDS	*Acquired Immuno Deficiency Syndrome*
APE	*Association des Parents d'Elèves*
AQ / GQ	*Assurance de la Qualité / Gestion de la Qualité*
AS	*Agent de Santé*
AVA	*Agent de Vulgarisation Agricole*
AVS	*Agent Villageois de Santé*
BASICS	Basic Support for Institutionalizing Child Survival
C / RAMS	*Charge de Recherche et d'Appui à la Mobilisation Sociale*
CAME	*Centrale d'Achat des Médicaments Essentiels*
CARDER	*Centre d'Action Régional pour le Développement Rural*
CBD	Community based distribution
CCC ou BCC	*Communication pour le Changement de Comportement*
CCS	*Complexe Communal de Santé*
CHD	*Centre Hospitalier Départemental*
CLEF	Children's Learning and Equity Fondations
CLUSA	Cooperative League of USA
COGEC	*Comité de gestion de la Commune*
COGES	*Comité de Gestion de la Sous-Préfecture*
CPS	*Centre de Promotion Sociale*
CREDESA	*Centre Régional pour le Développement de la Santé*
CRS	Catholic Relief Service
CSSP /CSCU	*Centre de Santé de la Sous-Préfecture / Centre de Santé de la Circonscription Urbaine*
DAA	*Division des Affaires Administratives*
DAF	*Division des Affaires Financières*
DBC	*Distribution à Base Communautaire*
DDE	*Direction Départementale de l'Education*
DDSP	*Direction Départementale de la Santé Publique*
DEM	*Division de l'Equipement et de la Maintenance*
DEP	*Division des Etudes et de la Planification*
DEPOLIPO	*Déclaration de Politique de Population*
DHA	*Division de l'Hygiène et Assainissement*
DI	*Division des Infrastructures*
DIEC	Division Information, Education and Communication
DLTS	*Division des Laboratoires et de la Transfusion Sanguine*
DMC	*Division des Maladies et des Catastrophes*
DMO	District Medical Officer
DNPS	*Direction Nationale de la Protection Sanitaire*
DP	*Division des Pharmacies*
DPP	*Direction de la Programmation et de la Prospective*
DSCSH	*Division de la Santé Communautaire et Soins Hospitaliers*
DSD	*Division des Statistiques sanitaires et de la Documentation*
DSF	*Direction de la Santé Familiale*
DSMI	*Division de la Santé Maternelle et Infantile / P F / Nutrition*
DV	*Division de la Vaccination*
EDUCOM	*Education Communautaire*
EEZ	*Equipe d'Encadrement de Zone*
ENIIAB	*Ecole Nationale des Infirmières et Infirmiers Adjoints du Bénin*
FH	Family health

FP	Family planning
FPLM	Family Planning Logistic Management Project
FSS	*Faculté des Sciences de la Santé*
GESCOME	*Projet de Gestion Communautaire*
GV	*Groupement Villageois*
HIV	Human Immuno-Deficiency Virus
HW	Health workers
HZMT	Health zone management team (EEZ in French)
IB	*Initiative de BAMAKO*
IEC	Information, Education and Communication
INMES	*Institut National Médico-Social*
INTRAH / PRIME	International Training for Health
IMCI	Integrated Management of Childhood Illness
IPPF	International Planned Parenthood Federation
MCDI	Medical Care Development, Inc.
MCH	Maternal and Child Health
MEG	*Medicament Essentiel Générique*
MOH	Ministry of Health
MST	*Maladie Sexuellement Transmissible*
OPT / PTT	*Office des Postes et Télécommunications / Postes, Télégrammes et Télécommunications*
ORTB	*Office de Radiodiffusion et de Télévision du BENIN*
PADS	*Programme d'Appui au Développement de la Santé*
PATH	Program for Appropriate Technology in Health
PBA / SSP	*Projet Benino-Allemand des Soins de Santé Primaires*
PCIME	*Prise en Charge Integrée des Maladies de l'Enfant*
PF	*Planification Familiale*
PFA	*Paralysie Flasque Aiguë*
PMA	*Paquet Minimum d'Activités*
PNLS	*Programme Nationale pour la Lutte Contre le SIDA*
PNS / SF ou PNS / FH	*Politiques, Normes et Standards pour la Santé Familaile* or Policies , Norms and Standards for Family Health.
POLICY PROJECT	*Projet Pour Renforcer les Politiques Favorables à la SR*
PROSAF	*Promotion Integrée de Santé Familiale dans le Borgou*
PSI / ABMS	Population Service International / *Association Béninoise pour le Marketing Social*
SA	*Service Administratif*
SAF	*Service Administratif et Financier*
SBC	*Services à Base Communautaire*
SF	*Santé Familiale*
SEPD	*Service des Etudes, Planification et Documentation*
SIBC	*Services d' Information à Base Communautaire*
SIDA	*Syndrome Immuno-Deficitaire Acquis*
SIMHA	*Services des Infrastructures, Maintenances, Hygiène et Assainissement*
SMI	*Santé Maternelle et Infantile*
SPLTS	*Service des Pharmacies, Laboratoires et Transfusions Sanguines*
SPPS	*Service de la Protection et de la Promotion Sociales*
SR	*Santé de la Reproduction*
SRO	*Sel de Réhydratation Orale*
SSF	*Service de la Santé Familiale*
URC	University Research Co., LLC
USPP	*Union Sous-Préfectorale des Producteurs*
UVS	*Unité Villageoise de Santé*
VAD	*Visite à Domicile*

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I. INTRODUCTION

In conjunction with the Ministry of Health of Benin, USAID/Benin has defined as its strategic objective in the health sector, "the increased use of family health services and prevention measures within a supportive policy environment." Through the Benin Integrated Family Health Project, renamed *Promotion Intégré de la Santé Familiale dans le Borgou* (PROSAF), USAID is supporting the implementation of a decentralized and integrated program of family health services in one geographical area. The Department of Borgou, located in the north and covering almost half of the land mass of the country, was selected as the site for the project based on the severity of its health problems, the presence of an emerging private health sector, and the possibility for integration with other USAID/Benin-supported activities in education, democracy and governance.

PROSAF supports the MOH's health sector strategy through its programmatic emphasis on family health, the improved prevention and management of the principal diseases, improved management of health services through capacity building and health zone development, and the development of innovative community-based initiatives and partnership with the private sector (for profit and not for profit organizations).

PROSAF is implemented by a team of four organizations that are collaborating with the Ministry of Health (at the central level and in Borgou Department), USAID, other donors, cooperating agencies, and NGOs. As prime contractor for PROSAF, University Research Co., LLC (URC) provides overall technical and administrative direction to the project and leads technical assistance in Borgou to improve health planning and coordination, increase access to integrated family health services and commodities, and increase the capacity of health workers to provide quality services. URC has partnered with the Association Béninoise pour la Promotion de la Famille (ABPF) to increase access to key family health services and products in Borgou, building on ABPF's experience delivering family planning and STD/HIV services throughout Benin. The Cooperative League of the United States of America (CLUSA) brings innovative expertise in training and empowering community level organizations in West Africa to fully participate in the management of health services. Behavior change communication activities are being supported by the Program for Appropriate Technology in Health (PATH).

Since the contract was award in early 1999, the PROSAF team has worked very closely with Regional Health Services (to be referred to hereafter by its French acronym DDSP) and other partners in Borgou to implement the program's five major components PROSAF:

1. *Improve health planning and coordination by:*
    - Strengthening departmental and sub-prefectural capacity to develop annual strategic and operational plans by using their epidemiological and programmatic data so that they can address problems and coordinate more effectively
    - Working to reinforce the coordinated leadership of the regional health services directorate of the public and private sectors, donors, USAID cooperating agencies, and other groups making resource contributions

2. *Increase access to family planning/maternal and child health/sexually transmitted disease/human immuno-deficiency virus (FP/MCH/STD/HIV) services and products by:*
   - Supporting community-based distribution approaches and social marketing
   - Ensuring that clinics offer an integrated package of family planning, maternal and child health and STD/HIV/AIDS services through training staff and improving drug supplies
   - Adapting and operationalizing the distribution system of essential family health products

3. *Increase the capacity of health care workers to provide quality services by:*
   - Increasing training capacity and skills transfer, improving and strengthening supervision, and introducing quality assurance methods and tools to ensure that the processes of care and support function effectively and efficiently

4. *Increase knowledge and behaviors supporting the use of FP/MCH/STD/HIV services, products, and prevention measures by:*
   - Strengthening behavior change communication strategies, focused both on traditional, community-focused media to improve understanding and generate demand, and on an increased range of communication agents: health workers, social workers, community leaders, etc.

5. *Increase public involvement in the planning and delivery of community-level health services and prevention measures by:*
   - Developing sustainable structures for community involvement in the design, planning, management, and financing of family health services
   - Strengthening the capacity of local NGO's to organize and develop village health management committees
   - Supporting health center management committees in developing and implementing action plans to address priority needs in training, revenue generation and health promotion

PROSAF's approach is based on the principle that people develop ownership when they participate in the development and implementation of systems and processes for health care delivery. Four quality management principles are also applied: client satisfaction, the use of data for decision-making, the analysis of systems and process, and teamwork.

This document includes a summary of the program's startup and technical activities during 1999, relating the outputs of the program to the Intermediate Results of the USAID mission's strategic plan to which they contribute.

II. PERFORMANCE REVIEW AND ANALYSIS

Intermediate Result 1: Improved Policy Environment for Family Health

PROSAF contributes to an improved policy environment for family health services by reinforcing the structures for decentralization in the health sector, participating in the movement toward implementing IMCI, expanding the role of health workers to handle obstetrical and neonatal emergencies in the periphery, and in disseminating family health policies, norms and standards.

Decentralization

The principal means of decentralization identified are the implementation of health zones and the revision of COGEC/S regulatory texts. The controversy regarding Comités de Gestion de la Commune (COGEC) and the Comités de Gestion de la Sous-Préfecture (COGES) has been discussed with the various actors in the field and among partners. PROSAF has participated in national level seminars where the issues have been discussed, but no decision have yet been made concerning the distribution of power, particularly with regard to the management of health center cost recovery funds. While PROSAF will continue to monitor progress toward amending the regulatory texts governing the status of these community structures, it will implement its community participation approach in the spirit of the original Bamako Initiative: that the community manage their health facilities and resources in collaboration with health personnel.

To encourage the move toward decentralization, PROSAF organized meetings, mini training workshops and analysis of the health management system in Borgou according to the newly identified health zones. This work in zonal health teams to identify and analyze priority problems and strategic intervention areas according to SWOT (strengths, weaknesses, opportunities and threats) not only reinforced the spirit of teamwork, but also the sense of belonging to the same geographic area. Teams also exhibited the tendency to defend their interests before the DDSP and its partners as zones when priorities were discussed during the management assessment national dissemination workshop. PROSAF joins other partners in the process of developing a training program for Health Zone Management Teams (HZMT) as the next step toward effective health zones.

Following the feasibility study of the health zones in southern Borgou, the recommendation to create three zones was accepted, and only an official decree by the MOH remains. The three zones are Sinende/Bembereke, N'dali/Parakou and Tchaourou. Each of these newly proposed zones has a mission hospital that will take on the role of the zone hospital. This phenomenon will accelerate the definition of certain crucial roles and responsibilities among the public and private health sectors. There are now a total of seven health zones in the Borgou. The geographical areas of these zones relate to the expected communes and arrondissements that will be the new administrative entities when the decentralization law comes into effect.

Leadership for Coordinated Management

Two aspects of coordination are important to the success of PROSAF: (1) collaboration and coordination between USAID-funded activities in the Borgou, and (2) the support of the DDSP to fully execute its responsibility to coordinate all health sector interventions in the region.

Semi-annual meetings with all USAID partners in the health sector were held to coordinate work plans, to hold discussions around themes of common interest and to make recommendations on issues for improvement. The themes identified concerned primarily community involvement issues such as motivation of village health workers and the financial contribution of communities to micro-projects.

The first coordination workshop was co-facilitated by PROSAF, USAID/Benin and the Regional Health Director (DDS). While the first meeting was successful in getting people to share information about activities and some of the difficulties experienced in the field, it was viewed as only a first step in the process of building relationships to enable real coordination of efforts and eventual synergy. The workshop participants proposed the following mechanisms to promote coordination and collaboration:

- Hold coordination workshops every six months
- Initiate a series of encounters on a monthly basis with those partners interested in various themes identified during the workshop
- Produce a written information bulletin
- Collect, summarize and disseminate the various health and community-based studies recently carried out in Benin

It was widely acknowledged that the coordination of efforts would take on significant importance as the planning processes get underway in the target sub-prefectures.

Using the opportunity offered at the July meeting of USAID partners in the health sector, the PROSAF team led a mini-workshop to collect and organize information concerning the training plans and surveys planned by the partners for the rest of 1999. This effort aided in avoiding scheduling conflicts in the field and also identifying where PROSAF could play a role in supporting other activities through follow up or sharing resources. For example, BASICS, CRS and PROSAF coordinated the timing of their surveys to accommodate staffing needs.

The partners drew up a draft inventory of training tools and manuals pertaining to the reinforcement of family health. (See Annex 1). This listing further made evident that there are many resources available, and that partners only need to be informed of where to find them. The inventory will be further exploited to develop a reference list and library to reduce duplication of effort in future curriculum development.

A similar listing was created for IEC materials and the collection of materials is underway. The interest in creating reference summaries of studies, training materials, and IEC tools and having an information exchange bulletin highlights the importance of information sharing and cataloguing. One collection and summary review of 12 recent studies concerning family health in Benin has been distributed to USAID partners. The principle supporters of these studies were the PBA/SSP (German-supported primary health care project) and BASICS.

The desired coordination and collaboration for greater synergy among programs is developing in the Borgou, as witnessed in the organization of World AIDS Day, where all the partners and the NGOs brought together their efforts and their resources. PROSAF led the organization of this important series of events, which was supported primarily by the logistics of PSI. According to the DDSP, this activity was the first of its kind in the department. The training activity for the dissemination of the Family Health Policies, Norms and Standards, developed by PRIME and the DSF, was also executed together by the DDSP, the Santé II BAD project, and PROSAF.

The second meeting of USAID health partners was developed around issues concerning community-based health agents. The experiences of PSEO/AFRICARE and GESCOME served as points of reference for outlining recommendations for the future development of community-based services. (See Annex 2). This meeting was also marked by reflection on the benefits that partners have experienced from coordination and collaboration, as well as a word of caution that not all activities necessarily benefit from collaboration and that there needs to be flexibility in interpreting the need to coordinate. The partners agreed that the coordinated work plan for 2000 would be reorganized according to categories of activities that contribute to the four USAID/Benin Intermediate Results for the health Strategic Objective.

BENEFITS OF COORDINATION

- *strengthening team spirit*
- *the possibility of assessing the situation*
- *sharing experiences*
- *facilitation of field interventions (for example, product procurement)*
- *decrease in duplication of costs and effort*
- *development of synergy*

As the newest USAID-funded health program in Benin, PROSAF made significant effort to establish the contacts necessary to understanding the background and accomplishments of our partners. Discussions and planning small projects together have begun to create the relationships necessary for the team spirit of collaboration and coordination to develop.

Family Health Policies, Norms and Standards, and Innovative Approaches to the Care of Children and Mothers

PRIME and the DSF held the national dissemination of Family Health Policies, Norms and Standards (PNS/FH) in April 1999 and a regional dissemination session for trainers in July. For the Borgou, the first of four sessions to disseminate these norms to sub-prefectoral teams was financed by the Santé II BAD project. PROSAF supported the completion of the dissemination of FH norms to the 120 providers that make up the S/P health teams. Follow- up/supervision field visits are planned for the first quarter of 2000 to see how teams are applying the PNS/FH. These PNS/FH also served as the basis for the quality of care observation instruments used in the management assessment.

The clinical guidelines and protocols, which are the tools for frontline health workers, will be available in early 2000. These tools are derived from the FH norms, and are being completed by PRIME and the DSF. Once the clinical guidelines are available health care providers will be trained in the content and purpose of the PNS/FH. These tools will be helpful in the development of supervision guidelines and tools as well.

PROSAF has been active in discussions at the national level concerning how to eliminate avoidable deaths of women during childbirth. These policy development workshops for expanding the role of midwives and communities in confronting obstetrical and neo-natal emergencies are facilitated by PRIME and the DSF. Norms and standards will be developed over the next year as the basis for training. PROSAF will identify the midwives to be trained in the Borgou and will guarantee their training for the new role at pilot sites. To compensate for a lack of midwives, PROSAF will determine the possibility of increasing the skills of nurse's aids through researching similar experiences in other countries and creating a demonstration initiative.

Working with the COGEC and COGES in quality design activities there is a possibility to create community-based teams for emergency obstetrical care (SONU teams). Through awareness raising, income-generating activities, and/or community solidarity schemes (mutuelles) PROSAF will encourage the sustainability of these community services. The enlarged municipal teams (EME) organized by GESCOM will also be able to support the SONU teams.

PROSAF participated in national level workshops to adopt and advocate for IMCI. Benin adopted the IMCI strategy in March 1999, but the official pilot sites have not yet been chosen. Discussions with BASICS, Africare and UNICEF led to a proposal that preparatory mechanisms be used to introduce integration practices to health workers and initiate communities to their role in improving child health by following on the nutrition work begun by BASICS and CRS, for example. PROSAF, Africare and BASICS are prepared to choose specific criteria to identify centers for implementing and testing community level IMCI interventions based on their baseline surveys and central level orientations.

Intermediate Result 2: Increased Access to Family Health Services and Products

PROSAF intends to increase access to family health services and products through three strategies: 1) improving the logistics management system (in collaboration with FPLM), 2) helping health centers to offer FH services and products everyday through an integrated approach, and 3) through the organized expansion of community-based distribution and availability of products and services with PSI and ABPF.

Strengthening the National Logistics Management System

The weaknesses in the present logistics and procurement systems in Borgou were identified by the management assessment. They can be summarized as follows:

- Lack of a policy to renew supplies and equipment, with the following consequences:
  - lack of vehicles to transport patients and lack of communication between the peripheral centers and the referral facilities
  - more than half of the health facilities do not have any sterilization equipment
- Inefficiency of the procurement network for MEG and contraceptive products, which frequently leads to products being out of stock, overstocked, or outdated. Procurement projections are not made
- The staff in charge of managing MEG and contraceptive products is neither available nor

trained, with the following consequences:
  - in more than a third of health facilities, orders for MEG and contraceptives are not based on a reliable assessment of monthly consumption
- ❖ The storage facilities do not follow the standards for maintaining the quality of medicines and contraceptive products
- ❖ Lack of reliable data banks about supplies and equipment

The logistic management system for all drugs, contraceptives, supplies and vaccines was identified as a priority during the management assessment and subsequent prioritization exercises with health workers, zonal teams, the DDSP and other partners. The DDSP partners validated this finding during the round table and accepted that it be included among the priorities of the DDSP interim 2000 plan.

During the last quarter of 1999, a training plan on contraceptive logistics management was developed for midwives and doctors in the Borgou, following a TOT workshop organized in October by the DSF/MOH and FPLM. This plan was approved by the DDSP, and the PSP agreed to finance it. The training plan for the health agents and the results of reflections on the construction of a regional warehouse for MEG are essential links in this process. While the MA assessed the presence and functionality of the logistics system, further process and tool analysis is needed. The FPLM assessment tools will be part of this analysis and the FPLM indicators for this system will be adapted for the Borgou.

Availability of Integrated Basic Package of Family Health Services

The M.A. showed that integrated family health services are available in 12% of the public and private centers five days of the week. Increasing the offer of integrated family health services will increase accessibility to these services as a client will receive care for all her needs on the same day, instead of having to come back when a service is not scheduled for the day of her visit.

The concept of integrated family services is not new, but implementation remains a challenge in most circumstances because it requires changing old habits and, in some cases, a slight increase in small medical equipment. Two days of brainstorming on the concept of integrated family health services took place in October and December. These planning sessions made it possible for all of the managers of private and public health facilities to recognize the need to integrate family health services and to agree on an approach for its implementation. At the end of the two sessions, the participants had:

- ❖ Identified the minimum package of family health services. It is a minimum list of services that each health facility in the department must provide in order to claim that it provides quality services and to improve family health. The services will have to be provided to patients according to the PCIME, SONU and GARE approaches. The integrated package includes:

  - Pre-natal care
  - Deliveries
  - Vaccinations
  - Growth monitoring
  - Family planning
  - Post natal care

- Curative care
- Testing for and management of STDs and AIDS
- IEC / BCC

❖ Selected, as a global strategy, to begin integrating family health services in a few pilot health facilities (one or two per sub-prefecture) and not to wait for major means or assistance from the government before going ahead with it. It was an important psychological step marking the beginning of ownership of the concept.
❖ Identified the various combinations for integrating services from each PMS/SF element.
❖ Attributed to each health facility representative a combination of services to integrate. That representative will develop a guide for health care providers that indicates the activity packages to be integrated and under what circumstances.

In the health zones, identified pilot health facilities will experiment with FH service integration and report on the feasibility of this integration in the next meeting.

In the preparation of these sessions, BASICS offered their experience with integrating the minimum package of nutrition into healthcare services as well as the introduction of an integrated health card for data collection purposes.

This work will serve also as a guide in the development of an integrated family health training curriculum, as it is based on practical experience from the health centers and gives further defines the necessary skills to be reinforced.

PRINCIPLE THEMES FOR IN-SERVICE TRAINING TO INSURE INTEGRATED CARE:

- *IMCI*
- *Utilisation of medical protocols*
- *Use of the partogramme*
- *Use of SNIGS tools*
- *Symtomatic treatment of STD and AIDS*
- *Safe motherhood practices*
- *Contraceptive technology*
- *Counseling*
- *Integration / polyvalence*

Community Based Distribution of Family Health Products

To further investigate the region's current experience with CBD, members of PROSAF, ABPF and the DDSP/Borgou formed a team to visit the three target sub-prefectures in July. The team was particularly interested in the characteristics of the CBD programs of the different partners such as UNICEF, CRS, PBA/SSP, religious organizations and ABPF. The information collected led to the conclusion that each of the CBD programs had a different approach, but that elements of success included:

❖ the gradual involvement of the community in management of the health service
❖ greater access to services
❖ improvement in attendance at health centers due to the referral system

Some of the common difficulties noted were:

❖ contraceptive products out of stock
❖ community health workers trained using inconsistent material
❖ poor organizational skills among community health workers
❖ irregular supervision of community health workers
❖ insufficient motivation of community health workers
❖ lack of real coordination between the different partners involved

- insufficient or non-existent IEC supports

Other USAID-funded partners have experiences that they shared at the November partners meeting. PROSAF and other partners agree that, given the lessons learned from the various experiences, the areas for collaboration to improve community-based services are:

- training on a commonly agreed upon minimum package of services
- supervision
- organization of an efficient supply / logistics system
- harmonization of IEC supports
- motivation schemes for community health workers and other community coordinators
- early inclusion of all actors in the definition and clarification of the support systems for CBD workers

The availability of family health products can also be expanded through vendors in the community and social marketing schemes. PROSAF and PSI are sharing information on the location of services and points of sale to be able to target areas for introduction of new points of sale or reinforce community-based distribution. PSI and PROSAF also agreed to make the most of the presence of the community facilitators currently working in the three target sub-prefectures in order to better determine field needs and identify the most appropriate sites for the distribution of family health products.

In December, eight community facilitators, 11 zone animators and three resource persons reported that, based on their community data collection, there are 144 villages in which the community interventions of PROSAF will be implemented. The detailed mapping of all the Borgou sub-prefectures, including all key locations (i.e. markets, communal centers, and large villages), was also completed based on maps provided by PSI. Beyond the concentration zones of PROSAF, ABPF will provide family health services through their zone animators and motivators or community volunteers.

Intermediate Result 3: Improved Quality of Management and Services

PROSAF contributes to the quality and management of services by developing the capacity of providers. Beyond training in the classical sense, PROSAF will use innovative methodologies to develop skills in quality assurance. These methodologies include team learning, problem solving, client-focused design of services, continuous monitoring for improvement and on-the-job training. Much of this new learning will be reinforced by a facilitative supervision system that will focus on improved worker performance and linkages to the community.

Increasing capacity of health officials to plan and deliver health services using improved data collection practices

The first step in planning for improvements in the quality health services was a systems management assessment. The protocol for this assessment was developed with the assistance of two consultants, Dr. Karki Mahamane and Abdourahamane Hassane, and in conjunction with a team from the DDSP staff. The assessment principally examined the functioning of management and support systems from the DDSP level to the community, but quality of care provided under the minimum package of primary health care services, and particularly the integration of care for women and children, were also explored. This assessment complemented other studies done recently in the Borgou, most notably the baseline health facilities assessment done for BASICS last year. The plan to increase the capacity of health personnel to plan and deliver quality services is being developed based on the results of the assessment. The data collected will be used to decide which strategies are needed to improve the quality of services and management.

MANAGEMENT ASSESSMENT TOOLS

1. *Checklists for sub-system norms*
2. *Interview of DMO on HIS*
3. *Interview of DMO on supervision*
4. *Interview of health workers on training received in past 12 months*
5. *Interview and verification (record review) on organizational capacities of health services*
6. *Observation of quality of care*
7. *Client exit interview*
8. *Provider interview*
9. *Community perception of care provision*
10. *COGES/COGEC interviews*

The general objectives of this assessment were to:

- ❖ create a baseline database for the management of the health system that allows for planning, follow-up and evaluation of the program
- ❖ develop the capacity of those involved in the health system to evaluate the health management system on a routine basis

The intermediate objectives illustrate the content of the assessment itself (Annex 3 gives more detail in the specific objectives):

1. Evaluate the management capacity of the Borgou health system, particularly of the seven principal support systems identified as essential, in relation to the results expected from PROSAF

2. Evaluate the availability, accessibility and use of family health services and products

3. Evaluate the quality of maternal and infant health care services (prenatal consultation, well baby consultation, delivery, postnatal consultation, immunization, curative care, health education), including family planning and prevention of STD/AIDS

4. Involve health system personnel in data collection, data analysis and use of data for planning, implementation and the follow-up/evaluation of activities intended to improve family health care in Borgou

The first move towards achieving these objectives was the creation of a 13-member steering committee, made up of DDSP and PROSAF staff, to manage the process and ensure that participation was a main feature. Guided by the technical support of Dr. Karki Mahamane, the steering committee and the health teams proceeded through the following five stages to accomplish the management assessment:

STEPS IN THE MANAGEMENT ASSESSMENT PROCESS

1. *Tool development*
2. *Protocol*
3. *Training of sub-prefecture teams for data collection**
4. *Data collection*
5. *Manual analysis*
6. *Self-analysis**
7. *Sub-systems analysis*
8. *Epi-Info analysis*
9. *Presentation/report presentation*
10. *Internal dissemination and strategic challenges**
11. *Presentation refinement*
12. *National dissemination*
13. *Round table*

**involved use of Quality Assurance concepts*

Stage 1: Preparation for the training of sub-prefecture health teams in data collection
During this stage, the members of the steering committee reviewed the questionnaires designed by the consultants. Along with representatives of the DPP and the DNSP, they made pertinent comments for the improvement of the questionnaires. The steering committee organized the training of the data-collection teams, made up of health personnel from the sub-prefectures. This stage strengthened the capacity of the steering committee to supervise the data collection as well.

Stage 2 : Training in data collection for the health teams from the sub-prefectures
This training enabled the data collection team members from the sub-prefectures to develop their ability to administer a questionnaire, to conduct an interview, to manage a focus group and to observe an on-going family health consultation without interfering. The data collection team members learned the questionnaires intended for interviews with a client in local languages. During this stage, the supervisors made final changes, taking into account the opinions and contributions made by the data collection teams. One of the important results of this stage was the joint programming by the paired sub-prefectoral teams for the data collection and coordination with the supervision teams.

The data collection teams in each sub-prefecture were made up of five persons: the chief medical officer (team leader), a midwife or head nurse, the administrator or his assistant, the social worker or a community worker, and a local surveyor. The PROSAF community facilitators and ABPF zone animators also joined the teams for the client and community interviews.

Stage 3 : Data collection and manual analysis of preliminary results concerning the quality of services
Data collection lasted two weeks and was carried out by paired teams. In the first week, the team from sub-prefecture A went to sub-prefecture B for data collection, and this was reversed the second week. This paired team method gave the health teams from the sub-prefectures the chance to meet, to discuss their respective results, to talk about the reasons for poor results and to jointly consider solutions to problems.

The completed and checked questionnaires were sent gradually to the data processing and statistics center of the SEPD/DDSP, where the data was entered into EPI Info.

Stage 4 : Training for the health teams in the use of EPI Info results analysis
A team made up of SEPD/DDSP staff and two members of PROSAF organized this training. The sub-prefecture teams were grouped according to their health zones and introduced to computer equipment available in their area. Following a brief introduction to computers, the participants learned how to access the analysis module of EPI Info and how to extract the results from their respective sub-prefectures using the database from the whole region. They also learned how to create Excel tables, using the results obtained and to produce charts.

The participants acknowledged that this training was very practical and useful. For the sub-prefecture teams coming from the same health zone, it was an opportunity to help each other access their results, review together the results of their own area, discuss the results amongst themselves, and prepare the presentation of preliminary results at the self-analysis workshop. The instructors felt that this training was a first experience of on-site training in response to specific needs.

Stage 5: Health care sub-systems self-analysis workshop
This workshop was attended by the chief medical officers and their administrators (or their representatives) from the 14 sub-prefectures, the steering committee, all the DDSP and regional hospital services, representatives from the three central directorates of the MOH (DSF, DPP, DNPS), and other health sector partners. The objectives of this important workshop were to:

- share first impressions on the management assessment
- present the preliminary results by health zone
- review the concepts of norms, standards and procedures in health system management
- analyze sub-systems according to client needs (expected results), processes and inputs
- train health workers at the level of the DDSP, the CSSP/CU and the CCS to do a self - analysis of their health management support systems using checklists based on norms for these systems.

SEVEN SUPPORT SYSTEMS IDENTIFIED AS INFLUENCING THE QUALITY OF SERVICES OFFERED:

1. *Training/supervision*
2. *Information, education and communication*
3. *Planning*
4. *Information management*
5. *Community participation*
6. *Logistics and supply*
7. *Service organization*

The self-analysis workshop used a participatory methodology of discovery. Participants first identified the major problems encountered during the preliminary analyses of the assessment, and then determined the sub-systems that affected those quality problems.

The systems analysis helped health personnel identify the clients of the service or system, the results expected by the client, the processes that produce the expected results, the inputs used in the processes and finally the input suppliers. Through several group exercises, the participants came to understand the links among the components of the system and the manner in which they influence health care services and their performance.

The following conclusions were derived from the group exercises:

- ❖ sub-system analysis requires team-work, a methodology, time, unwavering attention, good documentation and is an exercise that should be repeated periodically.
- ❖ the importance of continuing the efforts made in developing and communicating norms and indicators in the health sector.

The process had the full support of the DDSP and was closely monitored by the central level, which would already like to see Borgou share its experience with other regions. The self-analysis workshop highlighted the interest and the sense of commitment of all who participated in the process.

Stage 6 : Health care sub-systems self–analysis data collection in the sub-prefectures and report preparation

Each team returned to their sub-prefecture to assess their sub-systems using the checklists and analyzing the information in four categories: 1) norms exist and are applied for the system, 2) norms exist but are not applied, 3) non-existing norms that are applied and 4) non-existing norms that are not applied.

Each zone team consolidated their analyses to write a report for the regional dissemination workshop.

Stage 7 : Regional and national dissemination workshops and the round table with partners

Following the management assessment, departmental and national dissemination workshops and the round table with DDSP partners allowed the elaboration of the principle components of health zone and DDSP plans to reinforce progress and to correct poor performance of the Borgou health system. These components are:

1. the priority problems of health zones and DDSP services,
2. the domains of quality and the health sub-systems affected,
3. the definition of strategic intervention axes,
4. the analysis of strengths, weaknesses, opportunities and threats,
5. the outline of the DDSP interim plan for 2000

Throughout the management assessment process, health officials at both the department and zone levels developed their analytical and planning capacity, as well as their sense of ownership of the data and the system they reflect. Through their participation in all stages of the assessment and dissemination, they are now capable of collecting and analyzing health system data, identifying priority problems and establishing strategic intervention axes. While the principle participants in the M.A. were health personnel, there are feedback steps for the community as the planning process continues and as the community facilitators begin organizing the community structures for self management.

At the round table following the regional dissemination workshop, a consensus was developed for the strategic axes that the DDSP and it partners would include in the next planning process for the region's triennial strategic plan (2000 – 2002). The strategic axes agreed upon are summarized in the box below.

The preliminary results of the assessment showed that the health workers understood the mechanics of collection, but that the usefulness of the data was not always appreciated. In particular, there was a minimal sense of ownership of data to be used for action at the local level.

STRATEGIC AXES DEVELOPED AT THE ROUND TABLE OF THE DDSP AND ITS PARTNERS:

- *Reinforcement of integration and continuity in primary family health care services, as well as fighting endemic and epidemic diseases and the referral system*
- *Reinforcement of IEC and BCC capacities in the zones*
- *Increasing the capacity of health personnel in the zones to use data and put in place a monitoring and evaluation system*
- *Development of the management capacities of the health zone teams, including institutional support*
- *Reinforcement of the fight against STD/HIV/AIDS*
- *Development of community capacity to participate in and manage their health centers*

The management assessment allowed heads of public and private health facilities that provide family health services to participate for the first time in exhaustive data collection on the quality of clinical services and health system management. They also collected information on the perceptions and expectations of clients and the general population. The indicators measured cover most family health indicators of the DDSP, USAID, and PROSAF, and they complement those measured by SNIGS, the 1996 DHS, the 1998 BASICS and 1999 CRS surveys.

A significant innovation was at the level of the data collection procedures used in the course of the MA. Besides the engaging participative methodology used through out the assessment, health facility personnel collected performance data according to a more dynamic approach of system and support sub-systems by comparing the existing situation to norms. This was a first, and is distinguished from the classic data collection approach of the SNIGS and semi-annual monitoring, where the emphasis is not on the performance level of the system and sub-systems, but rather on service utilization figures, for which the quality improvement decision opportunities are limited.

The next challenge that PROSAF will face with the DDSP and all its partners is the integration of family health indicators into the SNIGS, and to help service providers to routinely use the new data collection procedures in a revised monitoring framework to be used quarterly.

Throughout the management assessment process, quality assurance principles and concepts were promoted. The entire process reflected teamwork, from the steering committee, data collection and analysis process in the sub-prefectures and zones to the presentations in the national dissemination workshop. Adult learning principles animated all encounters by emphasizing discovery methods and feedback mechanisms. The client on all levels, from the clients observed and interviewed in the field to the DDSP, was respected. The management assessment was about understanding systems and using data for decision-making, and its use of self-diagnosis tools insured that it would be integrated into the system for on-going use. The emphasis on norms for quality services, systems analysis, and the dimensions of quality serves as a preview to the introduction of quality assurance methodologies and teams next year.

Besides the advantages inherent to the management assessment process, the timing of the activity was also fortunate. The DDSP is at the end of a three-year plan (1997 – 1999), and the evaluation of that plan began at the end of December. The information gained from the assessment, and even the processes and concepts introduced during it, should enrich the strategic planning process that will be launched for the next three-year plan. It dovetails nicely with the introduction of quality assurance as a main strategy in the next triennial period.

Development of a regional in-service training system

The identification of training needs is being carried out through (i) analysis of surveys and research carried out in Borgou by BASICS, PRIME and other partners, (ii) analysis by the DDSP of the plan for on-going training and improvement, and (iii) the results of the management assessment in the Borgou. A preliminary assessment of information available at the DDSP shows that training has emphasized nutrition and reproductive health in the past 30 months. The exact number of health workers trained is available, as there is no database for tracking in-service training.

The principle training needs of the actors in the Borgou health system were clarified through the departmental and national MA dissemination workshops, as well as the round table of DDSP partners. Training needs fall into two categories:

(1) *clinical services:* IMCI, SONU, integrated family health services, pre- and post-natal consultations, CN, IEC and counseling;
(2) *health systems management:* logistics and supply of MEG and family health products, use of data for decision making, referral and counter-referral, formative supervision, and community participation.

Given the variety and the quantity of these needs, it will be necessary to reformulate, integrate and consolidate them in order to define coherent "training packages" that can easily be inserted into a training plan that is integrated with that of the DDSP. This plan will include curriculum development and testing, and the expansion of the program in the Borgou. However, for domains such as IMCI, SONU, and logistics and supply of MEG and family health products, work is well advanced. Curricula exist and training plans are already developed or underway - they only need to be validated, tested, and executed. These next steps come under the competencies of the regional training team.

In consultation with the DDSP, a regional training team was selected. This team will be developing curricula and delivering training primarily to health workers. The criteria for the selection were:

- the team must be made up of members from both the private and public sectors,
- the members must be stable, and
- the members should have training aptitude and be interested in training.

Twelve members were chosen at this consultation, nine from the public sector and three from the private sector. Up to fifteen members will be considered. An instructor from the nursing school in Parakou will be added.

There were some suggestions that the structure of the team be reconsidered to favor a more decentralized approach. Other discussions on training were held among PROSAF's technical

team and two consultants, Jonathan Smith and Dr. Karki Mahamane. It seems important to consider the reinforcement of the training system in which results, strategies, training activities and resources are well structured and linked. Potential strategies include the development of a system for tracking who-is-trained-in-what in a database, development of a local training team, use of pre-service training institutions, introduction of innovative training methods and the establishment of a follow-up and supervision system. A particular need is to be able to evaluate changes in health worker performance as the result of training and link it to on-going supervision and monitoring systems.

Training is one of the main sub-systems for which an organizational structure still needs to be determined. This will be the subject of discussion and definition during a workshop to be organized in consultation with the DDSP and other partners at the beginning of 2000, before instructor training begins in the region. Initial discussions showed that the principle partners agree on the use of the systems approach to training, and that it will be helpful for the clear articulation of training results, strategies, activities, and resources.

Development of a health worker performance monitoring and facilitative supervision system

In July, the PROSAF coordinator and representatives from PBA-SSP and PADS attended a working session at the DDSP on the methodology of supervision. It was determined that, despite there being supervisory resources available, there was a large rift between the theoretical standards and their practical implementation on the field, reflected by irregular supervision at all levels and a poor understanding of methodology. These reflections were confirmed by the management assessment, which showed that only 7% of health facilities received four supervision visits in the past year. Health workers did not seem to have an appreciation for the importance of supervision. While reports are written, they are not used in any systematic way to make decisions.

Unfortunately, the activities in the work plan jointly developed by the DDSP and partners have not begun. According to PROSAF, two reasons could explain this situation:

(1) everyone is waiting for the assessment of the 1997-1999 triennial DDSP plan and for the development of the new 2000-2002 plan, which should take into account concerns related to formative supervision,
(2) during the last quarter of 1999, most partners, including the DDSP, instead gave priority to activities that had already financed but not yet completed, including the management assessment.

As the development of the health zone management teams becomes a reality, formative supervision will be a cornerstone module to be developed for their training. PROSAF will join the national process being launched for the development of the module.

The reporting system to monitor training and health worker performance is regarded as a component of the training/supervision sub-system and is thus the responsibility of supervisors and quality assurance teams.

Intermediate Result 4: Increased Demand for and Practice of Behaviors Supporting Use of FP/MCH/STD/HIV Services, Products and Prevention Measures in Borgou

PROSAF is working at both the community level and the provider level to increase the demand for family health services and the use of prevention measures. At the community level, PROSAF is working to revitalize and empower community structures. Community organizing efforts are concentrated in two zones (previously three sub-prefectures) to increase awareness of health issues that the community can address. The community structures are also being supported to plan and reinforce health services delivery. Behavior change strategies will be based on cultural considerations and targeted to influential members of families and communities. Traditional media will reinforce the one-on-one approaches such as negotiation within a person's lifestyle or small support group encounters. Modern media will focus on specific target groups and community-wide campaigns. At the provider level, PROSAF is working to improve communication, negotiation and listening skills. Providers will also receive behavior change training help to enable them to be more empathetic, positive and creative.

Identification of appropriate strategies and messages, and development and testing of specific materials and messages on family health themes

PROSAF has established links with traditional media groups, such as griots and theatre groups, and local radio stations (facilitated by BASICS and GESCOM). An evaluation of the capacities of griot and theatre groups was part of the immersion / community data collection for community facilitators.

Informal contacts with public and private radio, television, and publishing companies and journalists have led to the conclusion that there are very limited production capacities and facilities in all media. This has implications for plans to produce materials and multi-media communications. Contacts with partners such as PSI, ABPF, the MOH IEC unit and Public Health Institute reconfirmed the need to coordinate, especially in production and dissemination of IEC materials and specifying the social marketing and communication techniques for the Borgou.

A workshop was held in October to define the regional IEC committee's scope of work and the behavior change communication (BCC) strategies to be put in place. This workshop included health workers, NGOs and partner agencies, traditional and modern media, communities and communication agents. An outline of the role and responsibilities for the regional IEC/BCC committee and a draft of the strategy for the committee was developed (see Annex 4 for the draft of the charter for the regional IEC/BCC committee). Although the official naming of the regional committee has been delayed, the proposed members worked together for the World AIDS day. The central level was not able to attend the workshop and therefore must be brought into the loop before the committee can be made official. A draft catalogue of IEC materials, studies and curricula in use in the Borgou was proposed at this workshop and will be finalized in early 2000.

A preparatory step to identifying appropriate IEC strategies and messages will be an analysis of the questionnaires used for KAP and focus group studies in the past three to four years in Benin. The KAP and focus groups will help determine, in particular, the messages to be specifically

targeted for FP services. PROSAF will also participate in a study of the dynamics of decision making for health in the family, in collaboration with FRONTIERS.

Increasing the capacity of health workers counsel clients and to develop, communicate and measure impact of IEC messages

Data collection on IEC capacity was an integral part of the management assessment. Preliminary results showed that there was a need for IEC supports for most family health messages. The lack of counseling during all types of consultations was marked, and there was an obvious need for appropriate locale to deliver group health education sessions.

In coordination with other program components, PROSAF will develop behavior change communication materials and strategies to contribute to improving the capacity of health workers to provide quality health care services. Themes will be determined in response to the results of the management assessment as well as other studies. PROSAF will concentrate on the techniques for communicating and the attitudes to be used with clients. This will be the first training to be carried out by PROSAF for health center staff

During the USAID health partners meeting in July, opportunities for collaboration with JHPIEGO and INTRAH/PRIME were identified. There is a basis for harmonization of approaches and the integration of the BCC/IEC in the basic curricula. (See Annex 5)

Identification of training needs of COGES and COGEC and strengthening their capacities to manage resources and become more involved in health prevention and outreach activities in the three target sub-prefectures

The process used to select the three sub-prefectures for intensive community level interventions took into account criteria developed with the DDSP staff and included:

- weakest health services utilization indicators,
- absence of other major health sector partners (notably GTZ and IUED),
- presence of other USAID partners to test the synergy potential, and
- a combination of sub-prefectures that make up health zones, the intended future decentralized health management structure.

See Annex 6 for a summary of the selection analysis.

PROSAF's community interventions will be organized around COGEC and COGES. The texts regulating the functioning of these community structures are currently being debated in Benin. The debate concerns primarily the power to manage funds generated by the cost recovery system for drugs, as well as other procedural issues such as membership mandates and the changing of that membership. However, the support process for the COGES, COGEC and village health committees began with the following four activities:

- the recruitment of local field agents (community facilitators)
- guidance session for community facilitators and ABPF zone coordinators
- data collection immersion exercise in the field
- rapid evaluation of community participation in Borgou

An initial field visit by PROSAF staff revealed a few situations which, though not surprising, definitely merit improvement:

- all of the maternities visited were managed by nurses, not midwives
- infection prevention conditions were precarious at best
- finances and medication stocks were managed by the health personnel
- duplication of work exists in some of the paper trail and data collection forms; and

One of the most impressive observations was the willingness of the population, represented by the COGEC and COGES, to financially support health services and personnel. This is most obviously illustrated by the fact that 50% of the health personnel are paid by community funds.

Eight local field agents, called community facilitators, were recruited and sent to the three target sub-prefectures. Recruitment was carried out with the help of the DDS and five members of the COGES representing the communities of the target sub-prefectures. The COGES members intervened at the final stage of recruitment when it was necessary to interview the candidates in order to choose those most suitable according to their values and their philosophy on working in rural areas.

The community facilitators were oriented in a weeklong session at the beginning of August. The ABPF area coordinators and three resource persons working in the target sub-prefectures also participated in this meeting. This session enabled the participants to become familiar with the project's approach and to organize the material necessary for their field immersion.

After assisting with the management assessment, the facilitators started their one-month immersion in their assigned locations. During this month, they collected information to allow them to get to know their surroundings and to prepare the KAP study as part of the IEC portion of the program. More specifically, they:

- acquainted themselves with the organization of the health care system
- introduced themselves to the technical, administrative, and traditional authorities, and community leaders
- introduced themselves to the COGES, COGEC, and CVS and sought information about their organization and functions
- determined the different ways in which communities use the family health care system
- identified other actors intervening in the area
- visited all the villages and hamlets in the area concerned and sought information on their social and cultural habits

An evaluation of current community participation in the 14 sub-prefectures and urban circumscriptions in Borgou was integrated into the overall management assessment. Four tools were designed to collect information from members of the COGEC/COGES, the community and health workers. These tools assessed the following characteristics:

- the legitimacy of the COGEC and the COGES
- the representative nature of members of the COGEC and the COGES
- the capacity of members of these organizations to be effective and to assume their

responsibilities
- ❖ the practicality of the COGEC and the COGES
- ❖ the existence of a coherent system of on-going accompaniment of community structures in organizing their responsibilities

The facilitators also analyzed the questionnaire on community perceptions concerning their health care services. The communities were very expressive and their comments can be summarized as follows:
- ❖ deficient quantity and quality of staff members, and frequent absences or non-availability of those in charge
- ❖ need for specialists (doctors) in all areas
- ❖ permanent need for drugs
- ❖ need for information on family planning

The process of supporting the COGES, COGEC and village health committees continued with the realization of the following three activities:

1. Orientation seminar for the heads of health posts in the three concentration sub-prefectures. Approximately 40 health workers participated in an orientation meeting on PROSAF's five components. The objective of this meeting was to discuss PROSAF's activities in the three concentration sub-prefectures and to define the contribution of the health workers in the implementation of the program. At the end of the meeting, the participants defined their contributions for the execution of the program, which became known as the Kandi Declaration. (See Annex 7).

2. After the data collection for the management assessment, the analysis continued and permitted PROSAF to draw conclusions on the functioning of the COGEC and COGES and on community expectations vis à vis the health system. Primary analyses reveal the following:
    - In general, COGEC and COGES exist in all the health centers. 75% of villages are therein represented, decisions are rarely made by an individual, and they have the clear intention of carrying out family health promotion activities. However, these structures have significant shortcomings and these are seen in the irregularity of meetings, unavailability of COGEC members, lack of action plans and budgets, unfamiliarity with guiding texts, lack of a durable mechanism for motivation, not respecting the expiry of terms, and the absence of regular feedback to the community.
    - The communities have formulated various expectations that implicate the health system, health workers, the COGEC/COGES, and the communities themselves. In terms of the health workers, the communities expect better reception at the facilities and continued availability. The communities expect the COGEC to truly look out for their health and to report regularly on their management.

3. Eight community facilitators, 11 zone animators, and 3 resource people participated in their second training. The objective of the session was to take stock of the immersion phase in order to structure PROSAF's community participation approach, and to plan the first steps of the intervention. The session also allowed the participants to develop the intervention approach, and to develop pedagogical tools for the animation of the first phase. The lessons learned from the immersion phase in the communities can be summarized as follows:
   - health workers can present a block to activities if they are not truly integrated into the process
   - in order to have full participation of communities, the program of activities should take into account their availability
   - if an adequate motivation mechanism is not found, this could lead members of community structures to lose interest in activities
   - the effectiveness of meetings and other activities could be compromised if the facilitators do not take into account the conflicts that exist between communities when arranging meeting locations
   - to assure better representation of communities within the structures, it is important to visit all the villages and hamlets in the zone and to associate them with the process from the start
   - the development of listening skills and informal relations are an advantage in accessing privileged information in the field.

Organizing local NGOs to train social workers, agricultural and extension agents in health IEC and BCC activities to be included in operational community-based development programs

Community facilitators have inventoried the NGO and community-based programs in the three target sub-prefectures. ROBS, with the help of PRIME, has already trained trainers for IEC in family health and community distribution. PROSAF will identify other groups to receive this training as CBD develops. The trainers trained by ROBS will serve as resources. Contacts and discussions held with AFRICARE, MCDI and World Education point toward an interesting and innovatory collaboration in this field.

PROSAF will draw on lessons learned from the AFRICARE PSEO Project in the application of IEC activities to community-based services. IEC activity programming in SBC will be carried out with the COGEC/COGES, health workers, community facilitators and area coordinators. Some of the content of the IEC/BCC training may need to be adapted to local realities.

III. PROGRAM MANAGEMENT

Personnel

All of the five key contract-stipulated technical staff were in place by the beginning of April 1999. As of the end of 1999 eight technical staff and four administrative staff, as well as six drivers and several guardians, operate PROSAF. Eight community facilitators, assigned to the three target sub-prefectures, are employed by CLUSA. Nine zone animators were also hired under the ABPF sub-contract.

CORE PROSAF STAFF

Name	Position	Employer
Lauri WINTER *	Chief Of Party	URC
Marcel SAGBOHAN *	Deputy Chief of Party and Monitoring and Evaluation Specialist	URC
Mbaye SEYE *	BCC Specialist	PATH
Salwa KAZADI *	Training Specialist	URC
Télesphore KABORE *	Community Mobilization Specialist	CLUSA
Aimé ATOLOU	Quality Assurance Specialist	URC
Ibrahim BANIGORO	Representative / Technical Assistant of ABPF	ABPF
Emile AKOUWANOU	IEC Specialist	URC
Emmanuel BIAOU	Community Facilitator (Banikoara)	CLUSA
Salomon MATCHOUNDO	Community Facilitator (Bembereke)	CLUSA
Fousséni BAKARI ADAMOU	Community Facilitator (Bembereke)	CLUSA
Simey BIBOUBAH	Community Facilitator (Banikoara)	CLUSA
Abdoulaye HAKIBOU	Community Facilitator (Banikoara)	CLUSA
Fatouma CHABI GADO	Community Facilitator (Sinende)	CLUSA
Issifou MOUSSA YARI	Community Facilitator (Bembereke)	CLUSA
Bio Sacka Mama	Community Facilitator (Sinende)	CLUSA
Alain AKPADJI	Office Manager	URC
Martin ODJO	Accountant	URC
Mirielle DOSSOUVI	Secretary	URC
Richard FANOU	Coursier	URC

** key technical staff as stipulated in PROSAF contract*

As communication and documentation is a concern of the health partners in the Borgou, and an essential tool for promoting coordination and collaboration, PROSAF will hire a documentation specialist/archivist at the beginning of 2000. An internal computer network administrator will also be hired in the new year.

Program Start-Up

When the full technical team was in place, a series of launch workshops were held to inform partners and collaborators of the intended scope of activities that PROSAF would undertake over the next five years. The first workshop brought together program staff from the Association Béninoise pour la Promotion de la Famille (ABPF), the local contract partner, and the DDSP/B staff. The second workshop was the official opening of PROSAF and was attended by representatives of all partner constituencies. A theatrical presentation and a song and dance troupe interpreting the program's vision animated the official opening ceremony. The Prefect of the department of the Borgou, M. Zourkanourgou, and the USAID/Benin Mission Director, Tom Parks, gave the official launch speeches and the King of Parakou gave a benediction for the

success of the program. The third workshop included USAID-funded cooperating agencies working in the health sector in the Borgou.

Various partners from all levels of the health system attended the launch workshop that followed the ceremony. Through various small group work sessions structured around the five program components, elements of a vision of the Borgou after five years of working toward quality integrated family health services were stated and recommendations for achieving that vision made. A summary of these vision elements and recommendations can be found in Annex 8.

KEY RECOMMENDATIONS AND ELEMENTS OF A VISION FOR PROSAF

- *Promote collaboration between the public and private sectors*
- *Set regular periods for follow-up and coordination of the program through agreed-upon mechanisms*
- *Carry out detailed budgeting of activities at all levels*
- *Take into account existing assets/skills*
- *Contribute to the creation of a mechanism for keeping trained personnel*
- *Work with communities to study different mechanisms for the mobilization and management of resources to finance activities*
- *Develop IEC awareness models directed to decision-makers (advocacy)*

Progress Indicators The indicators to measure the achievement of USAID and PROSAF objectives were discussed in order to harmonize their definitions and use by PROSAF and the other partners. The current levels of the majority of PROSAF monitoring and evaluation indicators were calculated for the national dissemination workshop. It will be therefore possible to measure progress in reference to these figures. A list of the proposed indicators for monitoring the performance of PROSAF can be found in Annex 9. This list contains the indicators from the management assessment as well as the indicators to be used from other sources such as the DHS 1996 and the BASICS facility assessment 1998.

IV. CHALLENGES AND OPPORTUNITIES

All change efforts confront challenges, but if the change process is conscious, opportunities can also be created as understanding of the environment grows. PROSAF has many opportunities to build on work started by other partners (supported by both USAID and other donors). PROSAF's main challenges and opportunities fall into the categories of decentralization, relationships with MOH counterparts, coordination with health sector partners, and communications issues.

Decentralization

Given the objective of the program to promote and assist in decentralization for health sector reform, PROSAF has discovered both challenges and opportunities. The major challenge underlying all efforts to empower health workers and their client communities is that the structures that have held the decision-making power and resources are afraid of losing some of that power and therefore resist any change, and if possible attempt to increase central control. As Benin is a highly centralized administration and tradition obliges most people to defer to the chief, there are some ingrained attitudes that will not change over night. PROSAF believes that it is possible to work toward changing these attitudes through various approaches that validate individuals, organizations and communities in their initiative taking and participation in planning.

However, there are some elements of the decentralization process, such as the revision and adoption of new regulatory texts for the COGEC/S, which present issues in respect to true representation in the committees and preserving their oversight rights in financial management. While the new texts have not been finalized, PROSAF is proceeding with the process of organizing communities to encourage them to become more involved in health issues. Constituting committees from the village level to the sub-prefecture level is part of this process. Therefore, if official texts significantly change the intentions of these structures, readjustments will need to be made.

Another policy that has not been clarified is that of the role of village health workers for community-based distribution of family health products. There are lessons to be learned from several experiences in the country. A potential problem related to expanding the coverage of these community-based services is the unreliability of contraceptive supply in particular. In reconsidering the logistics and supply system with FPLM, perhaps some solutions will be come clear.

As the Ministry moves toward implementing the reorganization of the health system into zones, PROSAF finds opportunities to integrate its teamwork and quality assurance approaches into the development of the zone management teams and their training. PROSAF will also adapt its facilitative supervision modules for this process. With the movement toward zone management there is also the opportunity to improve or adapt systems such as training, communication, community participation, logistics and planning to better support the anticipated redistribution of resources. Some of these systems do not function in a rational manner and redesigning will be challenging, as consensus will be a principle for success.

Relationships with MOH Counterparts

In the processes of change that PROSAF is supporting, one major problem remains constant: that of the ability of the public sector to absorb all the technical and financial assistance that is offered. The main reason for this is the lack of personnel. The personnel of the regional health service, PROSAF's direct counterparts, are asked to serve many masters. Besides the various partners and the Ministry, staff must fulfill their usual responsibilities as well. While planning and coordination can alleviate part of the problem, the equation simply does not balance.

This situation sets up competition for people's time at the DDSP and in the zones, and unfortunately, this is reflected in the application of per diem. While there is a national MOH policy for per diem, the rates and circumstances for pay are unevenly interpreted. Many of PROSAF's activities require that counterparts travel to meetings and workshops, particularly for consensus building on system development. PROSAF hopes to reduce the travel required by health personnel in the future, but some will remain necessary. While per diem is not intended to supplement salaries, it is often viewed this way, even at the highest levels of government. Understanding of the true spirit of per diem – to cover the additional expense of participating in certain activities - must be modeled at the central level if there is to be a change in the interpretation of per diem at the department level. This is closely linked to the personnel shortage because staff often find themselves in situations of being overburdened and "motivation" becomes an issue – i.e. they will participate in the activity for which they will be compensated.

Another aspect of the lack of health care personnel in health centers is one of qualifications. One of the dramatic service implications is that almost 50 % of the health care providers in the Borgou are "aides-soignants", a category of personnel that has very little health training and yet is usually the first line of contact between the population and the health system. There is controversy over increasing their level of competency. These aides-soignants are paid by community financing and are the most stable category of health worker. This resource could be more productive if the MOH developed a strategy to improve their skills without threatening other categories of workers. With clear norms and performance standards, conflict can be avoided.

Coordination with Health Sector Partners

Health sector partners are increasingly falling into line with the Ministry's policies and strategies. This potentially has the advantage that partner-supported activities will not be seen as extra work, but rather appropriated by health workers. This does not automatically simplify the task of coordinating through the DDSP, as working together to optimally use time and other resources will remain a challenge. Most partners have multiple clients to satisfy in terms of objectives and reporting requirements. But practical concessions such as co-financing arrangements or adapting certain techniques or innovations to implement activities for common goals will go a long way to limit some of the competition.

PROSAF is charged with coordinating USAID-funded projects in order to create synergy and rationalize resources. While the opportunities for this synergy seem obvious, it is a definite challenge to realize that coordination. PROSAF is the latest program funded by USAID to arrive in country. Therefore, relations have had to be built in order to identify the true points of mutual advantage for coordination. As all organizations need to justify their existence to their funding

agency (or clients or stock holders) it is not obvious that the incentive is present within the system to push programs to collaborate when the measure of success is not easily attributable to one organization. The challenge of coordination will be discovering the mutual benefits that an activity creates and demonstrating that benefit to potential contributing parties.

The strategic planning process for the next DDSP three-year plan offers the opportunity to rationalize resource use and coordinate interventions to enhance capacity of the health delivery system. All health sector partners want to have their activities included in the DDSP plan such that they are no longer seen as *project* activities, but rather as part of one coherent plan owned by the health system actors themselves. It should also ease the competition for time in the busy DDSP calendar. The next three-year planning process will begin after the evaluation of the 1997 – 1999 plan is completed. Some of the zones already have what would be considered a strategic plan in their health zone development plans. The newly constituted zones will begin their strategic planning processes early in 2000. PROSAF will support this planning process particularly for the new zone of Sinendé/Bembereke. Using the results of the management assessment, the national outline for zone development plans, and the health zone mapping process, PROSAF will help the zone develop its own vision of the future and plot a strategic course for the next three years. In Sinendé/Bemebreke PROSAF will coordinate with UNICEF as the principle outside partner. In Banikaora, where the zone already has a development plan, PROSAF will support the inclusion of strategic elements identified throughout the self-analysis process of the management assessment to improve the zone's plan. This will be coordinated through the zonal team with the PBA-SSP.

Following are two tables that illustrate PROSAF's activities in 1999, and highlight the work done with health sector partners. The first is a list of workshops and significant meetings organized by PROSAF, and the second is a list of workshops and seminars attended by PROSAF staff.

TABLEAU RECAPITULATIF DES ATELIERS/SEMINAIRES/JOURNEES DE REFLEXIONS ORGANISES PAR LE PROSAF EN 1999

N°	Date	Titre du séminaire	Lieu de déroulement	Participants	Consultant ou Facilitateur	Résultats obtenus
1.	19-20 mai	Lancement officiel du PROSAF	Parakou	DDSP/B, MSP. PADS, PBA/SSP, Communautés, Roi de Parakou, S/P (Bké, Sdé, Bkra, COGEC/S)	Tisna Veldhuyzen Van Zanten (URC) E. SOHOUENOU	Bon décollage du PROSAF. Recommandation pour la prise en compte de l'expérience des autres et sur la ''Vision''
2.	17-18 juin	Atelier de concertation avec les partenaires de l'USAID	Parakou	Partenaires USAID	MS, LW, E. SOHOUENOU	Début d'instauration d'un mécanisme de coordination et de collaboration entre partenaires USAID dans le Borgou
3.	3-5 août	Rencontre de connaissance mutuelle et d'orientation des Facilitateurs Communautaires / Animateurs de Zone	Guy Riobé	FC, AZ, C/RAMS CPS	TK	Elaboration des outils (guide) pour le stage d'immersion
4.	30-août - 03 septembre	Formation sur module analyse de Epi-Info	Malanville Kandi Parakou	Médecins-chefs, Infirmiers Majors	B. DADY	Intéressés formés sur module Epi-Info.
5.	9-13 août	Evaluation de la Qualité de Gestion du Système Sanitaire dans le Borgou	Parakou	Agents socio-sanitaires du département	M. KARKI	Notion de système de santé et de qualité de services comprises Enquêteurs formés
6.	20-24 septembre	Atelier de Préparation à l'Auto-analyse des sous-systèmes de gestion sanitaire dans le Borgou	Parakou	Agents socio-sanitaires du département	J. SMITH M. KARKI E. SOHOUENOU	Participants ont appris l'analyse de sous- système de santé
7.	19-21 octobre	Atelier de réflexion sur les stratégies IEC/CCC dans le département du Borgou	Natitingou (Tata-Somba)	PROSAF, PADS, PBA/SSP, ROBS, Journalistes, Assistants Sociaux, DDSP/B, COGEC/S, CARDER, PSI	M.P. GUIDIBI	- Stratégies retenues pour le département - Attributions du comité départemental IEC
8.	26 octobre	Journée de Réflexion sur le concept de Services Intégrés de Santé Familiale	Parakou	ABPF, OSV-JORDAN, Médecins-Coordonnateurs Hôpitaux privés et confessionnels, BPA/SSP, PADS, PROSAF, DDSP/S	DDSP-SSF MSa. AA IB	Concept de services intégrés de santé familiale compris et accepté de tous
9.	1-5 novembre	Team – Building	Natitingou (Tata-Somba)	Equipe technique et administratif de PROSAF	Pape SENE (CLUSA)	Equipe PROSAF plus renforcée
10.	19 novembre	Rencontre d'orientation des chefs de postes des sous-préfectures de concentration de PROSAF sur le volet	Kandi	Chefs postes des sous-préfectures Bembèrèkè, Sinendé et Banikoara	TK AA	Chefs-postes sensibilisés sur la participation communautaire

N°	Date	Titre du séminaire	Lieu de déroulement	Participants	Consultant ou Facilitateur	Résultats obtenus
		renforcement de la participation des communautés à la gestion du système de santé				
11.	22-23 novembre	Rencontre de concertation des Partenaires USAID avec thème de discussion sur les relais communautaires	Parakou	Partenaires USAID	TK SK	-Consensus sur les rôle s des relais communautaires et les mécanismes de leur motivation - Rôle des agents de santé dans le fonctionnement durable des structures communautaires
12.	15-17 novembre	Atelier départemental de dissémination des résultats de l'Evaluation de la Qualité de la Gestion du Système Sanitaire dans le Borgou	Parakou	Agents socio-sanitaires, Médecins-chefs, Gestionnaires, Assistants sociaux, Représentants du MSP, PADS, BPA/SSP, ROBS	J. Smith E. Sohouénou M. Karki	Existence de Rapport par zone de l'évaluation de la qualité de la gestion sanitaire dans le Borgou Début de dégagement des axes stratégiques
13.	11-13 novembre	Atelier de dissémination de politiques normes et standards aux agents socio-sanitaires des sous-préfectures de Tchaourou, Parakou et N'dali	Hôpital Sounon Séro Nikki SESSION 1	Médecins, Agents sociaux sanitaire, Infirmiers, Agents santé familiale	SK, AS, BS;DV	Agents socio-sanitaires formés sur utilisation documents de PNS / SF
14.	08-10 décembre	Atelier national de Dissémination des Résultats de la EQSGSB et Table Ronde des Partenaires du Département du Borgou.	Parakou	Agents socio-sanitaire du Borgou, MSP; Partenaires.	M.P. GUIDIBI M. NDIAYE SY	Validation Consensus sur les axes stratégiques dans le moyen terme à soutenir par les partenaires
15.	13-15 décembre	Atelier de dissémination de politiques normes et standards aux agents socio-sanitaires des sous-préfectures de Banikoara, Malanville-Karimama, Kandi-Gogounou-Ségbana	Boko SESSION 2	Médecins, Agents soci-sanitaires, Infirmiers, Agents santé familiale	SK, AB, AJ.	Idem. N12
16.	13-15 décembre	Atelier de dissémination de politiques normes et standards aux agents socio-sanitaires des sous-préfectures Nikki-Kalalé-Pèrèrè	Parakou SESSION 3	Médecins, Agents socio-sanitaires, Infirmiers -Santé familiale	AS, BS, DV	Idem. N12
17.	13-18 décembre	Atelier de restitution du stage d'immersion des facilitateurs communautaires et animateurs de zone	Banikoara	Facilitateurs communautaires, Animateur de zone	TK	Bilan du stage d'immersion, outils pour l'animation des réunions villageoises développées
18.	15 décembre	Atelier de réflexion sur l'intégration des services de santé familiale	CFAAP	Médecins coordonnateurs de zones ; Jordan ;PADS	SM, IB, AA.	Consensus sur PMA/ SF Contenu étude de faisabilité arrêté

TABLEAU RECAPITULATIF DES ATELIERS / SEMINAIRES / JOURNEES DE REFLEXIONS QUI ONT NECESSITE LA PARTICIPATION DES MEMBRES DU PROSAF

No	Date	Titre du Séminaire/ Atelier/ Journée de Réflexions	Lieu de déroulement	Membres PROSAF / Partenaires	Implication pour PROSAF
1.	20-24 / 3 / 99	Séminaire national d'orientation et d'adoption de la PCIME	Bohicon	L.W, SK. MS	PROSAF informé sur PCIME
2.	22-26/3/ 99	Réflexion sur les relais communautaires	Abomey-Calavi	TK	Besoin de clarification du PMA pour la SBC. Porter une grande attention aux questions de Motivation des ASBC.
3.	9/4/99	Journée d'information et d'échanges avec les médecins-chefs, les Responsables de Projets et les Partenaires sur la boîte â images PMA/ N.	BASICS (Parakou)	TK	Information et formation sur utilisation boîte à images
4.	21/ 4 / 99	Réunion du collectif des Médecins-Chefs du Borgou	Hôpital BOKO	Equipe PROSAF	PROSAF appuiera telles rencontres
5.	24 /6 /99	Réunion des Partenaires de tous les secteurs de l'USAID	Cotonou	LW	Informations pour collaboration et pour coordination des activités
6.	24- 25 / 6 /99	Atelier de replanification MCDI	Parakou	TK	Informations
7.	28 / 6 /99- 2 / 7 / 99	Mise en œuvre de l'AQ des soins au niveau des Districts sanitaires en Afrique Francophone	Abidjan, Côte d'Ivoire	AA; DDSP	BANIKOARA retenu comme zone pilote sur le plan national pour l' AQ
8.	5-16 / 7 / 99	Formation des Formateurs en AQ et en Coaching	Mangochi, Malawi	SK	Développer les capacités en AQ
9.	20-27 / 99	Atelier d'Orientation et de Préparation des Séminaires Départementaux de Dissémination des PNS / SF.	Parakou	SK ; AA ;LW	PROSAF fera la Dissémination dans le Borgou.
10.	29 / 7 / 99	Réunion des Partenaires Santé USAID	Cotonou	Equipe PROSAF	Permettre à PROSAF de mieux coordonner les activités des Partenaires USAID avec les informations sur la formation
11.	1 – 6 / 8 / 99	Journée de Réflexion sur la Réduction de la Mortalité Maternelle et le rôle des sages-femmes.	Cotonou	SK	Détermination du rôle de la sage-femme et du Plan d'action national en matière des SONU
12.	2 – 6 / 8 / 99	Atelier de formation des formateurs sur la Logistique Contraceptive	Bohicon	IB	PROSAF informé sur contenu de la formation en Logistique Contraceptive rédigée par FPLM et DDSP
13.	1-3 / 9 / 99	Séminaire départemental d'impact du SIDA sur les ressources du BENIN	Parakou	EA ; SM AA ;MS ;S	Les plans d'actions à suivre par PROSAF et DDSP.
14.	9 / 9 / 99	Roll-back Malaria	Cotonou	LW	Informations.
15.	1 / 10 / 99	Réflexion sur les Indicateurs en SF	Cotonou	AA ; SK	Permettra au PROSAF de choisir ses propres Indicateurs
16.	14 / 10 / 99	Journée de Plaidoyer sur la PCIME	Cotonou	SK	Informations
17.	15 / 10 /99	Soins obstétricaux non couverts Harmonisation avec le Zou	Savè	AA	Informations pour la préparation et participation dans une recherche

No	Date	Titre du Séminaire/ Atelier/ Journée de Réflexions	Lieu de déroulement	Membres PROSAF / Partenaires	Implication pour PROSAF
18.	20 / 10 /99	Atelier de Restitution de l'Enquête CAP et anthropométrique réalisée par le CRS	Parakou	LW	Permettre au PROSAF de développer des messages pour le CCC en Nutrition et mieux collaborer avec le CRS.
19.	20-22 / 10 /99	Atelier de Restitution de la Recherche sur la Participation des Populations à la Gestion des Services de Santé	Cotonou	TK	Informations sur les discussions sur les textes et statuts juridiques des COGECS
20.	28 / 10 / 99	Restitution de l'Equipe de Faisabilité des Zones	Parakou	LW	Acceptation des propositions de formaliser 3 zones sanitaires : Sinendé / Bembèrèkè ; N'dali /Parakou et Tchaourou
21.	29 / 10 / 99	Atelier de Formation des Formateurs sur l'Installation des UVS, Mutuelles de Santé	Parakou	TK ; MOUSSA YARI ISSIFOU	Informations. Possibilité de Collaboration avec le PAMER pour la redynamisation des UVS.
22.	11 / 11 / 99	Séminaire d'information sur le Réseau de Prévention régionale de la Mortalité Maternelle	Parakou	LW ; AA	Information. Voir les liens et collaborations entre SONU et étude des besoins obstétricaux non couverts.
23.	18 / 11 / 99	Atelier de Restitution des Résultats de la Supervision départementale sur l'utilisation du matériel IEC-PMA /NUT. Et les Instruments de Gestion du SNIGS	Parakou	EA	Informations pour collaboration éventuelle avec BASICS dans les interventions communautaires
24.	8 –12 / 11 / 99	Appui à l'Evaluation à mi-parcours du PSEO	Pôbè	IB	Partage d'expériences. Leçons tirés à appliquer dans la relance des activités SBC dans le Borgou.
25.	20 / 11 / 99	Rencontre des Rois et Chefs traditionnels du BENIN pour une déclaration sur les Mutilations génitales féminines	Parakou	IB	Informations
26.	22-23 / 11/ 99	2me Rencontre semestrielle des Partenaires de l'USAID	Parakou	LW ; AA SM ;AE	Suivi collaboration entre Partenaires USAID. Recommandation pour la capitalisation des expériences SBC.
27.	23-25 /11 / 99	Restitution de la Conférence internationale sur le SIDA tenue à Lusaka en ZAMBIE	Akassato	MS	Informations
28.	25-26 /11 / 99	CDEEP / Borgou	Parakou	LW	Informations pour une meilleure coordination avec les autres Partenaires et la DDSP.
29.	29-30 /11 /99	Atelier de Suivi des Journées de Réflexion sur la réduction de la Mortalité Maternelle	Akassato	SK	Informations. Planification de l'Atelier de Planification des actions SONU au niveau départemental.

Communication Issues

Coordination also necessitates communication, which has been a major challenge for PROSAF. Telecommunications between Parakou, the rest of the Benin, and the outside world is a continuous struggle. E-mail is one tool that PROSAF has tried to exploit with varying success. It is difficult and time consuming to get a connection to the server in Cotonou, but the advantage is that a message is transmitted to several partners at once, which would not be possible at all if each had to be telephoned individually.

This communication problem is compounded by the program's distance from Cotonou. Many of PROSAF's interventions in systems improvement and norm creation require the implication of the authorities at the central level of the Ministry of Health (i.e. in Cotonou). This means inviting the concerned parties to activities in the Borgou, and they are not always available to make the trip. Therefore PROSAF has adopted alternative strategies, such as visiting MOH partners in their offices in Cotonou to keep them apprised of activities. This is equally a dilemma when needing to coordinate with USAID-funded partners, especially centrally funded programs that are not stationed in Benin. While the USAID mission has facilitated these connections, PROSAF will need to increase communications with these partners to enable joint work planning.

Other practical considerations of being more visible at the MOH are to take advantage of the opportunities that can present themselves when information is shared. Because there is always a "political" aspect to the exchange of information, proximity is useful. Partners who have a longer experience in Benin have advised PROSAF to be more visible at the MOH to enhance the exchange of information and the opportunities to explain our approaches. Since there are many reforms going on - such as IMCI or emergency obstetrical and neonatal care - PROSAF can demonstrate different approaches as long as the MOH understands the pilot nature of some of its innovations. Because PROSAF has its operations and focus in the region, it also has the opportunity to bring information to the Ministry on the feasibility of certain approaches. For example, PROSAF has already started to apply Quality Assurance approaches in the Borgou and the Ministry has given its accord to intensively demonstrate the approach in Banikaora as a pilot zone, thus legitimizing the whole experience.

PROSAF has had a positive start in the Borgou. From the Ministry in Cotonou to the health workers in the periphery, there is enthusiasm about the program's participatory approach. This is an opportunity and a challenge to maintain. PROSAF's approach of starting with what is available and solving problems locally, before looking beyond for resources, might be disappointing to those hoping for new equipment or motorcycles, but PROSAF feels that with time and experience, pride and a new sense of responsibility can bring sustainable change.

V. PROGRESS ACHIEVED IN YEAR ONE

Intermediate Result 1: Improved Policy Environment

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 1.4: Review decentralization plans, make recommendations, and apply accepted policies and procedures	Review official policies and procedures	The principal policies identified to implement decentralization are the implementation of the health zones and the revision of the COGEC/S regulatory texts	While a formal review has not been done, PROSAF has implemented all of its activities to promote health management by zones, officially recognized or not. There has also been active participation in the discussion of the renewal of COGEC/S regulatory texts	PROSAF joins other partners in the process of developing training for health zone management teams (HZMT). The passage of the regulatory texts for community participation organization is pending as revisions are still contended both health sector and community representatives
OP 1.5: Provide leadership for coordinated management of USAID funded activities	Create coordinated management team Manage ongoing coordination processes	Two semi-annual meetings with all the USAID partners were held to coordinate activity calendars. and create discussions around common themes of interest and adhoc working groups for making recommendations on issues for improvement Collected, summarized and distributed a review of studies concerning family health	Development of the relationships necessary to create the spirit of collaboration and coordination continues	As communication and documentation is a concern of the partners and as these provide the essential tools for on-going coordination and collaboration PROSAF will hire a person to support this activity Inventory of IEC curricula and materials almost complete. Inventory of training curricula and materials in progress.
OP 3.1: Assist MOH to adapt and pilot test IMCI strategy in collaboration with BASICS	Identify pilot sites for IMCI training and investigate possible compliance issues	Participated in national level workshops to adopt and advocate for IMCI	Benin adopted the IMCI strategy in March 1999. As yet the official choice of the pilot sites has not been made. Discussions with BASICS, AFRICARE and UNICEF have led to the proposal to use preparatory mechanisms to introduce integration practices and initiate communities to their role in child health	PROSAF , Africare and BASICS are prepared to chose specific criteria to identify sites for implementing and testing IMCI based on their baseline surveys and the central level IMCI committee's orientations

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 3.2: Assist MOH to expand role of midwives, including provision of emergency post-partum and neonatal care (PRIME)	Identify midwives for training Meet with midwives to discuss issues of implementation in new role Work with PRIME to develop in-service training curriculum, based on pre-service training curriculum	Participated in the national level discussions and planning workshops for expanding the role of midwives and communities in confronting obstetrical and neo-natal emergencies	The expanded role of mid wives continues to be defined through workshops facilitated by PRIME.	A planning process for putting in place an implementation activity for the expanded role for midwives in the Borgou starts in February 2000. Adaptation of curricula is planned as well One adaptation to be considered in conjunction with this activity is the inclusion of aide soignantes in the skill improvement plan for obstectrical emergencies
OP 3.3: Disseminate norms, standards and protocols of family health to health agents	Develop and implement standards dissemination component of management assessment Develop dissemination system	PROSAF financed and completed the dissemination of FH norms to the S/P mgmt teams in the Borgou.	The dissemination system is the plan of the S/P teams to continue informing other HWs of the norms and their importance	The clinical guidelines, which are the tools for front line HWs, will be available in early 2000. These tools are derived from the FH norms, and are being completed by PRIME. These norms are also the basis for the new integrated FH training plan.
OP 5.4: Recommend and finance sustainable community level interventions using innovative approaches to increase community participation	Community based strategic and operational planning in the target zones		These "micro-finance" projects will be part of the community level strategic plans which will be the result of the self diagnosis process done in the first quarter of 2000 with support of the PROSAF comm. facilitators	There are several projects, both funded by USAID and others, considering income generation activities for more sustainable interventions at the community level.

Intermediate Result 2: Increased Access to FP/MCH/STD/HIV Services and Products

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 2.1: Assist MOH to develop national logistics management system (with FPLM)	Review implementation of national logistics management system within Borgou Suggest modifications in national plan to better meet local needs	ABPF technical assistant on PROSAF team attended the TOT held by FPLM with other personnel, private and public sectors, to improve the logistics system for contraceptives.	The management assessment (M.A.) and the subsequent prioritization exercises with HWs, the DDSP and partners identified the improvement of the logistic management system for all drugs, contraceptives, supplies and vaccines as priority.	While the MA assessed the presence and functionality of the logistics system, further process and tool analysis is needed. The FPLM assessment tools will be part of this analysis and the FPLM indicator for this system will be adapted for the Borgou
OP 2.2: Improve supply and commodity distribution to and throughout Borgou, emphasizing family health commodities	Conduct management assessment	The M.A. showed that 24% of clients were unable to get contraceptive refills and 86% of health centers experienced a stock out of at least 1 essential drug in the past 12 months..	PROSAF ABPF, and PSI are sharing information on location of services and points of sale to be able to target areas for introduction of points of sale or reinforce CBD	Related to the comments above as well as the expansion of CBD coverage, which will be undertaken over the next year.
OP 2.3: Expand availability of integrated basic package of family health services	Facilitate consensus regarding the objectives of integration Assess clinic capacity to provide integrated services, as well as current performance	Th eM.A. showed that integrated family health services are available in only 12% of the public and private centers. 2 consensus workshops to define the integrated package of family health services were held and definition of a guide for integrating those services in health centers drafted.	The assessment of health center capacity to offer integrated services is underway in selected centers through out the department and will be examined in February.	Testing the proposals that will follow the assessment in the selected centers will provide direction for more wide spread integration activities A guide for the integration of FH services is drafted. Plan for implementation will be gradual due to mostly to personnel shortages

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 2.4: Work with PSI and others to develop and implement strategy to increase community-level distribution of family health products	Review related CBD experience in Borgou and elsewhere	Information on the location of points of sale has been shared. A survey by the PROSAF community facilitators identified 144 villages to be covered with CBD and /or points of sale for FH products. The Africare/ Pobe CBD experience lessons learned and others from CLUSA experience elsewhere have been incorporated in the recommendations made at the November partners meeting.		The definition of the CBD strategy for the Borgou is important step toward this output. A workshop for consensus will be held early 2000.The hiring and integration of ABPF zone animators was slightly delayed, but they have all been assigned as of the end of 1999.
	Plan for PROSAF CBD activities, including links with social marketing			

Intermediate Result 3: Improved Quality of FP/MCH/STD/HIV Management and Prevention Services

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 1.1: Develop and implement plan to increase capacity of Dept. and SP officials to plan and deliver health services	Conduct management assessment Plan for building management capacity for personnel Implement plan to strengthen management capacities	The management assessment has been completed and the results have been disseminated at the regional and the national levels	The process used to accomplish the M.A. was one of self-analysis. The steps included peer observations and interviews, analysis of sub-systems according to norms and focus groups in the communities. There was a mid-process restitution with COGEC/S members and sub-prefets. Significant committment to change and enthusiasm for quality improvement has been generated through the methodology of the M.A.	While communities were involved in the data collection and analysis they are yet to have a full restitution of the results of the M.A. This will occur during the strategic planning process that will continue through the first trimester 2000. This planning process will dovetail with the planning processes being initiated in villages and communes by the community facilitators in the 3 target S/Ps. The information from the M.A. will be integrated into existing plans in some zones and will contribute to the triennial plan being prepared in the first quarter of 2000.
OP 1.2: Develop annual strategic and operational action plans, in collaboration with public, private and donor partners	Review health care needs Conduct strategic planning Develop operational plans	The Management assessment reviewed the management sub-systems and the quality of family health services in the 14 S/Ps. And the process of strategic planning at the zonal and the regional level has started with the identification of the strategic challenges made evident from the analysis of the data collected and the sub-systems analyzed. These challenges were translated into priorities and validated by a round table with key actors and partners.	The evaluation of the DDSP three-year plan 1997-1999 has been co-financed by PROSAF, PBA-SSP, and PADS, but planning for the new three-year plan should be finished by march 1999. PROSAF has introduced quality management approach of focusing on inputs definition, process analysis and improvement, and definition of norms for all the clinical and managerial / administration processes.	The different zones are at different levels of planning, as are the private sector institutions. This will mean intensive and close follow-up needs for at least 6 S/P (aprox. 3 zones) and the 2 private centers.

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 1.3: Improve data collection procedures for family health indicators	Identify strengths and weaknesses of current system Quarterly review and data by sub-prefecture staff and DDS	The M.A. identified that HWs know how to collect data and calculate some indicators. However the weakness is in the use of the data for planning and problem solving. Certain FH indicators are not calculated, such as CYP, although all data is routinely collected		The current system relies on semi-annual monitoring activities, however these results are not examined in a regular forum for decision-making. In the zones there is some exploitation of these results at a very local level. PROSAF is providing the lead in coordinating partner support for quarterly zone and departmental management meetings.
OP 3.4: Assess training needs of all types of health workers and develop training plan to meet needs	Develop and implement training needs component for management assessment (see output 1.1) Develop process for in-service training development involving DDS and pre-service training staff	The M.A identified that only 30% of the personnel had participated in 3 in-service training sessions in the last 12 months.	A draft strategy paper outlining the steps toward a department wide in-service training plan is being circulated among partners	Since there is no norm for required in-service training for the different categories of personnel and no records kept on who received what training the standards will need to be determined as part of the training system to be developed
OP 3.5: Develop regional training team with skills to provide in-service training	Conduct needs assessment of regional training team Conduct in-service training for regional training team in TOT, innovative training methods	A regional training team was identified with the DDSP early in the start –up of the program.	The training team was essentially the resurrection of a previously identified group. Almost all are clinicians with service provision positions.	The configuration of the regional training team is being reconsidered A more decentralized design is sought because the original group of 14 people drawn from all levels might create important absences from health centers. These issues will be debated in a consensus workshop in February 2000.
OP 3.6: Develop creative ways to increase knowledge of health workers, including easy access and exchange of health info and techniques		Not yet	To be developed in years 2 and 3.	The activities contributing to this result will only be determined once the training plan is in place

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 3.7: Assist DDS to develop formative supervision plan	Assess supervision system as part of management assessment	Only 6 % of the health centers had had 4 supervision visits in the last year.	Supervision is a top priority system for all actors in the health care system and their partners. A coordination of effort was initiated by the DDSP to culminate in the development of a formative supervision training curriculum this year. Facilitative supervision is considered as an integral part of the quality assurance.	While the norm proposed by PROSAF is quarterly supervision visit the actual norm in Benin in monthly supervision visits. The development of the curriculum for supervision was delayed, because this skill will be developed in the training for the health zone management teams aas part of their quality management / assurance training. This will be planned when the regional three-year plan is prepared
	Train DDS team in supervisory skills			
	Develop improved supervision system			
	Implement and monitor improved supervision system			
OP 3.8: Develop reporting system to monitor training and performance of HWs	Develop QA/QM training materials	Not yet	Planned for years 2 and 3.	This reporting system is part of the training / supervision system to be designed in early 2000. QA/QM activities are the basis of both monitoring of performance and improvements.
OP 4.3: Include IEC and counseling in all in-service and pre-service training courses	Assess existing training activities and curriculums, both pre-service and in-service for BCC and materials development		Various curricula have been identified during the IEC/BCC workshop. There are modules that have been developed by JHPIEGO and the nursing schools for RH.	Analysis of the curricula remains to be done and adaptations for different categories of personnel. The intention is that IEC/BCC strategies be discussed in every training provided in the in-service training plan
	Develop an BCC and IEC training plan in coordination with other PROSAF training activities			

Intermediate Result 4: Increased Demand for and Practices Supporting Use of FP/MCH/STD/HIV Services, Products, and Prevention Measures

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 4.1: Conduct formative and qualitative research to identify appropriate strategies and messages	Assess capacity and IEC as part of management assessment Establish links with and assess capabilities of traditional media, e.g. griots and theater groups Conduct in-depth interviews and focus groups to fill in knowledge gaps and local priorities about health issues; identify preferred ways to receive information Implement IEC KAP survey Develop BCC messages and media	The M.A confirmed that IEC skills need to be reinforced as well as the tools and supports. Links have been established with the traditional media groups and the local radios. (these contacts were facilitated by BASICS and GESCOM) PROSAF used these groups for World AIDS day activities and invited them to the consensus workshop for IEC/BCC strategy for the region.	A draft of a catalogue of IEC materials, studies and curricula is being finalized A preparatory step for the research will be an analysis of the questionnaires of the KAP and focus group studies done in the past 3-4 years in Benin in order to compare and verify the variables used for calculating the key indicators needed by PROSAF and USAID	A KAP survey to be completed in the first half of 2000. It will serve as baseline for certain program indicators There will also be a study of the dynamics of decision making in the family for health in collaboration with FRONTIERS
OP 4.2: Develop and test specific materials and messages on FP themes using traditional media/ IEC	Establish IECCC, including range of community, communication and health members IECCC develop IEC strategy (in conjunction with annual strategic planning) Formalize griot network and conduct training workshop	An outline of the role and responsibilities for the regional IEC/BCC committee and a draft of the strategy for the committee was established in a department wide workshop. Theses results have been submitted to the DDSP for approval.	Although the IEC/BCC committee has not been made official, the proposed members have worked together for the World AIDS day.	The official naming of the regional committee has been delayed. The central level was not able to attend the workshop and therefore will be brought into the loopin early 2000. The KAP and focus groups will help determine the messages more specifically for FP services

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 4.4: In collaboration with BINGOs, HEPS and others, organize local NGOs to train social workers, ag extension agents in health IEC	Conduct an assessment of NGO and governmental community-based programs Develop a plan to add health component to BINGOS, HEPS and other groups' planned training activities Assess need for IEC training materials; develop materials targeted to non-health professionals	In the 3 target S/P Community facilitators have inventoried the NGO and community –based programs. .	ROBS with the help of PRIME have already trained trainers for IEC in RH CBD. PROSAF will identify other groups to receive this training as CBD develops. The already prepared trainers will be resources.	There may need to be some adaptation for local specificities in some of the content areas of the IEC/BCC training. As BINGOS is closing in June 2000 there will little opportunity to coordinate with the program directly but the NGO's of BINGOS will be included
O P 4.5: Include IEC activities in operational community-based development programs	Provide committees with information on IEC materials and activities available (materials, griots, etc) and help them include IEC activities in their work plans	Not yet	To be done in year 2.	
OP 4.6: Develop and carry out a plan to increase capacity of health officials to develop, communicate and measure impact of IEC messages	Conduct initial assessment.	The Management assessment showed only 26% of group IEC sessions were correctly organised and executed.	This is related to output 4.3 to include IEC/BCC in in-service and pre-service training.	BASICS has done some specific work on IEC for nutrition and the capacity to measure impact of messages, PROSAF will adapt their model and

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 5.1: Work with BINGOs and others to develop selection criteria, and based on criteria, ID 2-3 SPs for CLUSA community participation approach.	Identify BINGOS trained NGOs working in Borgou Select NGOs and other partners to assist in the development of selection criteria Develop criteria and make selections of sub-prefectures, communes and communities for project participation Identify local communities & villages interested in participating	Identification of BINGOS trained NGOs was one of the results of the first USAID partners coordination / /collaboration meetings. PROSAF identified criteria for SP selection together with USAID and DDSP. Selection of the 3 concentration SPs was completed and CLUSA has placed 8 community facilitators. ABPF has placed an additional 3 zone animators.	PROSAF has integrated training for CLUSA and ABPF community facilitators and zone animators. Detailed work plan for strengthening community participation is being implemented.	This output has been changed in its wording to reflect more correctly the intent. BINGOS-trained NGOs did not participate in identifying the target S/Ps, as the process of relationship building with the NGOs needed more time and the choice needed to be made. The criteria were developed with the DDSP. BINGOS ends in June2000 before many activities will be underway. Therefore their training may not be added. However the community facilitators will work with groups already trained by BINGOS, MCDI and World education.

Expected Results (Outputs)	**Planned Activities**	**Accomplishments**	**Progress towards achieving results**	**Remaining Issues**
OP 5.2: Provide follow-up of other related results packages with selected health centers and communities (training/ IEC activities in family health, prevention)	Orient and introduce PROSAF to communities/villages	Orientation of the health staff in the 3 target S/P to PROSAF and its community participation approach was added to the activities contributing to this output. Their help was solicited as part of the orientation activity. Community facilitators and Animators helped organize the World AIDS day activities in the S/Ps.	Community facilitators and ABPF zone animators participated fully in the M.A in the community level interviews and focus groups They also assisted with the analysis of the qualitative questionnaires and the regional dissemination preparation and workshop. In December the FC and AZ received their orientation Community self-assessment is planned for the first semester of 2000	As the training , QA and IEC /BCC plans are developed the community facilitators and ABPF animators will be implicated
	Assist villages in self-assessment of priority needs and current health care system			
	Develop and train village health councils (VHC)			
	Develop VHC action plans to address oversight mechanisms for COGES/COGEC and priority needs, including training, revenue generating and health promotion activities			
	Provide specific training required to carry out action plan			
	Local VHCs providing oversight, outreach and prevention services			

Expected Results (Outputs)	Planned Activities	Accomplishments	Progress towards achieving results	Remaining Issues
OP 5.3: Identify training needs of COGES and COGEC and strengthen capacities to manage resources and be more involved in health prevention and outreach activities	Orient and introduce PROSAF to selected COGESs & COGECs	The community facilitators were hired to work with communities, VHC and the COGEC/S. They will analyze more in-depth than the M.A. the training needs of these community structures. They have received their initial training to be able to engage the communities in reorganizing for the management of their health.		The text regulating the functioning of the community structures are being debated currently in Benin. It is mostly a struggle over the power to manage the money generated in the cost recovery system for drugs and secondly other procedural issues such as the membership mandates and changing of that membership.
	Assist COGESs & COGECs to reorganize or restructure as necessary			
	Develop COGES & COGEC action plans to address priority needs, including training needs, revenue generating activities and health outreach and prevention activities			
	Provide specific training required to implement action plans			
	COGES & COGEC activities ongoing including monthly outreach and reports to VHCs			

VI. PLANNED ACTIVITIES FOR 2000

PROSAF has made considerable effort to coordinate its activities with those of its partners, most importantly the DDSP. The following work plan was developed collaboratively and will be integrated to the extent possible with the plan of the DDSP.

Résultat intermédiaire I : Amélioration de l'environnement politique

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observations
1.	Suivi des zones dans processus de planification stratégique et opérationnelle :													Plans élaborés et opérationnels	Tous	DDS, PADS, PBA, PROSAF UNICEF CADZS	
	– Développement des plans stratégiques	X	X	X													
	– soutien à l'élaboration du plan de développement de la zone sanitaire de Sinendé / Bemèbrèke			X	X												
	– Elaboration des plans opérationnels et leur suivi		X	X			X			X			X				
2.	Contribution à l'élaboration du Plan Directeur (stratégique) de la DDS	X	X	X										Plan triennal 00-02 finalisé	1	DDS, Partenaires	Consultants
3.	Suivi des recommandations pour coordination et collaboration :													Recommandations suivies et exécutées	Tous	DDS, USAID, autres partenaires	Atelier USAID réunions sur centre d'intérêt POLICY et PNLS
	– 3ème et 4eme ateliers de concertation avec partenaires de USAID						X						X				
	– Suivi atelier de Policy sur le SIDA			X													
	– Travail planning conjoint USAID		X				X			X			X				
4.	Révision des indicateurs du PROSAF :													Paquet des indicateurs approuvé Outils de collecte	tous	PADS, PBA, DDS, USAID	A prendre en considération les indicateurs de USAID (cf activité et ateliers de dissémination et processus de planification)
	– Processus de planification avec DDS et partenaires		X														

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observations
	– Harmonisation avec indicateurs SNIGS et EQGSS et intégrer les indicateurs de qualité pour monitoring –	X	X	X	X												Frank Baer est le consultant identifié
	– Consultation pour le renforcement du système de monitoring et évaluation pour PROSAF		X	X													
5.	– Faire le monitoring de façon continue avec indicateurs choisis			X	X	X	X	X	X	X	X	X	X				
6.	Mise en place d'un mécanisme de revue trimestrielle pour les plans et les indicateurs		X	X			X			X			X	Mécanisme trimestriel de revue des plans et des indicateurs	1, 2	DDS autres partenaires	Plan Directeur DDS
7.	Soutien aux services d'études, programmation et documentation			X			X			X			X	Planification et coordination améliorée à la DDSP	1,2,3	DDSP, PADS, MSP, SNIGS	Consultant
8.	Clarification des mécanismes de décentralisation : anticipation des changements dans les structures décentralisées				X										1, 5	USAID, DDS partenaires, CADZS	
9.	Préparation pour la formation en prise en charge intégrée des maladies de l'enfant (PCIME)													Zones expérimentation et personnel à former identifiés	2,3	Africare, BASICS DDS, DSF	PCIME communautaire
	– Réflexion avec BASICS et Africare			X													
	– Sélection des zones pilote				X												
	– Identification des agents à former				X												
	– Activités préparatoires pour l'introduction de PCIME					X	X		X		X						

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observations
10.	Atelier de planification pour les actions SONU niveau départemental :			X										Plan des activités SONU élaboré	3	ASFB, DDS, GESCOME, PROSAF	PRIME, DSF cf. la formation des sages-femmes et aides soignants Quality design
	– Développement des équipes SONU dans le Borgou					X	X										
11.	Suivi des ateliers de dissémination des PNS/SF			X			X							Application par AS des PNS/SF	3	DDS, PROSAF	PRIME, DSF
12.	Orientation du staff de PROSAF aux PNS/SF	X												Application par staff des PNS/SF	Tous		
13.	Dissémination des protocoles de SF et suivi Fiches sommaires				X	X				X	X			Orientation et application des protocoles	3		PRIME, DSF A intégrer dans le curriculum intégré
14.	Développement des PNS en SONU et dissémination				X			X	X					PNS en SONU développé	3	ASFB, DSF, DDS, PROSAF	Ebauche déjà faite
15.	Atelier d'adaptation/ création des normes et procédures de qualité de gestion et systèmes Processus de création d'un manuel								X	X	X	X	X	Un manuel de référence sur les procédures standardisées pour les EEZ et les COGEC	1,3	DDS, MSP, autre partenaire CADZS	Consultants cf. normes des zones sanitaires (e.g. accueil)

Résultat intermédiaire II :Accès accru aux Services et Produits de Santé Familiale

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observations
17.	Mise en œuvre des plans de renforcement des capacités des AS à offrir des services intégrés :													Services SF intégrés	Tous	Hôpitaux PBA/SSP DDSP PADS	2 formations sanitaires par S/P avec services pour 2000
	– Elaboration et validation des guides		10 12														
	– Mise en place des propositions d'intégration (10%)			X	X	X	X										
	– Extension des efforts d'intégration (30%)							X	X	X	X	X	X				
18.	Révision et renforcement de gestion du système logistique et approvisionnement contraceptives et MEG													Système logistique/ approvis'n m'nt opérationnel	1, 2, 5	DDS, CAME, PSI, JORDAN, ABPF, ONGs, BASICS, FNUAP, PADS,PBA. FPLM	
	– Atelier de concertation pour un système logistique et approvisionnement			X													
	– Développement et harmonisation du système et outils de gestion			X	X	X	X										
	– Formation à l'utilisation des outils et système logistique			X		X		X	X	X							
19.	Evaluation des progrès des SBC : VOIR ACTIVITE No.43 & 44 sous IR 4					X	X	X	X	X	X	X	X	Système de monitoring et évaluation continue des activités communautaires	2 ,5	DDS, COGEC/S, autres partenaires	

Résultat intermédiaire III : Amélioration de la qualité de gestion et des services

NO	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observations
20.	Atelier de concertation pour le développement d'un système de formation continue		X											Système de formation mis en place avec un plan directeur de formation définissant un paquet de formation à exécuter avec les autres partenaires	Tous	PROSAF, DDS, PBA, PADS, ONG, Privés DPP, CADZS, BASICS	Consultant
	– adaptation d'un curriculum « standard » en SF				X	X	X										
	– adaptation d'un curriculum standard en gestion pour EEZ				X	X	X										
	– test pilot du curriculum standard SF					X											
	– appuis aux formations spécifiques dans les zones (counseling, assurance de qualité, logistique, facilitative supervision, SBC) (voir les autres résultats intermédiaires)					X	X	X	X	X	X	X	X				
	– suivi des formations pour évaluation des performances							X	X	X	X	X	X				
21.	Formation des formateurs													Formateurs performants	1, 2, 3, 4, 5	DDS, formateurs, superviseurs, encadreurs de zone	JHPIEGO PRIME
	– Pédagogie			X	X												
	– Conception de programme de formation et suivi					X											
22.	Orientation du staff PROSAF aux techniques et outils de facilitation / formation			X										Harmonisation de l'approche de formation à travers les volets de PROSAF	tous		
23.	Elaboration du plan d'amélioration du système de collecte des données de SF dans le SNIGS – Atelier de renforcement des outils de monitoring et technique de supervision					X								Plan finalisé et début de mise en œuvre	Tous	Secteur privé, ONG, DDS, DDS, DPP, SSDRO, PADS, PBA	Consultant Voir relation avec activité #5

NO	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observations
24. .	Séminaire d'orientation et de sensibilisation en AQ : - PROSAF		08												Tous	PROSAF, PADS, DDS, Med. chefs	Tisna
	– zones de concentration				X	X	X										
	– autres zones dans le Borgou								X	X		X	X				
25.	Mise en place équipes AQ dans les zones prioritaires						X								1, 3, 5	DDS, EEZ	
26.	Formation et implémentation des équipes en résolution des problèmes							X	X	X	X	X	X		Tous	Membres équipes AQ	Consultants
27.	Formation régionale en AQ : concepts et outils AQ (au Niger)					X	X							Un noyau des cadres formateurs AQ		Staff PROSAF, DDS	A Niamey Consultants
28.	Voyage d'études au Maroc										X					Staff PROSAF, DDS	
29.	Voyage d'étude en AQ au Niger									X						Staff PROSAF, DDS	Consultant

Résultat intermédiaire IV : Augmentation de la demande et des pratiques de soutien à l'utilisation des services, des produits et des mesures préventives

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observation
30.	Recherche qualitative :													Etude réalisée dans les 3 s/préfectures de concentration	2, 4, 5	CDIEC BASICS	Consultants local et international
	– Définir les termes de référence	X															
	– Recruter le consultant		X														
	– Faire une revue documentaire des études existantes		X	X													
	– Développer les outils, exécuter l'étude et rédiger le rapport final			X	X	X											
31.	Participation à la mise en place du comité départemental IEC :													CDIEC ou comité départemental opérationnel avec une stratégie CCC et plan de travail développé	1,4,5	Secteur privé, public, ONG	
	– Note de service DDS signée et diffusée		X														
	– Finalisation de la stratégie IEC/CCC					X											
	– Elaboration de plan de travail et suivi							X	X	X	X	X	X				
32.	Finalisation du catalogue sur les curriculum, études et supports de communication :		X	X	X									Catalogue finalisé, reproduit et distribué	4	CDIEC, secteur public, privé, ONG	Consultant junior
33.	Développer les supports IEC (traditionnels et modernes) :													Supports développé et disséminé	4, 5	CDIEC	Consultant
	– Scénarios et découpages							X									
	– Esquisses et pré-tests								X	X	X						
	– Finalisation											X	X				
	– Multiplication											X	X				
34.	Développement/ adaptation curriculum en counseling à l'usage des ASS y compris les ASBC					X	X							Curriculum élaboré / adapté et testé	3,4,5	Africare, DDS, CDIEC, ROBS PADS BASICS	Equipe départ. de formation, CDIEC

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observation
35.	Elaboration plan IEC pour le renforcement des SBC						X							Plan IEC développé et disséminé	2,3,4,5	BASICS	cf. curriculum ROBS
36.	Conduite de la formation en IEC de 10 ONG							X	X	X				10 ONG formées en IEC/CCC	3,4,5	CARE, Africare	
37.	Organiser des mini-campagnes IEC :														tous		
	– Journée mondiale de la santé				X												
	– Journée de l'enfant africain						X										
	– Journée mondiale contre le SIDA												X				
	– Journée nationale de vaccination											X	X				
38.	Participation à la Conférence africaine sur le SIDA à Ouaga												X		4		
39.	Etude de FRONTIERS sur la dynamique de prise de décision pour la santé dans les familles	X		X	X	X	X	X						Etude complétée et disséminé	1,4,5	FRONTIERS USAID	
40.	Négociation de partenariat avec les communautés	X	X	X										Engagement de chaque communauté à participer au programme est formalisé	2,5	ONG, DDS, PBA, PADS, UACOGEC, GESCOME, MCDI	

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observation
41.	Formation continue des facilitateurs communautaires et des animateurs de zones													Les capacités des agents de terrain à donner un appui aux communautés sont développées	Tous		Consultants pour planification, crédit, et quality design
42.	– Agents communautaires orientés et formés	X	X	X													
	– Suivi et coordination continue				X		X		X		X		X				
43.	Auto-analyse et auto-organisation COGEC/COGES et des SBC													Les forces et les faiblesses sont identifiées et des plans de re organisation des structures sont élaborés	tous	ONG, DDS, PADS, PBA	
	- Atelier de développement de vision, mission, et buts stratégiques et de définition des objectifs, des contenus et des méthodes				X												
	- Atelier d'auto-analyse				X												
	– Mise en place des comités villageois de santé				X												
	– Remembrement des COGEC et COGES				X												

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observation
44.	Atelier de capitalisation SBC			X										Des leçons sont tirées des différentes expériences écoulées et un plan de relance sont élaboré	tous	DDS, PBA, ROBS, Africare	
	– Recrutement des ASBC				X	X											
	– Formation des formateurs ASBC					X	X										
	– Formation des ASBC					X	X										
	– Equipement et déploiement des ASBC					X	X						X				
	– Voyage d'études au Burkina ou Mali pour agents santé/ COGEC							X				X					
45.	Suivi des ASBC													Système de monitoring et évaluation continue des activités communautaires	2 , 5	DDS, COGEC/S, autres partenaires	
	– Définition et mise en place d'1 système communautaire d'évaluation des progrès			X	X	X											
	– Application du système et analyse périodique des résultats					X	X	X	X	X	X	X	X				
	– Diffusion des résultats au niveau communautaire							X					X				
46.	Elaboration et mise en œuvre des plans d'action y inclus le quality design	X												Chaque CVS, COGEC, et COGES a son plan de travail développé pour 1 période donnée	tous	PBA, MCDI, DDS, autres	Les plans devront inclure des activités de santé les AGR, les formations les investissements
	– Atelier d'élaboration des projets de plans d'action					X	X										
	– Validation des plans d'action						X										
	– Formation continue des COGEC, CVS et COGES							X	X	X	X	X	X				
	– Mise en œuvre des plans d'action						X	X	X	X	X	X	X				

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observation
47.	Suivi de la mise en œuvre des plans d'action													Toutes les activités planifiées sont réalisées et évaluées	Tous	COGEC/S/Z, EEZ, DDS	
	– Suivi des activités de promotion de la santé						X	X	X	X	X	X	X				
	– Suivi des activités d'entretien et d'investissement									X	X	X	X				
	– Suivi des activités génératrices de revenus												X				
48.	Participation au développement des capacités en gestion de la participation communautaire du personnel de santé													Les capacités du personnel de santé à gérer la participation des communautés sont développées	3, 5, 1	DDSP, PADS, PBA, ONG, CADZS	
49.	– Atelier de réflexion sur la Décentralisation et la Participation Communautaire				X												
	– Formation sur des thèmes spécifiques liés à la décentralisation et la participation communautaire										X	X	X				

Gestion Du Programme:

N0	Activités	J	F	M	A	M	J	J	A	S	O	N	D	Résultats attendus	Volets impliqués	Partenaires impliquées	Observation
50.	Evaluation et planification des progrès du programme																
	Evaluation avec la DDS		X						X					Discussion des progrès et attentes, Règlement d'ordre intérieur basé sur les valeurs du PROSAF	Tous		
	Suivi du team building	X						X									
	Ecrire le rapport trimestriel			X			X			X			X				
51.	Preparation et redaction du rapport annuel										X	X					
52.	Visite du monitoring par URC		X						X								
53.	Visite de soutien administrative du siege		X				X				X	X					
54.	Renforcement institutionnel de ABPF																
55.	– Planification stratégique avec les volontaires			X	X									Un plan stratégique avec une vision long terme	1	ABPF Africare	Consultant
	– Développement des capacités des conseils consultatifs régionales dans le Borgou et le Ouen					X	X										
	– Etablissement des procédures de gestion pour l'antenne						X	X									

VII. ANNEXES

1. Manuels et Outils de Formation Conçus par les Organisations Financées par USAID
2. Rapport sur les Services à Base Communautaire dans les Sous-Préfectures de Bembereke, Banikoara et Sinende
3. Objectifs de l'Enquête de la Qualité du Système Sanitaire
4. Mise en Place du Comité Départemental IEC
5. Analyse du Plan des Activités de Formation des Partenaires USAID (Août 99 - 2000)
6. Critères de Sélection des 3 Sous-Préfectures pour l'Intervention plus Intensive au Niveau Communautaire
7. Déclaration de Kandi sur la Mobilisation Communautaire
8. Les Recommandations Formulées pour Garantir la Réalisation de la Vision
9. Liste des Indicateurs Clés de Suivi du PROSAF

ANNEX 1

Manuels et Outils de Formation Conçus par les Organisations Financées par USAID

ANNEX 1
MANUELS ET OUTILS DE FORMATION CONÇUS PAR LES ORGANISATIONS FINANCEES PAR USAID

ORGANISATION	OUTILS
JHPIEGO	• Manuel de formation sur les compétences cliniques • Manuel de formation sur l'élaboration des programmes • Module en PF [usage enseignant] • Outils modèle de stage • Carnet suivi stage Enseignant, étudiants, prestataires • Fiches Evaluation qualité, enseignants SR Théorie / pratique • Manuel de formation en prévention des infections
CRS	• Module de formation à l'usage des responsables CPS • Fiche collecte des données à l'usage des relais communautaires
POLICY	• Module de formation en plaidoyer • Module de formation en SR • Modèle de présentation en POWERPOINTsur le SIDA et EDS • Film sur SIDA • Brochure relation/ Population/ Développement • Projet Modèle rapide IV
GESCOME	• Module de Formation en Planification • Communication [à l'usage des équipes municipales
PSI	• Manuel SIDA [relais] bande dessinée • Module SIDA/TRO/SR développés avec le SFPS • Information de base sur le SIDA • Manuel TRO • Manuel de formation en Marketing Social à l'usage des relais communautaires [V. anglaise]
AFRICARE	• Module de formation des animateurs et Agents de développement social en IEC/PF/Palu/MST/SIDA ETUDE du milieu • Module de formation des relais communautaires • Module de formation des Comités de gestion Adaptation du module national • Sketches sur les trois (3) domaines section alimentaire en langue Nago
PRIME / INTRAH	• Module de formation des Auxiliaires de Pharmacie • Module Technologie contraceptive • Module de formation en IEC/SBC • Module en SR [en cours de finalisation] • Module de formation des formateurs • Manuel de formation en Prévention des infections
BASICS	• Modules en fon sur le PMA de Nutrition • Comite de formation en utilisation du PMA de Nutrition boite à image • Divers sketches • Conseil en alimentation à l'usage des conseillers en nutrition
UNICEF	Information à rechercher

ANNEX 2

Rapport sur les Services à Base Communautaire dans les Sous-Préfectures de Bembereke, Banikoara et Sinende

ANNEX 2
RAPPORT SUR LES SERVICES A BASE COMMUNAUTAIRE DANS LES SOUS-PREFECTURES DE BEMBEREKE, BANIKOARA ET SINENDE

INTRODUCTION

- L'amélioration de l'accès des populations à des services de Santé Familiale de qualité est une préoccupation majeure du Programmme Intégré de Santé Familiale du Borgou. Au nombre des stratégies à mettre en œuvre pour atteindre ce résultat, figurent les services à base communautaire (SBC). En la matière, le terrain du département n'est pas vierge et on note plusieurs expériences. C'est pour cerner ces expériences qu'une équipe composée de représentants du PROSAF et de la DDSP du Borgou a effectué du 07 au 09 juillet 99, une visite de terrain dans les trois sous-préfectures de Bembéréké, Banikoara et Sinendé.

Quelques résultats vous seront présentés à travers :
- Les généralités sur les trois sous-préfectures
- Une vue de l'organisation des SBC sur le terrain
- Les éléments de succes relevés et
- Les difficultés rencontrées par les différents acteurs.

I- GENERALITES SUR LES S/P DE BEMBEREKE, BANIKOARA ET SINENDE

	Caractéristiques	**BEMBEREKE**	**BANIKOARA**	**SINENDE**
1	Superficie	3348 km2	4.383 km2	2350 km2
2	Population totale	76.928 hab.	133.815 hab.	52.437 hab.
3	Enfants de 0-11 mois	3.539	6.155	
4	Femmes en âge de procréer	19.232	33.454	11.196
5	Nombre de communes	6	10	4
6	Nombre de villages	42	62	35
7	Nombre de centres de santé	8 dont un hôpital	8 dont un hôpital	4

II- ORGANISATION DES SBC

2.1 Les différents partenaires

Les rubriques	**BEMBEREKE**	**BANIKOARA**	**SINENDE**
Partenaires	UNICEF ABPF CSSP CPS PSI CRS	PBA-SSP ABPF CPS PSI CRS	UNICEF ABPF CPS CRS
Nombre de relais communautaires	UNICEF : 24 ABPF : 0 CSSP : 20 CPS/CRS : 17 PSI : ?	PBA-SSP : 23 ABPF : 12 CPS : 2	UNICEF : 36 AC ABPF : 0 CSSP : 44

2.2 Quelques caractéristiques de leur programme

Partenaires **Rubriques**	**UNICEF**	**ABPF**	**PBA-SSP**	**CPS-CRS**	**PSI**
Domaine d'intervention	Nutrition	**SR/PF**	PF	Nutrition	MST/SIDA
Motivation	20-25/pesée	30% de la vente	30% de la vente	25/pesée 500/séance	?
Formation - Contenu - Perdiem			Variable		
Supports IEC					
Sources d'approvision-nement	CAME	IPPF FNUAP USAID	FNUAP	CAME	USAID
Critères de recrutement	Idem pour Tous les Partenaires ▪ Résider dans le village ▪ Femme ▪ homme marié avec des enfants ▪ Accepté par la communauté				

III- LES ELEMENTS DE SUCCES

- ❖ L'implication progressive de la communauté dans la gestion des services de santé.
- ❖ Une plus grande accessibilité des services
- ❖ Une amélioration de la fréquentation des formations sanitaires grâce au système de référence

IV- LES DIFFICULTES RELEVEES

- ❖ Rupture de stock des produits contraceptifs
- ❖ Formation des relais communautaires avec des contenus variables
- ❖ Faible compétence des relais communautaires en technique d'animation
- ❖ Supervision irrégulière des relais communautaires
- ❖ Motivation des relais communautaires insuffisantes
- ❖ Manque de coordination réelle entre les différents partenaires
- ❖ Insuffisance voire inexistence de supports IEC

CONCLUSION

Il existe plusieurs programmes de SBC dans les trois sous-préfectures visités développés par quelques partenaires avec des approches plus ou moins différentes. Ne serait-il pas possible d'unir nos efforts autour de certains centres d'intérêt tel que :

- ❖ La formation ?
- ❖ L'organisation d'un système efficace d'approvisionnement ?
- ❖ L'harmonisation des supports IEC ?
- ❖ La motivation ?

ANNEX 3

Objectifs de l'Enquête de la Qualité du Système Sanitaire

ANNEX 3
OBJECTIFS DE L'ENQUETE DE LA QUALITE DU SYSTEME SANITAIRE

1. QUESTIONS DE RECHERCHE

Le cadre conceptuel se base sur le postulat que la persistance de la précarité de la situation sanitaire dans le Borgou traduite par les faibles performances en matière de couverture des besoins des clients (EDSB 1996) et une faible qualité des soins fournis (Evaluation Intégrée du Système Sanitaire du Borgou, Juillet 1998) n'est pas seulement liée à des manques de ressources ou à un manque de formation du personnel. D'autres facteurs, tel que le système de gestion sanitaire joueraient également un rôle prédominant.

Aussi, l'analyse du système sanitaire du Borgou devrait prendre en compte tant les composantes du sous-système de gestion que celles liées aux différents processus dont la santé familiale. Ainsi, l'analyse des processus composant la santé familiale devrait répondre aux questions ci-après :

1. Quelle est la disponibilité, l'accessibilité et l'utilisation actuelle des services et produits de santé familiale dans le Borgou ?

2. Quelle est la qualité actuelle des prestations de services et produits fournis dans le Borgou, en référence aux normes et standards de santé familiale ?

3. Quel est le niveau actuel des connaissances des clients sur les mesures et prestations offertes par les services de santé familiale dans le Borgou ?

4. Quelle est la performance actuelle des prestataires de services de santé familiale dans le Borgou ?

5. Quelle est la capacité actuelle du système sanitaire à soutenir la mise en œuvre des services et la fourniture des produits de santé familiale dans le Borgou ?

6. Quel est le degré d'intégration des activités de santé familiale tant au niveau des services de santé publics que privés ?

Pour améliorer les processus de santé familiale, il importe d'obtenir également une meilleure compréhension des autres intrants qui constituent le système d'appui représenté par les sous-systèmes de gestion. Les questions subséquentes orienteront l'analyse de ce système d'appui :

1. Quelles sont les capacités actuelles des différents acteurs système sanitaire du Borgou à élaborer une planification stratégique dans le contexte de la décentralisation ?

2. Quels sont les points forts et les points faibles du sous-système d'administration, de direction, d'organisation et de coordination tant interne et qu'externe au niveau de la DDSP et des CSSP/CU ?

3. Quelles sont les capacités actuelles de gestion des ressources humaines incluant la planification et le suivi de la formation continue des agents y compris la mise en place de mesures de motivation ?

4. Comment fonctionne le sous-système de supervision, quels sont ses points forts et ses points faibles ?

5. Quelle est la situation du sous-système de logistique, approvisionnement en médicaments, matériel et fourniture ?

6. Comment fonctionne le sous-système d'information de gestion sanitaire au niveau du département ? Comment se fait la coordination avec le secteur privé ? Les données sont-elles utilisées à tous les niveaux pour la prise de décision ?

7. Dans quelle mesure les normes et procédures sont-elles disponibles et appliquées en matière de comptabilité et gestion financière ? Quelle est la capacité du sous-système à coordonner les financements provenant des sources différentes ?

8. Quelles sont les capacités actuelles du sous-système IEC à promouvoir et soutenir l'acquisition de connaissances et le changement des comportements ?

9. Quel est le degré d'implication de la communauté dans le processus de la planification, du suivi et de l'évaluation des programmes et actions sanitaires au niveau du département, des sous-préfectures et des communes ?

10. Quelles opportunités pourraient être exploitées pour développer le partenariat avec la communauté et les ONG dans le secteur sanitaire du département ?

11. Quelles sont les capacités actuelles du département en matière de développement de la recherche opérationnelle ?

2. OBJECTIFS

2.1. Objectifs généraux

1. *Créer une banque de données pour la gestion du système sanitaire permettant la planification, le suivi et l'évaluation du programme.*

2. *Développer la capacité des acteurs du système de santé à évaluer le système de gestion sanitaire de façon routinière.*

2.2. Objectifs intermédiaires et spécifiques

1. *Evaluer les capacités de gestion du système sanitaire du Borgou en rapport avec les résultats attendus du Programme Intégré de Santé Familiale dans le département.*

1.1. Déterminer les forces et faiblesses des sous-systèmes de gestion ci-après, au niveau de la Direction Départementale de la Santé, des Centres de Santé de Sous-préfectures et de Communes Urbaines, des Complexes Communaux de Santé et des Structures de Participation communautaires :

- Sous-système de planification
- Sous-système d'administration, direction, organisation et coordination interne et externe
- Sous-système de gestion des ressources humaines
- Sous-système de formation du personnel
- Sous-système de supervision/suivi/évaluation
- Sous-système logistique, approvisionnement en produits, matériels et médicaments
- Sous-système d'information de gestion sanitaire
- Sous-système comptabilité et gestion financière
- Sous-système information-éducation-communication
- Sous-système participation communautaire et partenariat
- Sous-système recherche opérationnelle

1.2. Identifier les facteurs déterminant les tendances constatées.

2. Evaluer la disponibilité, l'accessibilité et l'utilisation des services et produits de santé familiale.

2.1. Déterminer les types de services disponibles en matière de santé familiale au niveau des différents points de prestation sanitaire publics et privés.

2.2. Déterminer l'accès des populations cibles aux services et prestations de santé familiale.

2.3. Déterminer l'utilisation des services et produits de santé familiale.

3. Evaluer la qualité des services offerts dans le cadre des activités de santé maternelle et infantile (consultation prénatale, consultation de nourrissons, Accouchement, consultation postnatale, vaccinations, soins curatifs, éducation pour la santé) incluant la planification familiale et la lutte contre les MST/SIDA.

3.1. Evaluer les connaissances, attitudes et pratiques des prestataires dans la prise la mise en œuvre des prestations de santé familiale.

3.2. Evaluer les connaissances, attitudes et pratiques des clients des services de et produits de santé familiale.

3.3. Identifier les facteurs susceptibles d'avoir un impact sur la qualité des prestations offertes dans le domaine de la santé maternelle et infantile, de la planification familiale et de la lutte contre les MST/SIDA.

3.4. Identifier les facteurs susceptibles d'avoir un impact sur la qualité des prestations offertes dans le domaine de la santé maternelle et infantile, de la planification familiale et de la lutte contre les MST/SIDA.

3. *Impliquer les acteurs du système dans le processus de collecte, d'analyse et d'utilisation des données pour la planification, la mise en œuvre et le suivi/évaluation des activités visant l'amélioration de la santé familiale dans le Borgou.*

4.1. Créer un cadre pour obtenir la participation des principaux acteurs au processus de collecte et d'analyse des données.

4.2. Former les principaux acteurs à l'adaptation et à l'utilisation du protocole pour le suivi et l'évaluation de leurs activités.

ANNEX 4

Mise en Place du Comité Départemental IEC

ANNEX 4
MISE EN PLACE DU COMITE DEPARTEMENTAL IEC

I. INTRODUCTION

- Le programme Promotion intégré de santé familiale dans le Borgou (PROSAF) et la Direction Départementale de la Santé (DDS) vont mettre en place un comité départemental IEC dans le but d'organiser et renforcer les activités de communication pour le changement de comportement. Entre autres objectifs, une telle initiative vise à regrouper tous les partenaires pour partager les expériences, harmoniser les interventions et coordonner la mise en œuvre des ressources dans le sens d'une synergie et d'une plus grande efficacité des programmes de santé dans le Borgou. Une telle démarche voudrait décourager la politique de programmes verticaux où plusieurs intervenants diffusent plusieurs messages différents auprès d'une même cible, mais plutôt favoriser l'émergence de programmes de communication guidés par le seul souci de l'intégration des interventions, l'utilisation rationnelle des ressources et l'orientation d'activités vers la satisfaction des besoins des populations.

II. MISSION

- ❖ Définir les politiques et stratégies de changement de comportement dans le Borgou en adéquation avec la politique nationale IEC du Bénin
- ❖ Etablir un système de relations de travail entre les différents responsables IEC des programmes de santé dans le Borgou.
- ❖ Identifier les rôles et responsabilités ainsi que les mécanismes de collaboration et de coordination entre les différents intervenants
- ❖ Impliquer la population dans la formulation des politiques de communication
- ❖ Elaborer des approches stratégiques novatrices et adaptées aux besoins des populations en matière de santé.
- ❖ Développer et mettre en oeuvre des plans opérationnels de changement de comportement
- ❖ Evaluer et redéfinir de nouvelles initiatives susceptibles de modifier ou renforcer les comportements en matière de santé.

III. TERMES DE REFERENCES

ROLE DE CONCEPTION

- ❖ En partenariat avec les ONGs, les associations et certains leaders communautaires, définir les approches stratégiques en matière de communication pour le changement de comportement.
- ❖ Coordonner la conception des messages, des canaux et supports de communication en adéquation avec les besoins prioritaires en matière de communication pour le changement de comportement
- ❖ Assurer la conception et la coordination des campagnes de communication

ROLE DE FORMATION

- ❖ Assurer l'élaboration des curricula IEC ainsi que la formation des prestataires de services
- ❖ Veiller à l' introduction de l'IEC dans la formation des étudiants en santé,

- ❖ Organiser la formation et l' éducation des groupes religieux, des politiques, ainsi que des relais communautaires
- ❖

ROLE DE PRODUCTION ET DIFFUSION DES SUPPORTS IEC

- ❖ Assurer la conception et la coordination de la production des supports IEC et plus particulièrement : la définition des messages clefs, le développement des supports, l'organisation de leur diffusion / exploitation, la supervision des campagnes de communication, etc…

ROLE DE RECHERCHE / EVALUATION

- ❖ Faire l'inventaire des ONGs de Santé dans le Borgou, les étude sur les canaux et supports traditionnels, les études qualitatives et quantitatives, etc…

ROLE DE RELATIONS AVEC LES ONGS ET ASSOCIATIONS

- ❖ Assurer la coordination des activités IEC en collaboration étroite avec les ONGs, les associations et groupes religieux.

AUTRES ROLES

Le comité peut s'assigner tout autre rôle qu'il juge important et pertinent tel que les rapports de travail avec le service national IEC, les autres Ministères (Agriculture, Femme et Affaires sociales, Plan, etc…)

IV. COMPOSITION : (structures et organisations)

Le comité sera composé de membres issus de la DDS, des projets et agences de coopération en matière de santé, certaines ONGs et autres membres cooptés pour leurs intérêts ou domaines d'intervention spécifiques. Le nombre de membres peut varier entre (x et y); à fixer d'un commun accord entre le DDSP-Borgou et le PROSAF. Le comité sera dirigé par un bureau permanent de ( ) membres élus en son sein et sera composé de:

DDSP-Borgou :	2 membres	UACOGEC	1
DDPSF :	1	Griot	1
BASICS :	1	Troupe théâtrale	1
ABPF :	1	PROSAF	3
PBA :	1	USAID	1
PMSBS :	1	CARDER	1
Clinique JORDAN	1		
Autres cliniques privées :	2		
ORTB (journaliste)	1		
MCDI	1		
AFRICARE	1		
GESCOME	1		
ROBBS	1		
DD Alphabétisation	1		
CRS	1		
PSI	1		

FONCTIONNEMENT

- ❖ Des réunions rotatives permettront de développer une meilleure connaissance entre les membres et favoriser l'échange d'expérience à partir des différents programmes. Ces rencontres contribueront également à consolider l'esprit d'équipe ainsi que l'appartenance à une même famille de travail.
- ❖ Des noyaux seront constitués comme groupes de réflexion et d'action selon les centres d'intérêts identifiées par le comité. On pourrait ainsi avoir un groupe mass média, recherche, formation, etc..
- ❖ Le comité doit également réfléchir sur la cogestion de certains moyens de travail liés à la production, le transport, la communication, etc …
- La mise en place d'un bulletin d'information sur les activités du comité ainsi que l'organisation de manifestations à caractère culturel et sportif pour primer les centres de santé d'excellence pourraient favoriser l'émergence de programmes de qualité de santé familiale dans le Borgou.

PROGRAMME D'ACTIVITES

Dès son installation le comité procèdera à l'élaboration d'un programme annuel d'activités IEC en adéquation avec la mission qui lui est confiée, le programme d'activités du PROSAF et celui de la DDSP-Borgou. Ce programme doit être soumis aux deux précédentes structures pour approbation.

SUIVI ET SUPERVISION

Le comité devra effectuer des missions de suivi et supervision afin d'identifier les insuffisances et leur apporter les corrections nécessaires.

RENCONTRES PERIODIQUES

Le comité peut se réunir selon une périodicité qui sera déterminée par ses membres.

ANNEX 5

Analyse du Plan des Activités de Formation des Partenaires USAID (Août 99 - 2000)

ANNEX 5
ANALYSE DU PLAN DES ACTIVITES DE FORMATION
DES PARTENAIRES USAID (Août 99 - An 2000)

- L'analyse laisse apparaître quelques conflits potentiels (chevauchements) de dates, qui ne seront pas difficiles à surmonter avec une bonne communication et implique la coordination que nous proposons ci-dessous :

1. Conflits potentiels

Août 1999
- Atelier de plaidoyer sur le SIDA de POLICY (31/08-03/09)
- Enquête sur la gestion du système de santé (ESGS) PROSAF (9/08 – 27/08)et
- L'enquête KPC et anthropométrique du CRS (15/08 – 31/08)
- Le conflit a été évité en négociant un léger changement de date avec POLICY et substituant les assistants aux responsables des CPS à l'enquête de PROSAF.

Septembre 1999
- Finalisation du curriculum de formation en IEC/SBC du 30/08 au 11/09 : **INTRAH/PRIME**
- Atelier d'auto-analyse à Parakou du 20 au 24/10 (préparation : 13 - 19/10) : **PROSAF**
- Enquête **BASICS** sur impact IEC
- Formation pour l'approche gestion à la base communautaire de **CRS**

Octobre 1999
- Journées d'information sur enquête de BASICS pour journalistes : **BASICS**
- Prise en charge des MST/SIDA : 18 -22/10 : **PSI**
- Atelier de dissémination ESGS du 13 au 15 octobre : **PROSAF**

Novembre 1999
- Atelier de formation des formateurs (Equipe départementale) en compétences pédagogiques (2 semaines) : **PROSAF**
- Formation sur utilisation de boîtes à images : **BASICS**

Décembre 1999
- Formation en méthodologie de supervision et Assurance de Qualité : **DDS/PBA/PADS et PROSAF**
- Enquête CAP (sujet à la suite d'ESGS) : **PROSAF**

2. Coordination possible

PROSAF + JHPIEGO
Pour la formation des formateurs (équipe départementale du Borgou) en compétences pédagogiques, PROSAF travaillera en étroite collaboration avec JHPIEGO et les autres partenaires. **En effet, URC a toujours collaboré avec JHPIEGO pour l'approche de formation «apprendre pour maîtriser»**

POLICY+PROSAF + PSI

Atelier de Plaidoyer sur le SIDA, initié par Policy Project se fera en collaboration avec la DDSP et autres partenaires. Les trois (3) prochains jours seront avec les agents de santé. C'est une opportunité pour utiliser les décideurs et leaders d'opinion comme relais privilégiés, pour son programme SIDA dans le Borgou. A l'issue de cet atelier, un plan d'activités pour la lutte contre le SIDA sera ébauché et PROSAF assurera le suivi de ces activités, surtout ceux des partenaires financés par USAID.

BASICS + PROSAF + CRS

BASICS fera une formation sur l'utilisation de la boite à images sur PMA/Nutrition : cette activité de formation pourrait éventuellement se faire avec CRS et PROSAF. CRS va bientôt faire la formation sur la gestion des programmes à base communautaire. Il y a une possibilité également ici pour une intégration / collaboration sur le PMA nutrition.

PROSAF + DDS + PBA + PADS

- Une Formation en méthodologie et technique de Supervision se planifie en collaboration avec la DDSP/B, PBA, PADS et autres partenaires pour les équipes des agents de santé dans les sous-préfectures : zones sanitaires pour l'amélioration de la qualité des services. PROSAF compte promouvoir cette activité en incluant les éléments de l'Assurance de Qualité et de la résolution des problèmes. Ceci sera une bonne suite de l'évaluation de gestion du système sanitaire**.**

FPLM

Amélioration du Système Logistique et d'Approvisionnement en contraceptif: la formation des formateurs vient de s'achever. Cette occasion constitue une opportunité pour PROSAF et les autres partenaires (FPLM /PSI /BASICS /PBA /PDSS /DDSP/B.) de redynamiser le système logistique et d'approvisionnement du Borgou et de voir comment intégrer ce système au système d'approvisionnement à travers le CAME.

PROSAF+ASFB+GESCOM

Pour les Soins Obstétricaux et Néonatals d'Urgence (SONU), PROSAF en collaboration avec l'Association des Sages-femmes du Bénin, mettra en place dans une sous-préfecture du Borgou identifiée comme site pilote, une équipe opérationnelle SONU. (Qui sensibilisera la communauté sur les SONU ?) Il serait souhaitable que cette activité soit soutenue par les équipes municipales animées par GESCOM.

PROSAF+AFRICARE+PBA+ABPF+PRIME

Des efforts en matière d'IEC pour la PF/MST/SIDA seront soutenus, mêmes initiés par PROSAF avec un accent particulier sur les services à base communautaire. Une implication des autres partenaires tels que AFRICARE, PBA, ABPF, PRIME est souhaitable pour appliquer les leçons apprises et harmoniser certains aspects de formation en IEC et contenu technique.Il y a aussi le suivi et soutien du plan de dissémination des Protocoles, Normes et Standards pour la Santé Familiale dans le Borgou. Ceci aura fait avec le DDSP/B, INTRAH_PRIME et PROSAF.

ANNEX 6

Critères de Sélection des 3 Sous-Préfectures pour l'Intervention Intensive au Niveau Communautaire

ANNEX 6
CRITERES DE SELECTION DES 3 SOUS-PREFECTURES POUR L'INTERVENTION PLUS INTENSIVE AU NIVEAU COMMUNAUTAIRE

Sous préfectures	Situation sanitaire	Risque de double emploi avec autre partenaire dans intervention pour les zones sanitaires	Risque de double emploi avec autre partenaire dans intervention COGEC	Partenaires USAID intervenant dans la santé au niveau communautaire
Karimama	3	+	-	-
Malanville	7	+	-	-
Banikoara	1	+	-	++
Kandi	4	+	-	+++
Gogounou	2	+	-	-
Segbana	5	+	-	+
Sinendé	8	-	-	++
Bembèrèkè	6	-	-	++
Kalalé		+	+	-
Nikki		+	+	-
N'dali		+	+	-
Pèrèrè		+	+	-
Parakou		+	+	++
Tchaourou		+	+	-

- **Situation sanitaire** : selon 5 indicateurs de couverture DTCP3, VAR, CPN, CN , et accouchements assistés les S/P sont classés par ordre du pire à la meilleur. *Banikaora* est le S/P avec les indicateurs les plus bas.
- **L'appui aux COGEC** est donner aux S/Ps du Sud., ainsi ils étaient éliminés
- Nous avons aussi chercher a voir les S/P ou il y avait déjà une **intervention financée par USAID**.pour capitaliser sur les synergies potentielles.
- ***Un autre critère s'ajoute : celui de*** *l'appui aux zones sanitaires par autres partenaires****. Ceci nous a amené à mettre de côte tout les sous-préfectures sauf*** Sinendé et Bembèrèkè.

Les sous-prefectures retenues sont : SINENDE , BEMBEREKE , et BANIKOARA

ANNEX 7

Déclaration de Kandi sur la Mobilisation Communautaire

ANNEX 7
DECLARATION DE KANDI SUR LA MOBILISATION COMMUNAUTAIRE PAR LES FACILITATEURS COMMUNAUTAIRES (PROSAF) ET LES ANIMATEURS DE ZONES (ABPF) AU COURS DE LEUR 2EME SESSION DE FORMATION

1. DISPONIBILITE

- Disponibilité
- Assurer la formation
- Recevoir les cas référés
- Collaborer avec les agents des UVS
- Recenser le nombre des UVS dans la commune
- Suivre les activités des SBC
- Suivre et superviser les activités des relais
- Promouvoir un cadre de concertation entre agents de santé et communauté

2. ADOPTION DE L'ASSURANCE QUALITE

- Améliorer l'accueil
- Faire une large dissémination des résultats de l'enquête
- Prendre en compte les résultats de l'enquête pour corriger les imperfections
- Mettre en application les informations reçues relatives à l'assurance qualité
- Entretenir une franche collaboration avec tous les clients
- Donner une bonne prestation
- Améliorer la qualité des consultations
- Veiller au respect des principes de l'assurance qualité
- Mettre en œuvre les différentes dimensions de l'assurance qualité
- Promouvoir les services de qualité
- Disponibilité à servir des soins de qualité aux clients
- Changer de comportement pour augmenter l'utilisation des services de santé

3. APPUI AUX SBC ET AUX COGEC/COGES

- Disposé à travailler en équipe avec COGEC, agents de santé et autres intervenants
- Informer les membres COGEC sur les objectifs du programme
- Mettre à la disposition de la communauté mon engin
- Susciter des idées pour une organisation communautaire structurée
- Collaborer avec les communautés si elles le sont aussi
- Assister les Facilitateurs Communautaires sur le terrain
- Héberger les Facilitateurs Communautaires
- Aider PROSAF en collaborant avec la communauté
- Aider la communauté à mieux gérer les problèmes de la santé familiale
- Aider le PROSAF à mener les activités dans les communautés
- Travailler avec les Facilitateurs Communautaires et les Animateurs de Zone

- ❖ Rendre la participation communautaire plus efficace

4. CONTRIBUTION AUX ETUDES ET A LA PLANIFICATION

- ❖ Identifier les principaux problèmes de la communauté
- ❖ Planifier les activités du centre
- ❖ Améliorer la planification
- ❖ Réaliser une étude de milieu
- ❖ Contribuer à l'étude sociologique du milieu en rapport avec les pesanteurs socioculturelles

5. CONTRIBUTION AUX ACTIVITES DE COMMUNICATION

- ❖ Prendre part aux séances d'information avec les membres COGEC/COGES sur la participation communautaire
- ❖ Aider à réaliser et à diffuser des émissions d'IEC au niveau des radios communautaires
- ❖ Aider à faire les séances de sensibilisation

ANNEX 8

Les Recommandations Formulées pour Garantir la Réalisation de la Vision

ANNEX 8
LES RECOMMANDATIONS FORMULEES POUR GARANTIR LA REALISATION DE LA VISION

COMPOSANTE DU PROGRAMME	ACTIONS RECOMMANDEES	ECUEILS A EVITER
En matière de planification et de coordination	• Promouvoir la planification stratégique et opérationnelle à tous les niveaux, orientée vers la satisfaction des besoins des populations • Promouvoir la collaboration entre les secteurs public et privé • Rendre effective et opérationnelle la collaboration entre le PROSAF et les autres partenaires	• Confondre la qualité des services avec la simple implantation des structures ou leur équipement • Ignorer les communautés bénéficiaires des services • Ignorer les réalités du milieu
En matière d'accès aux services de qualité	• Contribuer à la promotion de la collaboration entre les secteurs public et privé en s'appuyant sur les textes existants • Promouvoir une culture de recherche-action à différents niveaux de la pyramide en vue d'aider à identifier les besoins et à promouvoir l'autofinancement à terme • Promouvoir la mise en place des commissions de planification à tous les niveaux avec un calendrier précis des activités • Fixer les périodes régulières de suivi et de coordination du Programme à travers les mécanismes retenus • Utiliser le plan triennal de la DDSP dans la planification du PROSAF • Faire une bonne budgétisation détaillée à tous les niveaux • Avoir une bonne collaboration avec les autres partenaires et avec les autres acteurs en vue de les inciter ou de les aider à exécuter les tâches • Veiller à envoyer à temps le plan d'action annuel au niveau central • Définir les indicateurs de suivi du programme • Rendre opérationnel le Comité de pilotage • Rédiger pour le PROSAF un manuel de procédure comptable et financier compréhensible pour les acteurs et le vulgariser	• Piloter à vue • Conserver les informations importantes à soi • S'engager dans des actions de concurrence inutile

COMPOSANTE DU PROGRAMME	ACTIONS RECOMMANDEES	ECUEILS A EVITER
En matière de développement de la capacité des agents de santé	• Faire une étude du milieu • Evaluer les besoins par enquête avec la participation de la communauté • Mettre en place un système de suivi / évaluation des formations • Prendre en compte les acquis existants • Impliquer fortement les relais communautaires dans les formations • Mettre en place des mécanismes de pérennisation du programme • Collaborer avec les autres partenaires • Donner aux acteurs les moyens nécessaires à l'exécution du programme • Privilégier les formations sur site • Contribuer à créer un mécanisme de maintien du personnel formé	• Concevoir des programmes de formation sans tenir compte des besoins identifiés • Former toujours les mêmes agents • Dupliquer les programmes • Former des agents sans les utiliser • Déplacer constamment les agents pour les formations
En matière de renforcement de la participation communautaire	• Fournir des services de formation et de suivi aux communautés dans leur effort d'organisation • Etudier avec les communautés les différents mécanismes de mobilisation et de gestion des ressources pour le financement des activités • Contribuer à créer un environnement favorable à la participation et à l'épanouissement des communautés dans la gestion des services • Veiller à ce que les femmes autant que les hommes bénéficient de tous les services de formation, afin qu'elles puissent assumer efficacement des responsabilités au sein des structures • Mettre en place des programmes d'alphabétisation fonctionnelle avec des approches novatrices pour les membres des structures communautaires et le personnel de santé	
En matière de communication pour le changement de comportement	• Institutionnaliser les approches novatrices d'IEC dans les attributions des agents de santé • Développer des modèles de sensibilisation à l'endroit des décideurs (plaidoyer) • Utiliser les opportunités qu'offre la décentralisation pour assurer une plus grande implication des décideurs (élus locaux) • Etablir et renforcer le système de concertation entre les acteurs et les décideurs en matière d'IEC • Organiser des journées d'information sanitaire à l'endroit des autorités du département	• Mettre en place un Comité sans ressources • Nommer au sein du comité des personnes appartenant à plusieurs autres comités • Créer un comité à effectif pléthorique • Laisser politiser les actions d'IEC

ANNEX 9

Liste des Indicateurs Clés de Suivi du PROSAF

ANNEX 9
LISTE DES INDICATEURS CLES DE SUIVI DU PROSAF[1]

Indicateurs / Définitions	Etat de l'indicateur (Juillet 99)	Instruments de collecte des données[2]
Capacité de planification et de budgétisation aux niveau de la DDSP et des Zones sanitaires, CSSP/CU, et CCS		
Nombre de services DDS, Zones sanitaires, CSSP/CU et CCS ayant développé un plan stratégique selon les normes	4 ZS sur 7	Liste de contrôle sur les composantes du système de gestion au niveau de la DDSP **(N° 1A.)**
Nombre de services DDS , de zones sanitaires, de CSSP/CU et de CCS ayant développé un plan opérationnel selon les normes (RI 1.2)	4 ZS sur 7	Liste de contrôle sur les composantes du système de gestion au niveau des CSSP/CU/ZS **(N° 1B.)**
Nombre de services DDS, de Zones sanitaires, de CCSP/CU et de CCS qui ont élaboré des plans opérationnels à partir des plans stratégiques		
Nombre de services DDS, de Zones sanitaires, de CCSP/CU et de CCS ayant élaboré des plans opérationnels et l'ayant appliqué		
Disponibilité de données pour la planification		
% des services de santé fournissant les rapports trimestriels à temps et avec des données fiables	76,2% (n=44)	Questionnaire d'évaluation du SNIGS au niveau de la DDSP et des CSSP/CU **(N° 3A. et 3B.)** Guide d'entretien avec le responsable sur les capacités et le fonctionnement du centre de santé **(N° 5)**
Nombre d'unité de la DDSP ayant des compétences en formation		Liste de contrôle sur les composantes du système de gestion au niveau de la DDSP **(N° 1A.)** Fiche d'étude documentaire **(N° 11)**
Performance des agents de santé en PCIME		
% de cas observés où la prise en charge par les agents de santé est conforme aux standards de la PCIME (RI 3.1)	0%	Fiche d'étude documentaire **(N° 11)** Rapport de l'Evaluation Intégrée du Système Sanitaire du Borgou, BASICS, 1998
% d'enfants malades pour lesquels les 4 signes de danger sont recherchés	2,9%	

[1] Beaucoup d'indicateurs de PROSAF correspondent aux indicateurs de l'USAID. Ils sont identifiés par le numéro du résultat intermédiaire (RI) ou d'objectif strategique (OS) approprié.

[2] Le plupart de ces mesures viennent de l'Evaluation de la Qualité de la Gestion du Système Sanitaire dans le Borgou, menée par PROSAF de juillet à décembre 1999. Les numéros d'instruments correspondent aux outils utilisés pendant l'evaluation.

Indicateurs / Définitions	Etat de l'indicateur (Juillet 99)	Instruments de collecte des données[2]
% d'enfants malades dont l'état nutritionnel est évalué / les 4 tâches effectuées	0%	
% d'enfants malades de 0 à 4 mois correctement évalué pour l'allaitement maternel (les 3 tâches effectuées)	0%	
% d'enfants correctement examinés pour la toux/ difficultés respiratoires (les 4 tâches effectuées)	6,3%	
% d'enfants correctement examinés pour la diarrhée/ dysenterie (les 5 tâches effectuées)	6,6%	
% d'enfants correctement examinés pour la fièvre (les 4 tâches effectuées)	1,9%	
% d'enfants malades pour lesquels le problème est correctement évalué par l'agent de santé et le traitement est approprié	79,3%	
% de cas où des tâches préventives sont effectuées pour l'enfant malade et sa mère en même temps que la prise en charge curative de l'enfant / au moins 6 tâches effectuées	15,4%	
Performances des agents de santé en PF		
% des consultations observés conformes aux normes et standards de la PF (RI 3.2)	0% (n=51)	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA **(N° 6 – PF/BK)**
Performance dans la prise en charge des urgences néonatales et obstétricales (R.I. 3.3)		
Proportion de cas où des sages femmes se conforment aux nouvelles normes et standards en post-partum L'AS explique les signes de danger à guetter à la suite de l'accouchement	0% (n=23) 17,3%	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA **(N° 6 – CPoN/AF)**
Proportion de cas où des sages femmes se conforment aux nouvelles normes et standards en urgences néonatales L'AS explique les signes de danger à guetter chez le nouveau né L'AS explique les signes de danger à guetter au cours CpoN	57,1% 17,3% 10,7%	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA **(N° 6 – CPoN/X ; CPoN/AD ; ACC/T)**
Performance des agents de santé pour les soins de la mère et l'enfant		

Indicateurs / Définitions	Etat de l'indicateur (Juillet 99)	Instruments de collecte des données[2]
Proportion des consultations effectuées conformément aux standards des soins maternels et infantile. (RI 3.4)	CPN 0% (n= 430) CN 2,6% (n= 152) VAC 3,6% (n=331) IEC 26,2% (n=1130) Intégration du PMA 7,8% (n=1130) CC 2 ,6% (n=115)	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA **(N° 6 – CPN/H ; CN/AR ; VACC/AX ; IEC/BR)**
Performance des agents pour la prise en charge des MST/SIDA et leur prévention		
Proportion des consultations effectuées conformément aux standards de la prise en charge des MST/SIDA (RI 3.5)	31,1% (n=15)	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA **(N° 6 – CC/BM ; CC/BN)**
Proportion des agents de santé capable de reconnaître les signes cliniques des MST	60% (n=70)	Guide d'interview du prestataire de SMI/PF/MST/SIDA **(N° 8 – QS7/15)**
Proportion des agents de santé capable de traiter les MST selon l'approche syndromique	60% (n=70)	Guide d'interview du prestataire de SMI/PF/MST/SIDA **(N° 8)**
Accessibilité physique et organisationnelle des services de santé dans le Borgou		
Proportion de clientes percevant que le centre de santé est à une distance raisonnable (similaire à RI 2.7)	49,2% (très proche et proche) (n=951)	Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7 – Q.53 points 3 et 4)**
Intégration des services		
Proportion des formations sanitaires publiques et privées qui offrent des prestations intégrées (RI 2.3)	11,9% (n=44)	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA (N° 6 – Analyse des prestations reçues)
Ratio prestations offertes par rapport au nombre de clientes observées	1,2 (degré d'intégration)	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA **(N° 6 – CC/BO)**
Proportion de formation sanitaires publiques et privées où toutes les composantes du paquet minimum de santé familiale sont disponibles tous les jours de la semaine Proportion de formation sanitaires publiques et privées où toutes les composantes du paquet minimum de santé familiale sont disponibles 5jrs sur 7	11,9% (n=44)	Guide d'Inventaire et d'Entretien avec les responsables sur les capacités en ressources humaines, matériel, fournitures et équipement et fonctionnement de l'établissement sanitaire **(N° 5 – CAP/A)**
Proportion des formations sanitaires où au moins 80% des clientes reçoivent au moins deux (2) prestations du paquet essentiel de santé familiale (CPN, Assistance à l'accouchement, CPoN, CN, PF, Vaccinations, soins curatifs, IEC) à l'occasion d'une même visite.		**Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA** (N° 6)

Indicateurs / Définitions	Etat de l'indicateur (Juillet 99)	Instruments de collecte des données[2]
Proportion de formation sanitaires publiques et privées où le temps consacré à une consultation est conforme aux normes et standards en vigueur pour les prestations de santé familiale		
Durée médiane de la consultation	13 mn	
Durée médiane de l'attente	1h37 mn	
Efficacité du système logistique et approvi sionnement dans le Borgou		
Proportion des points de prestation de services et produits de PF, santé maternelle et infantile, MST/SIDA sans rupture de stock pendant les 12 derniers mois (RI 2.2)	14,3% (n=44)	Guide d'Inventaire et d'Entretien avec les responsables sur les capacités en ressources humaines, matériel, fournitures et équipement et fonctionnement de l'établissement sanitaire **(N° 5 – CAP/H ; CAP/I)**
Proportion des points de ventes de produits de PF, santé maternelle et infantile, MST/SIDA sans rupture de stock pendant les 12 derniers mois	L'évaluation n'a pas touché les ruptures de stock dans les points de vente	
Performance du système de supervision dans le Borgou		
Proportion de prestataires qui reçoivent une supervision formative trimestrielle de la DDSP 4 fois par an dans le Borgou (RI 3.6)	5,7% (n=70)	Questionnaire d'information auprès du personnel travaillant dans le système sanitaire (DDSP, CSSP/CU, CCS) sur les composantes du management sanitaire **(N° 4 – SUP/B, C)** Guide d'interview du prestataire de SMI/PF/MST/SIDA **(N° 8)**
Proportion prestataire qui reçoivent une supervision formative mensuelle du CSSP/CU 12 fois par an dans le Borgou	7,1%	
Performance du système de formation continue		
% des ateliers de formation continue basés sur les besoins et l'adaptation des curricula (si nécessaire)	***Indicateur non calculé à cause d'absence d'une unité chargée de la gestion de la formation et d'un système d'archivage des formations réalisées***	Liste de contrôle sur les composantes du système de gestion au niveau de la DDSP **(N° 1A.)** Liste de contrôle sur les composantes du système de gestion au niveau des CSSP/CU/ZS **(N° 1B.)** Questionnaire d'information auprès du personnel travaillant dans le système sanitaire (DDSP, CSSP/CU, CCS) sur les composantes du management sanitaire **(N° 4)** Guide d'interview du prestataire de SMI/PF/MST/SIDA **(N° 8 – FORM/A)**
Implication effective de la communauté dans les questions de santé		
% des communes de la zone d'intervention ayant des comités de gestion disposant de statuts définissant leur rôle dans la gestion des centres de santé	100%	Guide d'interview des COGES et des COGEC **(N° 9)**
% des communes de la zone d'intervention ayant des comités de gestion disposant de plan d'action	80% (surtout zone PBA et UACOGEC)	

Indicateurs / Définitions	Etat de l'indicateur (Juillet 99)	Instruments de collecte des données[2]
% des COGES et COGEC participant au projet et ayant des statuts définissant leur rôle dans la gestion des centres de santé.	100%	
Accès au service de sensibilisation et de prévention par l'implication de la communauté		
% des COGES et des COGEC dans la zone d'intervention du projet menant des activités de sensibilisation et des réunions communautaires une fois par mois	70,6% (n=51)	Guide d'interview des COGES et des COGEC **(N° 9)**
Collaboration avec la communauté pour la gestion des activités des centres de santé		
% CSSP/CU effectuant au moins une réunion mensuelle avec les COGES dans la zone d'intervention du projet	57,1% (n=14)	Guide d'Inventaire et d'Entretien avec les responsables sur les capacités en ressources humaines, matériel, fournitures et équipement et fonctionnement de l'établissement sanitaire **(N° 5)**
% de CCS effectuant au moins une réunion mensuelle avec les COGEC dans la zone d'intervention du projet	46,4% n=42	Guide d'Inventaire et d'Entretien avec les responsables sur les capacités en ressources humaines, matériel, fournitures et équipement et fonctionnement de l'établissement sanitaire **(N° 5)**
% de COGES et de COGES disposant d'un plan d'action incluant des actions de santé familiale n=51	48,4% ont fait des sensibilisations sur les vaccinations 35,5% sur les accouchement à domicile 45,2% sur la fréquentation du centre 22,6% sur l'hygiène et l'assainisse ment	Guide d'interview des COGES et des COGEC **(N° 9)**
Implication de la communauté dans la génération des ressources		
% des COGEC participant au projet avec des dépôts pharmaceutiques viables	Cet indicateur ne correspond pas à la réalité	Guide d'interview des COGES et des COGEC **(N° 9)**
% des Comités de gestion participant au projet menant des activités génératrices de revenu autre que la vente de médicaments et contribuant au développement des services de santé	21% (n=51)	
Comportements en santé familiale		

Indicateurs / Définitions	Etat de l'indicateur (Juillet 99)	Instruments de collecte des données[2]
% des femmes de 15-49 ans utilisant une des méthodes modernes de contraception dans le Borgou (OS 1a)	2,5% (EDS 1996) 7,6% des utilisatrices des centres de santé (EQGSS) 42,2% des utilisatrices des centres de santé pour toutes méthodes confondues (EQGSS) (n=941)	Fiche d'étude documentaire **(N° 11)** Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7)** EDSB 1996
% des femmes de 15-49 ans qui reçoivent des produits de PF à base communautaire (similaire à RI 2.4)	0% (EQGSS)	
% des femmes en post-partum qui reçoivent la vitamine A	69,6%	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA **(N° 6 – ACC/Q.16 ; CPoN/Q.18)**
% des enfants qui reçoivent la vitamine A	21,1%	Guide d'observation intégrée de la prise en charge en SMI/PF/MST/SIDA **(N° 6 – CN, CPoN)**
% de femmes enceintes recevant la supplémentation en fer/acide folique	74%	
% des enfants recevant la vaccination contre la rougeole (OS 4)	43,4% (enfants dont les besoins en vaccination sont couverts)	
% de mères capables de décrire les signes et les symptômes du paludisme requérant recours au centre de santé	14,8% (2,4% en 98 enquête BASICS)	Fiche d'étude documentaire **(N° 11)** Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7)**
% de mères capables de décrire les signes et les symptômes de la diarrhée requérant un recours au centre de santé	1,7% (1,4% enquête BASICS en 98)	
% de mères capables de décrire les signes et les symptômes des IRA requérant un recours au centre de santé (RI 4.1)	8,7% (2,9% enquête BASICS en 98)	
% de mères capables de donner les règles pour les soins à domicile	5,2%	
% des adultes qui savent que le paludisme est transmis par les moustiques .	Confère enquête CRS	Fiche d'étude documentaire **(N° 11)**
% des adultes qui peuvent citer au moins une méthode de lutte contre le paludisme.	CRS	Rapport de l'Evaluation Intégrée du Système Sanitaire du Borgou, BASICS, 1998
% des enfants de moins de 4 mois exclusivement nourri au sein (RI 4.2)	19% (EDSB, 1996)	Rapport de l'Evaluation Intégrée du Système Sanitaire du Borgou, BASICS, 1998 EDSB 1996
% de mères capables de citer les aliments riches appropriés	CRS	Rapport de l'Evaluation Intégrée du Système Sanitaire du Borgou, BASICS, 1998
Indice Synthétique de Fécondité	7,35 (EDSB, 1996)	EDSB 1996

Indicateurs / Définitions	Etat de l'indicateur (Juillet 99)	Instruments de collecte des données[2]
Nombre idéal d'enfants désirés (femmes âgées de 15 à 49 ans lors de l'EDSB)	6,3 (EDSB, 1996)	EDSB 1996
% de femmes utilisant une méthode moderne de contraception au moment de l'EDSB	2,5 (EDSB, 1996)	Fiche d'étude documentaire **(N° 11)** EDSB 1996 Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7)**
% d'hommes utilisant une méthode moderne de contraception au moment de l'EDSB	7,7 (EDSB, 1996)	Fiche d'étude documentaire **(N° 11)** EDSB 1996
% des personnes ayant entendu un message à la radio et à la télévision sur la planification familiale	9,8% ***(EDSB, 1996)***	Fiche d'étude documentaire **(N° 11)** EDSB 1996 Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7)**
Distribution proportionnelle des clientes selon la source d'information sur les services et produits de santé familiale (n=951)	Radio 5,2% Télév 0,1% Voisin 22 ;9% Parent 26,2% Agent de santé 14,4% Conjoint 17,8%	Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7 – Q.9)**
% de couples qui approuve la planification familiale	23,8% (EDSB, 1996)	Fiche d'étude documentaire EDSB 1996
% de femme ayant reçu une campagne de PF dans 12 derniers mois précédents l'EDSB		Fiche d'étude documentaire **(N° 11)** EDSB 1996 Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7)**
Proportion de femmes ayant choisi une méthode contraceptive après la démonstration de l'agent de santé	82,4%	Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7)**
Distribution proportionnelle des clientes selon le type de méthode contraceptive choisi	Injectable 50% DIU 14,3% Pillule 35,7%	
% de la population âgée de plus de 15 ans connaissant au moins une méthode moderne de contraception.		Fiche d'étude documentaire **(N° 11)** EDSB 1996
% d'hommes connaissant au moins une méthode moderne de contraception	86,2% (EDSB, 1996)	Fiche d'étude documentaire **(N° 11)** EDSB 1996
% de femmes connaissant au moins une méthode de contraception	43,5% (EDSB, 1996)	Fiche d'étude documentaire **(N° 11)** EDSB 1996 Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7)**

Indicateurs / Définitions	Etat de l'indicateur (Juillet 99)	Instruments de collecte des données[2]
% de couples exprimant le désir d'espacer ou de limiter les naissances (similaire à RI 4.4)		Fiche d'étude documentaire **(N° 11)** EDSB 1996
% de femmes ayant entendu parler du SIDA	54,9% (EDSB, 1996)	
% d'hommes utilisant les condoms pour la prévention des MST/SIDA (parmi les hommes qui connaissent le sida et qui ont eu des rapports sexuels au cours des 12 derniers mois, % de ceux qui ont déjà utilisé le condom pour éviter les MST/SIDA)	20,5% (EDSB, 1996)	
Satisfaction des clients		
% des clientes aux niveaux des formations sanitaires publiques et privées qui trouvent que le temps d'attente est satisfaisant	55,2% convenable (n=951)	Guide d'interview de la cliente SMI/PF/MST/SIDA à la sortie de la consultation **(N° 7)**
% des clientes aux niveaux des formations sanitaires publiques et privées qui trouvent que le coût des services et produits de santé familiale est acceptable	79%	
Adéquation des attentes de la population avec les services et produits fournis	60%: Bloc opératoire 30,5%: un service de radiologie 6,7%: activité PF 1,9%: IEC 1%: consultation de nourrisson	Guide d'entretien avec les communautés sur l'offre de santé **(N° 10- Fenêtre d'analyse des attentes de clients)** **(N° 7 – Q.56 ; Q.57)**