



Maternal, Neonatal and Child Health/Family Planning/ Malaria Component



Annual Report

October 1st 2007 – September 30th 2008

Pour une amélioration de la santé de la famille Sénégalaise



INTRHEALTH
INTERNATIONAL

Our vision: To achieve the Millennium Development Goals (MDG) related to maternal health, the reduction of mortality for children under 5 and the fight against malaria.

Our obligations: Reduce maternal and child morbidity and mortality through the following key strategies: increase the use of family planning (FP) services; decentralize access to health services; increase service providers' accountability with a view to quality services; Increase male involvement; reinforce girls' and women's accountability; improve malaria treatment by using the Artemisinin Based Combination Therapy (ACT); and increase the use of Intermittent Preventive Treatment (IPT) to prevent pregnant women malaria.

Our strategic partners: DSR, PNLP, DLSI, and DANSE.

Our implementing partners: The Population Council, Siggil Jigeen Network, and Helen Keller International (HKI).

The USAID's health program has four components: Policy and Finance; Community Health; HIV/AIDS and Tuberculosis; Maternal and Child Health/Family Planning

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List of acronyms

ACI	Africa Consultants International
BCC	Behavior Change Communication
CCF	Christian Children Fund
COPE	Client-Oriented Provider-Efficient
CPTS	Contraceptive Procurement Table In Senegal
CYP	Couple-Year-Protection
DANSE	Division of nutrition and child survival
DLSI	Division for AIDS and STI prevention
DSR	Division of Reproductive Health
DSSP	Division of Primary Health Care
ECD	District cadre team
ECR	Regional cadre team
FHI	Family Health International
FP	Family planning
ITN	Insecticide-treated bed nets
JLM	Journées Locales De Micronutrients
MHMP	Ministry of Health and Medical Prevention
MNCH	Maternal, neonatal and child health
NPP	National procurement pharmacy
PAC	Post abortion care
PMI	Presidential Malaria Initiative
PNLP	National Malaria Program
PSP	Provisional services points
RH	Reproductive health
RPP	Regional procurement pharmacy
SJ	Siggil Jigeen
SNEIPS	National education and health information service
SNIS	National health information service
USAID	United States Agency for International Development

I. INTRODUCTION

The MNCH/FP/MALARIA component is funded by USAID through the cooperation agreement # 685-A-00-06-00058-00 and is implemented by IntraHealth International. Between 2006 and 2011, its goal is to support the Ministry of Health and Medical Prevention (MHMP) in the area of Maternal, Neonatal and Child Health/Family Planning/Malaria (MNCH/FP/MALARIA).

As part of the USAID Health Program, this component, which started in 2006, covers the following regions:

- Thiès, Louga, Kaolack, Kolda and Ziguinchor (for MNCH/FP)
- Dakar and Saint Louis (for FP only)
- All regions within Senegal (to fight malaria)

The **MNCH/FP/Malaria** component is now developed in partnership with the Population Council, the Siggil Jigéen Network, Helen Keller International (HKI) and the Youssou N'Dour Foundation.

The **MNCH/FP/Malaria component** is implemented in a context of high maternal mortality in spite of decreased rates observed over the past few years (DHS IV indicates a maternal mortality rate of 401/100,000 live births). The neonatal mortality rate (34% in DHS IV in 2005) has leveled off, between the DHS conducted in 1992, 1997 and 2005, despite the decrease in child and adolescent mortality. It now accounts for 50% of the child mortality rate. While the contraceptive prevalence rate has increased, it is far from reflecting the efforts that have been made over the past decades and, as a result, the extend of unmet needs remains compelling (31% of women, who would like to space or limit their pregnancies do not use contraceptive methods). Therefore, there is a need to reposition family planning and to reduce maternal and neonatal mortality.

The MNCH/FP/Malaria component is aimed at overcoming the challenges Senegal must face by helping the country meet the objectives included in the Ministry of Health's enrolment plan, as well as the Millennium Development Goals (MDG). More specifically, this component is intended to:

- Increase the access to family planning (FP) and reduce maternal and neonatal mortality in compliance with Senegal's Ministry of Health's enrolment plan and the National Plan for Health Development (PNDS Phase II, 2004-2008)
- Decentralize access to health care while maintaining high quality health services
- Encourage leadership among health programs managers and health services providers in order for them to be committed to high quality service delivery
- Bring about men's acceptance of family planning services
- Empower women and young girls in order for them to make informed decisions regarding their own health
- Improve knowledge among providers and clients regarding malaria and malaria treatment in order to save lives
- Increase the accessibility to high quality services and information in order to prevent malaria and manage malaria cases.

II. PROGRAM DESCRIPTION

In order to meet these objectives, the **MNCH/FP/Malaria** component focuses on the following areas of intervention:

Intervention area 1: Increased access to FP services

At this level, we aim at strengthening access to different FP methods, as well as information related to family planning. This includes eliminating barriers between supply and demand, whether it is in for clinical- and community-based services or for services delivered by the public or the private sector. The key interventions that will be developed should contribute to an increased utilization of modern contraceptive methods.

Intervention area 2: Strengthening the integrated MNCH/FP package

Our goal is to reduce maternal, neonatal and child mortality and morbidity by reinforcing our position and by making “the services package” available in every structure. Strengthening the providers’ ability to offer this package will be a key factor of success. We expect to effectively integrate mother-and-child health services and decrease maternal and neonatal morbidity and mortality.

Intervention area 3: Communication and Demand Creation

In this area, we will focus on the acceptability and the demand of FP and MNCH information and products by promoting FP as a lifestyle and by encouraging demand for the “Mother-to-be” care package. The expected results are as follows: Increased utilization of FP services; providers’ increased capacity to offer high quality MNCH services and population’s improved ability to make informed decisions regarding family health.

Intervention area 4: Strengthening the health system in a decentralized environment

The goal is to develop leadership abilities among managers and providers in order to ensure high quality service delivery. Approaches based on the continuing improvement of performance will be used in order to meet this objective. As a result, we expect a better sense of responsibility and leadership within the health care system.

Intervention area 5: The fight against malaria (Presidential Malaria Initiative)

We aim at better managing malaria cases among pregnant women and children that are less than 5 years of age, while increasing the acceptability of and demand for information and products to fight malaria, including insecticide-treated bed nets (ITN), fever treatment, malaria prevention during pregnancy, as well as malaria vector control. Key interventions in that area are meant to increase the access to information and the availability of quality services in order to prevent and treat malaria cases and to improve provider and client knowledge on issues related to the fight against malaria.

IntraHealth received significant financial support from USAID through the Presidential Malaria Initiative (PMI) in order to implement the 2007-2008 action plan. This program, which primarily targets service providers working in all of the country’s facilities, emphasizes the management of malaria cases, as well malaria prevention and behavior change communication.

III. SUMMARY OF ACHIEVEMENTS AND RESULTS

Intervention Area 1: Increased access to FP

During the reporting period, key interventions conducted in the public and the private sectors have helped strengthen the access to FP services.

In the private sector, ten new companies enrolled in the network of enterprises that take part in the project. Private sector providers' capacities strengthening started with the orientation of providers in the self-assessment approach and the introduction of the services quality improvement package. The providers' training sessions in the FP services package and the policies, norms and protocols (PNP) were also conducted with the 20 private enterprises that enrolled in the project.

A consultation framework has been set up between the public and private sectors and has allowed for a discussion regarding the integration of private sector data in the national health information system. A collaboration framework between these two sectors has been proposed through the creation of an agreement memorandum between private enterprises and the medical regions. In the public sector, training sessions in FP counseling have increased and have helped strengthen the capacities of over 600 providers. Post-training follow-ups have also started and have shown how newly-acquired skills and knowledge have efficiently been put into practice. This has resulted in a noticeable increase in FP services utilization in some provisional services points (PSP).

The institutional support given to the division of reproductive health (DSR) has helped secure the national contraceptive commodity procurement system. All regions have been supplied on a regular basis over the year thanks to a better coordination between the DSR, the national procurement pharmacy (NPP) and the different partners. The support given to DSR in the organization of the annual review of the contraceptive commodity procurement schedule allowed for the identification of the country's contraceptive needs over this period. The regular supervision of the regional and districts procurement pharmacies' (RPP) warehouses and the monitoring of the action plans implementation have helped keep contraceptives stock-outs in PSPs to a minimum. Major initiatives have also been conducted in order to expand the range of contraceptive methods and to improve access to FP services. The FP service package has been integrated in the implementation of advanced strategies planned by the districts. Negotiations with CEFOREP are underway regarding the training of regional doctors in tubal ligation (TL). The FP national day has been organized and the national FP campaign has been launched.

Strengthening the FP services package in the private sector

The efforts that were initiated during the first year in order to increase the private sector's capacity to offer high quality FP services have continued over the period of time covered in this report. Thus, with the information and advocacy sessions targeting enterprises managers, the number of private enterprises that confirmed their enrollment in the project rose from ten¹, during the first year to 20 during the second year². An agreement memorandum defining the guidelines of the partnership between the enterprises and the MHMP across the medical regions and districts has been finalized and

¹ Enterprises enrolled in **Year 1**: In Dakar: Student Medical Services (COUD); The Social Insurance Office; Port Autonome de Dakar; Dakar Dem Dikk, Sénégal Pêche, SOCO CIM. In Saint Louis: University Regional Center (CROUS), Grands Domaines du Sénégal (GDS), SOCAS, and CSS.

² The enterprises enrolled in Year 2 are located in Dakar : ICS, MTOA, SDE, SONATEL, SENELEC, SDV Sénégal, ASECNA, Maïmouna de Rufisque's post office and clinic.

validated. This memorandum clarifies the contraceptive products procurement procedures, as well as the flow of data collection and transfer. It should be signed by the different stakeholders during the next quarter (October-December 2008).

Moreover, the consultation framework with the private sector enterprises was strengthened in March 2008 when a brainstorming session was held to discuss integrating private sector data into the national health information system. This meeting brought together MSPM decision-makers (directors and service managers) and private sector enterprises representatives and made important recommendations: the implementation of a formal consultation framework between the public and the private sectors; the development of a document aimed at dividing private health structures into categories; the clarification of the private sector data transfer and validation processes; indicator definitions and types of tools for the private sector.



The strengthening of the private sector's capacity of offer high quality FP services has started to take shape through the training of providers from the private sector in the services quality self-assessment approach. Indeed, in June 2008, two training sessions of this kind took place in Dakar and Saint Louis with the technical support of PSP-One³. In Dakar, this session helped train 31 providers (20 women and 11 men), coming from fourteen enterprises, in the concept of service quality, the contents of the service quality improvement package and the utilization of the self-assessment tool. In Saint Louis, 12 providers (5 women and 7 men) coming from 4 enterprises have been trained in this approach. This orientation will enable the private sector to integrate and implement the service quality standards defined by the MHMP. An operational plan has been developed with PSP-One's technical support in order to monitor and evaluate the implementation of this approach in the targeted structures.

In order to keep on reinforcing private sector structures' capacities to offer FP services, 28 providers (25 women and 3 men) coming from 20 enterprises were trained in July in the FP package, which included contraceptive technology and FP counseling. During these training sessions, the providers were also oriented in the RH policies, norms and protocols.

Strengthening provider capacity in FP

Adaptation of the training tools: With the prospect of strengthening the providers' capacities in quality FP service delivery, the training tools have been readapted in order to take into account the new training approaches based on skills and on-site training. These instructional support materials have also been reviewed to take into consideration the latest WHO updates and guidelines in the area of FP. These include the updated period of action of IUDs and contraceptive implants, WHO new guidelines regarding the irregular use of contraceptive pills, emergency contraception, the re-injection window, the effective duration of a vasectomy and the medical eligibility criteria.

³ PSP-One (Private Sector Partnerships-One for better health) is a project funded by USAID that advocates for a greater involvement of the private sector in health care services.

Training in FP package and supervision techniques: During the period of time covered in this report, in the regions of Dakar and Saint Louis, 32 tutors and supervisors (26 women and 6 men) have been trained in the FP services package and supervision techniques. These agents acquired skills in insertion and removal techniques for IUD and Norplant. They also improved their FP counseling skills and were



trained in the management of data collection support systems, the use of checklists, contraceptive logistics, self-assessment techniques and the systematic identification of RH clients needs. In order for participants to put their newly-acquired skills into practice right after their training, a kit of resources has been handed out to them at the end of the session. It included a box for the insertion and removal of IUD, two puncture needles for the insertion of contraceptive implants, along with FP consultation forms, FP posters, an FP products presentation stand, several checklists, a summary of WHO medical eligibility criteria.

Post-training follow-ups for trained tutors showed: i) a significant improvement in technical skills⁴; ii) ownership of the approach by the health committees, which started mobilizing resources to improve the providers' work environment; iii) effective supervision of the site's providers by the tutors; iv) noticeable improvement of the contraceptive method utilization rate in the PSPs, particularly among head-of-posts nurses (ICP), who are now involved in FP services delivery⁵.

In other regions (Thiès, Kaolack, and Louga) that benefitted from the on-site training approach, tutors and supervisors were trained in FP, which is an essential part of the MNCH/FP/Malaria package taught during the tutoring training sessions.

As part of the World Midwives Day, IntraHealth provided technical support to the national association of registered midwives to provide updates to almost 300 midwives in FP.

Provider skill development in FP counseling: As part of the repositioning and promotion of FP, it has been deemed a priority to increase the number of training sessions in FP counseling during the project's second year. These sessions have targeted qualified providers (midwives, nurses) and counselors. As a result, during Year 2, 580 providers have strengthened their FP counseling capacities in 32 training sessions. It is important to note that all qualified providers in the 8 Dakar districts and the 5 Saint Louis districts have been trained in FP counseling. In the region of Saint Louis, where the training sessions have targeted head nurses, we have noted a greater involvement by these providers in FP service delivery, which was not always true in the past. Indeed, FP service delivery in health posts used to be mostly delegated to "matrones". Thus, this behavior change could have a positive impact on the repositioning of FP in these areas.

⁴ During the post-training follow-up with Saint Louis' tutors that was conducted in April 2008, the average skills test scores were recorded as follows: 77% for FP counseling, 88% for Norplant insertion and 84% for IUD insertion. During the post-training follow-ups with Dakar's tutors conducted in June 2008, the average skills test results were as follows: 74% for FP counseling and 84% for IUD insertion.

⁵ FP service delivery was previously delegated to "matrones" (auxiliary midwives) in some health centers.

Post-training follow-up sessions showed that newly-acquired skills were effectively put into practice. Performance scores during these sessions ranged from 61% to 91%. It has been noted that job aids were used effectively, especially the contraceptive methods presentation stand and the FP registers, which were available in most of the PSPs that were visited. The follow-up visits also showed a significant increase in the utilization of FP methods in some health posts. However, these visits also highlighted certain constraints, particularly the unavailability of FP consultation forms, the non-compliance with the norms for infections prevention, the non-compliance with the price of contraceptive commodity recommended by the MHMP.

Efficient advocacy efforts for sustainable FP services: During Year 2, the Siggil Jigéen Network's activities have increased and expanded in seven regions of intervention. These advocacy efforts have been organized step by step: the training of focal points in advocacy, the development of an advocacy plan aimed at promoting FP, communication sessions and, finally, advocacy sessions aimed at solving the major problems identified during the communication sessions. These activities have been supported on a regular basis by community leaders through community radio stations.

All focal points from SJ have been set up and have become operational on the field. They now work in close collaboration with the health districts and the medical regions. The Siggil Jigéen members located in Dakar have been oriented in FP, which enabled the organization of an advocacy session regarding the virtual conference on family planning repositioning. The broadcasting of FP messages via the mass media and community radio stations enabled the broadcasting of 43 FP-related radio shows. The involvement of religious leaders during these shows helped clarify the position of Islam on FP. This year, 38 communication sessions have been held in health centers, including the ones in Thiès, Saint-Louis, Kaolack and Ziguinchor. The sessions created a consultation framework between the providers and the community and helped identify the main obstacles to the utilization of FP services⁶. The advocacy sessions got the different stakeholders more involved and helped solve the identified problems. For instance, Pout managed to hire a midwife and received a new ambulance with the support of the city hall. Similarly, in Sédhiou, in order to reduce the number of child deliveries at home, the MCD has set up a hotline, available from 10 pm, for people in need of an ambulance.

Advocacy activities in FP also helped get local leaders, as well as women and youth community association, more involved. Some of these community-based organizations showed their commitment in supporting the SJ's focal points and in raising awareness among the population in their program. The radio shows and the communication sessions helped highlight the necessity of FP among community leaders, religious leaders and the population as a whole.

However, the consolidation of SGN's activities, as well as the effective support from social and development partners regarding the FP communication plan will be major challenges to the repositioning of FP in these regions.

⁶ A file regarding the content of these sessions is currently being developed and it will allow for an in-depth documentation of their results.

Securing the contraceptive products procurement chain

The institutional support given to the DSR has allowed for a better coordination of the partner activities in the acquisition of contraceptive products. The Project has supported the DSR in the annual review of the contraceptive products acquisition schedules and the monitoring of planned orders, during this



reviewing process, allowed for the timely reception of orders. The regular supervision of RPP and districts warehouses and the orientation of regional and districts pharmacists in contraceptive products logistics helped increase the availability of these commodities in the PSPs. With the support from NPPs⁷, the medical regions have been regularly supplied with contraceptive products during the year. Since such an operational coordination and monitoring process has been set up, stock outs have been kept to a minimum.

However, some major challenges are still left to overcome in order for this system to become more efficient. Contraceptive products should be effectively integrated in the NPPs official distribution chain⁸. Moreover, the difficulty of collecting the real consumption data from the PSPs remains a recurring problem, which should be urgently solved. Finally, the lack of harmonization in the price of contraceptives is a major obstacle to the accessibility of these products by the population.

Implementation of advanced strategies integrating FP

As part of the advanced strategies initiated by the malaria prevention component, FP has been integrated as part of the service package, which is offered by head-of-post nurses visiting health huts. Some districts started trying out this approach. In the long run, these integrated advanced strategies will help improve the accessibility of FP services and increase the utilization of contraceptive methods. The documentation of this initiative is underway.

Extending the range of contraceptive methods

As part of the policy extending the range of contraceptive methods, which aims at letting clients make informed decisions and at meeting FP needs, the Project will support the DSR in extending the range of long-acting methods.

Increasing contraceptive method choices is a priority in the area of FP service delivery. This strategy aims to diversify FP options and guarantee increased client knowledge about choices. Increasing method

⁷ The procurement of medical regions in contraceptives is done in coordination with the central NPP and DSR warehouse through the transfer of essential medicine to the RPPs.

⁸ The Ministry strongly recommended that the NPP and the DSR find some common ground in order to solve this problem.

choices will also respond to the unmet needs of FP clients. Within this framework, the project supported the DSR to extend long-acting methods. During the year negotiations were also held with CEFOREP to extend Voluntary Surgical Contraception (VSC) in the health districts. This project aims to ensure the training of providers at the regional hospital and type II health center level on VSC techniques. VSC training is justified due to the fact that, even though modern contraceptive use showed a slight increase (8% in 1997 and 10.3% in 2005), unmet FP needs has not decreased (28% in 1997 and 33% in 2005). So, in the view of repositioning FP, and long term methods in particular, IntraHealth foresaw support to the MSP, with technical assistance from CEFOREP, to improve access to VSC in facility level. Discussions with these institutions are now underway.

In addition, within the implementation of on-site training, ICP tutors benefited from IUD insertion and removal training. Despite being included in the RH policies, protocols and norms, the MSP had not yet decided to strengthen nurse capacity to insert and remove Norplant IUDs. After strong advocacy from IntraHealth, approval was granted by the DSR to train nurses in IUD removal and insertion in a pilot phase. This pilot's evaluation will make it possible to argue for passage of a scale up of trainings. Advocacy is ongoing for nurses to benefit from training on Norplant insertion and removal and to thus enable nurses to increase their skills in this area.

Lastly, IntraHealth is also supporting the DSR to introduce Jadelle and the Levonogesterl IUD (Mirena) in Senegal These initiatives will, in the long term, make it possible to improve access to FP methods.

Intervention Area 2: Strengthening MNCH services

During Year 2, the institutional support to the DSR has taken shape with the duplication and dissemination of revised policies, norms and protocols and with the organization of an annual meeting regarding the planning of RH activities, which enabled the regions to develop annual draft work plans for the year 2008. The implementation of the tutoring training approach has started with the orientation of targeted tutors and supervisors in the integrated MNCH/FP/Malaria service package, as well as in learning and supervising techniques for adults. In the regions, tutors started to use this approach. During our check-in visits on the field, we noticed that they had a good command of skills, particularly in the area of IUD insertion and removal and essential newborn care.

The increasing number of AMTSL and essential newborn care (ENC) decentralized training sessions has helped train most qualified providers in the five MNCH regions. The integration of AMTSL and ENC in the training sessions and the reinforcement of providers' capacities in these areas helped improve mother-child management in the PSP, whose providers have been trained. Assistance during delivery by a skilled birth attendant, as well as AMTSL and ENC increasing use are among the most tangible results we recorded. The extension of post abortion care (PAC), in compliance with the MHMP's recommendations, has started and, in the long run, it will improve access to these services.

Institutional support to the DSR

During Year 2, support has been given to the DSR in the duplication and the dissemination of revised policies, norms and protocols (PNP). Indeed, 475 copies of resources have officially been submitted to the DSR in order to be disseminated in the regions. The tutoring training sessions and the orientation

workshops in supportive supervision have also been used to integrate the orientation of ECR/ECD members in these PNP documents.

Furthermore, in February 2008, the Project contributed to the organization of the annual RH activities planning meeting. This meeting, which brought together all the medical regions and the development partners, helped assess the impact of RH activities in 2007. It also allowed for the integration of the Project's activities in the regions' annual work plan (AWP) drafts.

Implementation of the integrated package and tutoring training

The tutorat is an on-site training approach which involves integrating into health teams a provider who is a "tutor" who supervises and supports each provider to achieve tasks and improve performance. The approach follows each provider through the acquisition or strengthening of target competences. Also, the training approach makes it possible to reduce constraints of traditional training approaches which interrupt services during trainings, personnel mobility, lack of supervisor involvement, non-applicability of acquired skills, inadequacy between real provider needs and trainings, inadequate selection of participants, etc. The tutorat will be tested in five regions and the final evaluation results will be shared with the MSP.

The resource package developed as part of training in the tutoring approach has been finalized and shared with the MHMP. It includes the strategy description, the facilitator's guide, the tutor's manual, the supervisor's manual and the provider's manual, and the self assessment tool package.

Within the implementation of the MNCH/FP/Malaria package of services, IntraHealth is providing a central space to strengthen service quality. Innovative approaches have been integrated into the Tutorat including a package of simple and practical tools which will aid providers to self identify variations in service quality and to develop action plans with short term, interim and long term goals to improve the quality of their services. Thus the Tutorat stresses the analysis of variation in quality and problem solving in areas of weakness in Thiès, Louga, Dakar, Saint-Louis and Kaolack. These regions were identified to test the tutor training approach on the MNCH/FP/Malaria package of services. A pool of **72 tutors and supervisors** (9 men and 63 women) are available to implement the Tutorat.

Tutors were selected by regional and district teams based on defined criteria. Selections were approved by a central team (DSR/IH) and seven **(7) training sessions** organized at the regional level during the year. This made it possible to strengthen technical skills and coaching of the 35 tutors and their 37 supervisors. Regional training schools and hospital midwives were also involved in regional training sessions. Applying lessons learned from previous trainings, the tutorat strategy was readjusted to guarantee the approach's success and to reduce implementation costs. Thus, the contents of the training package were reduced. The Thiès, Saint-Louis, Louga, Kaolack and Dakar were retained for pilot implementation and each tutor will have to manage providers in two to three PPSs per year.

Provider training on the tutorat actually started in four **(4) health centers** on a grand scale in the Thiès region (Thiès, Mbour, Joal et Tivaouane), **five (5) health posts** in the Saint Louis region and in seven **(7) health centers** in the Dakar region.

Post training follow up with tutors and supervisors showed a good command and application of acquired skills, improvement in tutor work environments, and effective management of site personnel.

Strengthening the providers' capacities in AMTSL and ENC

The integration of AMTSL and ENC in the training curriculum in newborn health surveillance has been



the most important innovation to this project. With the training of providers initiated in Year 1, a pool of local trainers has been made available for every region. These trainers have managed to implement the regional training plans with the punctual support from agents of the DSR and the project. The utilization of local skills, especially for pediatricians and gynecologists working at the regional level, has helped boost the number of decentralized training sessions. Moreover, during Year 2, 504 providers have had their AMTSL and newborn management skills strengthened.

Post-training follow-up visits have become effective and have shown a good knowledge and practice of AMTSL procedures. Indeed, the data collected from the interviews of providers during the first post training visit have confirmed that trained agents had a good knowledge of these procedures: intramuscular oxytocin administration in the minute after birth (95%); controlled umbilical cord traction (86%); fundal massage (87%). Moreover, results have shown that

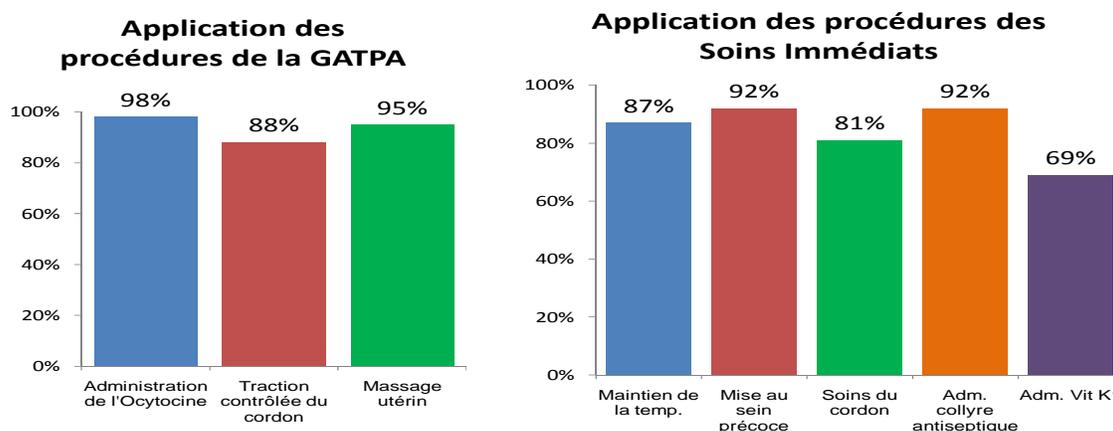
key procedures have been performed by providers in 83% of births observed during these visits: oxytocin administration (98%); controlled cord traction (88%); fundal massage (95%).

Also, the results of the first follow-up visit had shown a good knowledge and command of the newborn management procedures during delivery. During our visit, 91% of interviewed providers mentioned that maintaining the child's temperature was one of the key procedures to be used in the improvement of newborn survival (in comparison with 88% for umbilical cord care, 80% for early breastfeeding, 89% for antiseptic drops and 72% for K1 vitamin supplementation. Data collected during the visits showed that providers appropriately performed newborn management procedures: In 87% of observed cases, the temperature has been maintained (in comparison with 92% for early breastfeeding, 81% for umbilical cord care, 92% for antiseptic drop and 69% for the supplementation of K1 vitamin.

The introduction of AMTSL and ENC procedures has had a positive impact. Routine data show an increasing use of AMTSL during vaginal births. The number of births with AMTSL has increased from 3,751 in 2007 to 46,565 in 2008. The proportion of births with AMTSL has kept growing throughout the year, from 13% during the first quarter to 26% in the second quarter and 38% in the third. The fact that AMTSL has been made a priority has allowed for a very high achievement rate for this annual planned

objective. Indeed, the achievement rate reaches 582% in comparison with the 2008 objective. The same applies to newborn management. The number of newborns, who received immediate care, has increased from 5,552 in 2007 to 160,122 in 2008. For this 2008 objective, the achievement rate is 213%.

The introduction of AMTSL and ENC has had induced effects on the quality of births management in the facilities. The achievement rate for the objective related to births in the presence of qualified providers reached 160% in the third quarter. With the implementation of the integrated training approach⁹, the providers' involvement in the promotion of assisted delivery in the facilities resulted in a significant increase in that area. The proportion of assisted deliveries increased from 47% in the first quarter to 54% in the second and 77% in the third. This innovative approach has also had induced effects on the implementation of new guidelines for postnatal consultation on Day 3. The achievement rate for postnatal consultation between day 1 and day 3 reached 122% in the third quarter.



Strengthening providers' skills in post abortion care (PAC)

Post abortion care services (PAC) offered were tested and introduced in Senegal in 1997-98 with support from development partners. Since 2000, the program is in an expanding phase and an evaluation of program implementation was conducted by the Population Council with financial support from USAID. One of the evaluation's recommendations was to continue to support the improvement of access and quality of PAC services. USAID supported provider skill strengthening in five PAC regions from 2003-2005. Since this time, new providers have been recruited and assigned to district health centers to ensure the continuity of PAC services at the health center level. IntraHealth supports the MSP through the DSR to reinforce PAC skills including Intrauterine Manual Extraction by qualified providers (midwives and nurses) at newly recruited or affected health centers. Thus it was planned to support the five regions of Thiès, Kaolack, Louga, Ziguinchor and Kolda and train 75 providers in nine training sessions. The first two sessions were held June 16-20 and June 30 – July 4, 2008 respectively in health centers in Mbour and Thiès. Nineteen (19) midwives were trained.

⁹ In order to rationalize the resources and to increase the impact of the training activities, leadership- and responsibility-based training approaches have been integrated as a preliminary step toward AMTSL sessions. This integration helped advocate for the management of births by qualified providers.

Development and dissemination of job aids on the MNCH/FP package

Job aids have been developed and made available to providers in order to remind them of certain procedures that are part of their daily tasks. Thus, a resources package intended for FP providers has been developed and duplicated in **300 copies**.

This package includes:

- A poster “Do you know your family planning options?”
- The checklist “How can you be reasonably sure a client is not pregnant”
- The checklist for clients wanting to start using DMPA¹⁰
- The checklist for clients wanting to start using COC
- The checklist for clients wanting to start using IUD
- The WHO eligibility criteria form
- A practice notebook with checklists¹¹
- The brochure on FP rumors management

A poster on AMTSL and integrated ENC has been developed with the DSR and has been shared with USAID, BASICS Washington and POPPHI. The poster is currently being finalized based on the feedback we received.

A poster on the logistical management of contraceptives has been developed for our supervision missions in the districts’ and RPP’s warehouses.

Other Activities

In 2008, the IntraHealth team actively took part in several dialogue and planning sessions related to the national RH program:

1. To monitoring Roadmap activities aimed at reducing maternal and neonatal morbidity and mortality, IntraHealth supported the DSR in the organization of a RH activity planning workshop for 2008. The workshop was held from February 13-15 in Dakar and participating partners included the MCR, RH coordinators, SSP from Senegal’s 11 medical regions, Health Management, DANSE, DLSI, the PNLP, SNIS, DES, DSSP, partners, the CGO, and CEFOPREP. Each region presented an assessment of RH activities from 2007 and an annual work plan.

Workshop objectives included:

- The Strengthening of RH activity monitoring
- The Strengthening of RH activity coordination in 2008 by ensuring collaboration in activity planning
- Bottleneck identification and proposed solutions

¹⁰ The checklists are the ones produced by FHI

¹¹ These notebooks help monitor the utilization of checklists by providers, each section being numbered.

2. From June to August 2008, IntraHealth participated in the development of the MSP's **Second Decennial Plan 2009-2018**. IntraHealth also participated in an orientation meeting and contributed to the commission's work which took place from June to July 2008. These meetings analyzed the real health status of women, infants, newborns, children and adolescents and mapped intervention progress, evaluated performance, identified bottlenecks and documented lessons learned. The plan's first draft is expected October 30, 2008.
3. IntraHealth provided technical support in the development and implementation of DSR research by the DSR with financial and technical support from the USAID Community Health project. Activities included:
 - « A study of the preventing of post partum hemorrhage in health centers through the administration of Misoprostol". The study's objective is to improve responsibility for childbirth outcomes at the community level. IntraHealth contributed greatly to the study's technical focus which will be rolled out at the health hut level with matrones. A partnership was developed with Abt Associates, CCF, IntraHealth, CEFOREP and the DSR. The protocol was submitted to the ethics committee for approval.
 - IntraHealth participated in various steering committee meetings on the study of matrones offering the pill during training material development and approval. IntraHealth integrated best practices (checklists, injectables grace periods, pill memory aids and pill packs) into the training materials for matrones.
 - IntraHealth contributed to study implementation for community mobilization around PAC. IH supported the choosing of test sites, training material development and the training of trainers.
4. Within the framework of repositioning FP in Senegal, IntraHealth actively participated in the work of the pilot technical committee charged with developing the RAPID model as an advocacy tool for FP promotion.
5. Finally, IntraHealth participated in a reorganization workshop for the national drug monitoring system held in Thiès in June 2008. Drug monitoring is an essential part of the quality assurance system for drugs in Senegal.



Intervention Area 3: Communication and demand creation

The national FP communication plan has been shared and validated by the MSP and its ownership by the MSP is effective. Indeed, we noted a real involvement from the ministerial cabinet, through its communication director, in the national FP campaign's preliminary activities. Moreover, this plan has been shared with the members of the national committee against maternal mortality during a coordination meeting with the MHMP.

The MNCH/FP/MALARIA component has supported the DSR in the development of **a national campaign for the promotion of FP as a lifestyle**. The campaign's brief has been developed and preliminary steps have been initiated with local communication agencies. We have received several proposals for communication tools, including a logo, a tagline, an incentive campaign with TV and radio broadcasts, as well as posters. A documentary film on FP has been produced and, with the Project's support, it has

been aired twice during the National FP Day on RTS at times that could help reach a broader audience and also during the Thiès regional forum. Similarly, this year, two artists have been involved in the campaign: Didier Awadi has participated in two ads against maternal mortality and for the promotion of FP. Pape Diouf provided the campaign with a jingle. In order to emphasize these initiatives, the region of Thiès has held a regional forum on the repositioning of FP during the annual medical consultations organized by the Ministry of Health and Prevention.

The national FP promotion campaign has been launched jointly with the National FP day that was held at the *Méridien Président* Hotel. This event has allowed for a great mobilization of decision-makers and leaders regarding FP. For instance, the MHMP, the parliamentarians, the journalists and the artists that came to the event showed how committed they were in supporting this campaign and the initiatives taken for the repositioning of FP. The ownership of this campaign by the regions is also underway with the launch, in Thiès, of the regional FP promotion campaign. As a result of this initiative, the medical regions have been working on a regional communication plan and are implementing some activities for the repositioning of FP.

At the operational level, the community radio stations are increasingly solicited for the promotion of FP. Testimonies by satisfied users during FP forums have greatly helped raise awareness among the population about FP, especially regarding implants and IUD.

The combination of these different communication approaches, especially the radio shows, the communication sessions and the forums, has helped reach 6 million people during the course of the year. Our biggest challenge will be to maintain communication dynamics that have been expanded to the districts and to encourage the different stakeholders to integrate them.



The development of the **Mother to be Care Package** has started in the Kaolack medical region, which has decided to implement it in addition to the Young Mothers clubs. The contents of the package have been developed in August. Different steps and a methodology have been determined in order to implement 32 Young Mothers Clubs. The dissemination mode of the Mother to be Care Package has also been identified. The next step will be the identification of the most rational and user-friendly tools based on the existing ones.

Intervention Area 4: Strengthening the health system in a decentralized environment

Tangible results have been recorded in the reinforcement of the health system. The support given to medical regions and districts in the active collection of information and the organization of regular data reviews has helped improved the availability of RH data and has allowed for a better monitoring of the RH program's performance in general and the performance indicators of the MNCH/FP/Malaria component. The national health information system has been strengthened through the adoption of a harmonized list of indicators which will help collect harmonized data at the national level. The implementation of the revised management tools and the orientation of ECR/ECD members in the

national health information system remain important steps, which will help the MHMP better meet the current needs in program information.

With the orientation of ECR/ECD members in the supportive supervision schedule, the national activities supervision system has been reenergized. All the regions that have been oriented have proposed a supervision plan for the PSPs, the implementation of which has started in the Louga region. The orientation of providers in the leadership approach has been initiated in all districts and the public performance recognition process has started in a few districts within the Ziguinchor region. The integration of the leadership approach as a transversal approach in the other training sessions has helped strengthen the health system. Because of this approach, advocacy efforts have been made in order to reinforce the sense of responsibility among trained providers.

Strengthening the health information system

Crucial steps have been taken during the year in order to strengthen the health information system. For instance, the Project supported the MSP, mainly the DSR and the National health information system, in the harmonization of the monitoring indicators of the national RH program. The MSP currently has a harmonized list of indicators, which has been adopted and disseminated at the national and regional levels and that will help collect standardized data throughout the country. This document will be used as a benchmark for the monitoring of the RH national program.

The main collection support materials, including registers¹² and activity reports¹³, have been revised in order to integrate the new information needs of the national RH program and, above all, to document the innovative interventions, such as ENC, AMTSL and the assistance of qualified providers during births. These tools have been validated during a national workshop held in Thiès in March 2008. The Project has supported all the districts in providing an initial supply covering a period of six months. These support materials have officially been received by the MHMP on September, 26th 2008. All the ECR/ECD members, including the PHC (primary health care) supervisors, the regional and districts RH coordinators, as well as “master” midwives in health centers and hospitals, have participated in a general training in the health information system and, more specifically, in the filling out of the revised management tools. 157 members of the ECR/ECD have been trained.

The support given to medical regions and districts for the organization of quarterly review meetings regarding RH information and the active collection of data has helped significantly improve the availability and the quality of RH data. These meetings have helped raise awareness among ECR/ECD members on the programmatic importance of data.

The database used to monitor the program’s performance is currently being developed. An Excel database has been developed and its adaptation process on open-source software has been considered for the first quarter of Year 3. This database will be coupled with a map database.

¹² Registers of general consultation, antenatal consultation, child delivery, postnatal consultation, and FP and post abortion care.

¹³ Report on health post's scope of responsibility, Health center report and District report.

Suggestions on the technical aspects of the automatic data exchange system have been made and technical proposals in order to make it operational are currently being considered.

Strengthening the supervision system

The supportive supervision schedule for RH activities has been revised and validated during a workshop held in Thiès in May 2008. This integrated schedule has been adapted in order to better take into consideration the different elements of the MNCH/FP/Malaria package. It also takes into account the various elements of the logistical supervision of contraceptive products and the ones from the health information system. National stakeholders (DSSP, DSR, and CGO) were brought together in order to share their thoughts on supportive supervision. ECR members started to be trained in supportive supervision in the regions of Diourbel, Dakar, Thiès, Louga, Kaolack, Ziguinchor and Fatick. These regions now have a pool of supervisors at their disposal in order to implement supervision visits in the PSPs. These orientation workshops on supportive supervision have been coupled with the dissemination of PNPs. All the regions who have received training have proposed a supervision calendar. The supervision of PSPs has started in the Louga region in the districts of Dahra and Linguère. 59 PSPs have received supportive supervision. It is important to note the entire ownership of this process by the DSR. Indeed, the division of reproductive health ensures the coordination, the monitoring and the technical support to the medical regions in implementing the supervision plan.

In addition to the integrated supportive supervision approach, which started to be operational on the field, the Project has initiated a monitoring plan of innovative approaches (for tutoring, AMTSL and ENC), through the post-training follow-up visits. These visits, after the training in new skills, have been very useful in documenting the different approaches and have helped readjust the interventions based on the lessons learned. However, calendar constraints have prevented the different stakeholder from implementing the follow-up plan for trained providers.

Orientations for Year 3 are as follows: i) make the different levels of supervision operational; ii) make the supervision of PSPs operational; iii) use the results of supportive supervision in programs.

Strengthening leadership and transparency among providers

After the ECR/ECD members had been trained in Year 1, the project continued to encourage providers to assume more responsibility. 25 out of 41 targeted districts have adopted MNCH/FP/Malaria benchmarks and 25 districts have also identified expected levels of performance by providers and/or ECR/ECD members. All districts have started the orientation of providers in leadership. A total of 566 providers have been oriented in this approach. All districts in the regions of Kolda, Ziguinchor and Louga (except Kébémér) have shared roles and responsibilities, as well as desired levels of performance with the different stakeholders. Numerous districts are currently preparing the events devoted to the public recognition of performance and the selection criteria, based on the benchmarks, have been shared in certain areas. In the region of Ziguinchor, the districts of Thionck Essyl and Ziguinchor, which have reached the end of the cycle, have planned the events after the rainy season. Winners have even been announced in some areas.

During Year 3, sharing the benchmarks and the desired levels of performance in the PSPs and among the community will be a priority. The ownership of the process by the DSR and the ECR/ECD will also be one of the challenges to overcome during this period.

Intervention Area 5: Fight against Malaria

During the year, the population's access to quality health care services has been significantly improved.

The institutional support has helped improve the review of information by the revision of the data collecting tools and a better analysis at the operational level. Significant support has been given to the development, the duplication and the implementation of job aids in the area of IPT among pregnant women, the use of rapid diagnostic tests and the management of simple and complicated malaria cases. Similarly, as part of the improvement of the intermittent preventive treatment, all public sector PSPs in Senegal have been supplied with faucet buckets and cups in order to implement DOT.

In order to reinforce the providers' capacities, 1,804 providers (1,019 men and 785 women) have been trained in the monitoring and evaluation of health programs, the biological diagnostic of malaria, as well as the prevention and management of malaria integrating IPT and interpersonal communication.

In 31 districts within the regions of Ziguinchor, Diourbel, Fatick, Kaolack and Thiès, 678,556 long-acting insecticide-treated bed nets have been distributed, free of charge, to children 6-59 months old.

Thirty-three health districts have been supported in the development of integrated ICP advanced strategies at the health huts level in order for the population to have better access to quality health care. These strategies included inoculation, antenatal consultations with IPT and the distribution of discount coupons for long-acting ITN, postnatal consultations and the distribution of pills, injectables and condoms in health centers.

In the area of data management, support has been given to the revision, the duplication and the dissemination of management tools that integrated the latest RH updates.

Support has been given in the area of providers' supervision and a PNLP/IntraHealth joint supervision program targeting districts with low performance levels is currently supported.

In the area of communication, technical support has been given to the PNLP in the development of a communication plan, as well as the design and broadcast of adverts. The medical regions have also been supported in the development and implementation of malaria information and education campaigns aimed at the population.

Here are the main achievements recorded during Year 2 in the area of malaria prevention:

Institutional support to the PNLP

The project has helped reinforce the practicality of coordination, monitoring and planning authorities in the fight against malaria. This support has been materialized through the effective participation of the steering committee in all the meetings, the operations conducted by the sectional cadres and the program's review sessions. This support has also taken shape through the contributions made to the technical committee's activities. This committee revised the data collection tools in order to make them more user-friendly at the operational level. The Project has also supported the PNLP meetings as part of the planning of activities of the P15 and ABCD projects. The Project's contribution has also been focused on the development of strategic documents, such as the strategic plan, the Global Fund's Year 1 assessment report, the development of requests at the Global Fund, the strategic document regarding the introduction of RDT and the flowchart on RDT. IntraHealth has had a proactive role in the activities

of the technical committee. This committee is in charge of the development of the organizational strategy of the long-acting ITNs free distribution campaign and the design of the campaign's management tools. IntraHealth has also supported the program in the development of the pilot study regarding the introduction of the Home Management of Malaria (HMM) and in the training of home health care providers.

Development of job aids

IntraHealth has supported the program by organizing a workshop, in March 2008, aimed at the development of job aids and the revision of training support materials. This workshop helped design and reach a consensus on the following job aids:

- A poster on the management of simple malaria cases
- A poster on the management of serious malaria cases
- A poster on the intermittent preventive treatment of malaria among pregnant women.



Affiches Paludisme 70x85 cm

All posters were developed and approved by USAID and the PNL. Furthermore, ACT (Artemisinin-based combination therapy) information forms for clients have been produced. Similarly, 5,000 prescription books integrating the national guidelines for the management of malaria, as well as messages on malaria prevention intended for providers and clients have been produced. Additionally, a flowchart poster about RDT was designed and the national health information system was supported in the duplication of RH registers and activity reports integrating information from the malaria program.

In order to promote the use of IPT in compliance with norms, 30,000 disposable cups have been ordered for the directly-observable treatment with sulfadoxine-pyrimethamine (SP) along with 1,500 faucet buckets with messages about IPT and water hygiene. These materials have been made available at the PSP level.

Identification of malaria benchmarks

In order to implement the President's Malaria Initiative, orientation sessions in leadership targeting ECR/ECD members have been organized in the regions of Diourbel, Fatick, Matam and Tambacounda. These sessions have helped these regions identify benchmarks¹⁴ in the area of malaria prevention.

Refresher course in Malaria for providers

A national workshop for the development of instructional content in order to train providers in the management of malaria, IPT, the management of stocks and interpersonal communication was held in March and allowed for the development of:

- An interpersonal communication curriculum on malaria management integrating the PNLP's new orientation
- A training manual for laboratory technicians

This training curriculum was tested in the Sédhiou district in April 2008.

The training revolves around a series of approaches: First, the training of the ECR/ECD members in order for them to become trainers and then, the decentralized training of district providers. 271 ECD/ECR members (171 men and 100 women) have been trained in the integrated curriculum on malaria prevention and management and interpersonal communication. 10 training-of-trainers sessions have been conducted in Thiès, Tambacounda, Kaolack, Matam, Fatick, Diourbel, Ziguinchor, Louga and Saint-Louis. The training session that followed has, so far, helped reach **1,470 providers** (814 men and 656 women).

Strengthening diagnostic capacities in the regions

55 laboratory technicians (28 men and 27 women) have been trained in the biological diagnostic of malaria in Thiès (division of anti-parasitic research).

Improving supportive supervision in Malaria-focused PSPs

Between November and December 2007, a PNLP-PMI-IntraHealth joint supervision has been conducted among a sample group of 22 health centers and 44 health posts. The results from the supervision showed: i) the availability of trained providers in the area of malaria and the use of RDT; ii) the adequacy of the commodity procurement system; iii) the availability of RDT; iv) the effective implementation of guidelines regarding the diagnostic and the management of malaria.

The supervision process highlighted the following weaknesses: i) the unavailability and non compliance with the flowchart; ii) ACT and RDT stock outs that were linked to the non compliance with guidelines regarding the logistical management of contraceptives; iii) lack of confidence of some providers in the test's reliability; iv) the bad hygienic conditions during DOT administration; v) the non implementation of DOT; vi) the lack of interpersonal communication regarding IPT and the prescription of ITN during



¹⁴ See document in appendix

antenatal consultations; vii) the insufficient updating of management tools. Moreover, the supervision of laboratories has shown: i) a lack of involvement from the laboratory technicians in the supervision of health posts; ii) the lack of quality control; iii) the lack of support from the workforce in the laboratories.

The Project has supported a monitoring plan for districts encountering difficulties. The supervision visits have been used in order to distribute job aids (flowcharts on RDT, faucet bucket for the IPT).

The supervision visits have also targeted laboratories. 55 laboratory technicians have participated in a post-training follow-up and 38 of them have been given a microscope in addition to commodities needed for the diagnostic of malaria.

Supporting the medical regions in the review of RH/Malaria data

As part of the fight against malaria, support has been given to the medical regions in the organization of quarterly meetings for the review of RH data. These meetings, which started in 7 regions, were extended to four other regions included in the PMI. These sessions, which primarily focused on data management and utilization, have helped strengthen the availability of data and, above all, have shown the interest of providers and ECR/ECD members in using reliable data in programs.



Training of the MSP executives in the monitoring and evaluation of programs

As part of the strengthening of MSP staff capacities in health program monitoring and evaluation, the Project has endorsed the participation of 8 doctors and senior health technicians (six men and two women) in the international monitoring and evaluation course organized by the CESAG between June 16th and July 4th 2008. The participants in this course were district doctors (Nioro, South Dakar, Saint-Louis, Kolda, Sédhiou and North Dakar) and PHC supervisors (Matam district and one PNLN supervisors).

This course helped the participants:

- Identify the importance of the monitoring and evaluation of the programs implementation
- Identify and use the appropriate tools and methods for the collection of data during the monitoring and evaluation process
- Use the data resulting from the monitoring and evaluation process in decision-making
- Develop and/or strengthen a monitoring and evaluation plan
- Develop a monitoring and evaluation plan for a health program

Supporting ICP advanced strategies for health huts

As part of the decentralization program aimed at promoting a better access to services among the population, the districts have been supported in the development of ICP advanced strategies at the level of health huts. These integrated strategies are conducted in collaboration with the CCF. Thus, 321 providers (221 men and 100 women) have been oriented in the implementation of these strategies in

the regions of Louga, Thiès, Kaolack, Ziguinchor, Kolda, Fatick, Matam and Tambacounda. Activities started in Louga, Thiès, Kaolack, Ziguinchor and Kolda.

In August 2008, the regions of Tambacounda, Matam and Fatick started these strategies.

The data that was available during the compilation of the report showed that 33 districts have benefitted from this support. 683 visits have been conducted and helped obtain the following results:

- 22,814 children have been vaccinated
- 6,460 pregnant women have been consulted
- 3,163 IPT doses under DOT have been administered
- 4,714 VAT administered
- 1,583 antenatal consultations conducted
- 2,065 discount coupons for long-acting ITN have been distributed
- 1,475 FP products have been distributed to clients



Development of information kits for providers

In order to improve providers' performance, job aids have been duplicated and disseminated in 11 regions:

- 2,000 RDT flowcharts
- 1,500 job aids for the treatment of severe malaria cases
- 1,500 job aids for the treatment of malaria among pregnant women (IPT)
- 1,500 job aids for the treatment of simple malaria cases
- 1,500 interpersonal communication guides.

Mobilization for the coupled JLS campaign and ITN distribution

IntraHealth supported this activity by providing technical assistance during the development of the campaign and, more specifically, in the design of the national guide for the campaign's organization. IntraHealth helped organize the communication activities and provided financial support for the activities conducted by the various technical commissions. It also took part in the orientation of providers in the regions and the districts, the order of 752,450 free coupons, the duplication of management tools and the supervision and evaluation of the sessions.

For the campaign, IntraHealth oriented providers from the targeted regions. 149 providers (99 men and 50 women) from the ECR/ECD have been oriented in the organization guide for the free distribution of long-acting ITN from May 19th to 26th 2008. In turn, these cadre teams trained the providers from 31 districts involved in the campaign.



This campaign allowed for the distribution of 678,556 long-acting ITN to children 6-59 months old in the 31 targeted districts in the regions of Diourbel, Fatick, Thiès, Ziguinchor and Kaolack.

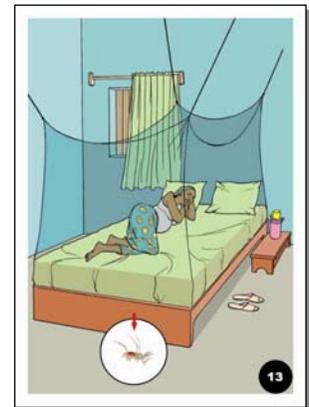
The Project has also supported the implementation of data management system in order to evaluate the campaign.

Results¹⁵ show:

- All the districts have met the pre-set objective of 85% in Vitamin A supplementation for children 6-59 months old and malaria treatment for children 12 to 59 months.
- The overall coverage rate in the five regions targeted by the free distribution of insecticide-treated bed nets and the supplementation of vitamin A among children 6-59 months old reaches **102%** in comparison with **101%** for the treatment of children 12-59 months old.
- The coverage rate of 94.8% is way beyond the objective that was set for the campaign (85%). Four regions (Fatick, Diourbel, Kaolack and Thiès) have overshoot the objective set at 85%. The region of Ziguinchor reached 83.2% and is rather close to the objective

Malaria information campaign

IntraHealth has supported the PNLP in the design and the finalization of a three-year communication strategic plan on malaria and the creation at the central level of TV and radio adverts for the promotion of long-acting ITN, early care seeking and treatment observance. This support has been extended at the decentralized level by helping the medical regions of Matam, Kaolack, Thiès, Diourbel, Fatick and Tambacounda. This helped provide the regions with a communication campaign plan in the fight against malaria and to create adverts using local languages (Puular, Sérère, Wolof, and Mandingue). Moreover, IntraHealth has supported the broadcast of 25 adverts on private television networks (WALF TV, RDV). After the communication plan had been validated with the medical regions, a workshop on the creation of audio-visual material for the campaign was held in June 2008. The costs were shared with the PNLP. During this workshop, three TV adverts were created. They dealt with the following themes: early care seeking, bed nets and treatment observance. In the same context, IntraHealth has provided technical and financial support during the celebration of the World Malaria Day on April 25th in Dagana.



The media coverage of certain activities, such as the training of laboratory technicians, the distribution of laboratory equipment, the PMI's launch in the Matam region and the free distribution of bed nets, was a great opportunity for communication on malaria and the PMI's action.

PMI scale-up in the regions that are not covered by the MNCH/FP component

IntraHealth has supported the Matam region in the organization of the PMI's activities launching event held on June 20th 2008. This event emphasized the extent of community mobilization and brought

¹⁵ See detailed results in appendix.

together all the regional stakeholders. During that event, buckets, microscopes and flowcharts for the management of malaria were given to district doctors by USAID representatives and members of local authorities. The project has also supported the advocacy event among regional leaders in order to promote their involvement in the fight against malaria. The presence of community leaders at this event did not go unnoticed.

IV. Program Implementation Challenges

Principal constraints encountered during activity implementation:

Intervention area 1: Increased access to FP

a) Strengthening the FP package in the private sector

- The lack of involvement from the division of private medicine has delayed the enrollment of enterprises and, above all, the implementation of a consultation framework with the private sector stakeholders.
- The limited availability and reactivity of company managers and private clinic directors has made the enrollment process and the implementation of planned activities throughout the year more difficult.
- The absence of standardized procedures between the public and the private sectors has also been a constraint. It is particularly true regarding the procurement of contraceptives in the private sector and the data collection and transfer system (non integration by the Ministry of Health of data related to the private sector services package in the national health information system). Therefore, it is difficult to document how the private sector actually contributes to the country's health system.
- The private sector is rarely associated with activities organized by the public sector.

b) Strengthening the FP services package in the public sector

- The lack of equipment and technical support materials (Kit for the insertion and removal for IUD and implants) has been a constraint for trained providers in the delivery of quality FP services. The availability of these resources is a prerequisite for the training. Advocacy efforts are currently being made among districts towards the acquisition of equipments and materials from the NPP. Needs have been identified and specific requests have been sent to the NPP so it could integrate them in the next bids.
- It was also difficult to plan and conduct the post-training follow-up visits for trained providers at the district level. This follow-up is crucial in order to help providers better put their newly-acquired skills into practice. Indeed, during the training of counseling trainers, the plan was to conduct a follow-up session of the providers after Day 15, Day 30 and Day 42, but calendar constraints made it impossible for coordinators to comply with the deadlines.
- Insufficient coordination by DSR to purchase contraceptive products by partners other than USAID.
- The lack, sometimes absence, of IEC supports materials in the PPSs.
- The unavailability of management tools and the absence of notification regarding IEC activities (FP counseling and educational dialogues) in the PPSs

- The difficulty of collecting data regarding the use of contraceptives, as the information is not transferred by the PPSs
- The delay in the integration of contraceptives at the NPP level.
- The strong solicitation of cadre teams in some regions has prevented the logistical supervision of NPP and districts warehouses.
- The schedule for planned communication sessions sometimes could not be implemented because of the lack of coordination between the districts.
- The number of sessions for each district (1) is insufficient, when compared with the needs identified by some of them. These districts would actually like to extend the dialogue sessions to all the PPSs.
- The ownership process of the FP communication plan by all stakeholders has been very long and the implementation of the plan is not yet effective in some regions.
- The resources allocated for the promotion of FP are way below what is actually necessary in order to reposition FP.

Intervention area 2: Strengthening the MNCH/FP/Malaria package

a) Implementation of the tutoring approach

- The training curriculum is too long and decreases the amount of time spent on practice.
- Insufficient follow-up training for tutors (lack of coordination and logistics).
- Lack of equipment and materials on sites (sterilizer and kit for the insertion and removal of IUD and Norplant) that could help the providers put their new skills into practice.
- Lack of involvement from district doctors regarding the support to be given to tutors during the implementation of the tutoring approach.
- Long time period between tutor training and the launch of onsite provider training.

b) Implementation of AMTSL and ENC

- Lack of equipments and materials for newborn management and for practicing newly acquired skills.
- Lack of AMTSL implementation by some providers who do not like to assist deliveries and, therefore, transfer the knowledge they acquired to “matrones” (auxiliary midwives) in some PPSs.
- Lack of systematic notification of AMTSL data and immediate newborn care in some districts
- Uterine rupture.
- Poor execution of newborn resuscitation by some trained providers.
- Difficulties in planning the post-training follow-up visits because of a busy calendar. Therefore, some providers have had to wait several months after the usual deadlines for their follow-up.

Intervention area 3: MNCH/FP services promotion and behavior change communication

- The FP communication plan's ownership process by all stakeholders has been very long.
- The resources allocated for the promotion of FP are low in comparison with the needs identified in the area of communication.
- The job aids' development process and the validation of these support materials have taken a long time.
- The development of the Future Mother Package has been delayed.



Intervention area 4: Strengthening the health system in a decentralized environment

a) Health information system

- The lack of funds allocated for the Monitoring and Evaluation component has been a major constraint in the implementation of the information system improvement plan, especially in the areas of active data collection and the periodic review of RH information.
- ICPs are still encountering difficulties in submitting their reports to the districts.
- The implementation of the revised management tools (registers and activity reports) has been delayed, as the validation process lasted longer than expected.
- The providers' training in GIS is insufficient.
- There is a need for stronger advocacy in order to strengthen the health information system.

b) Supervision

- The finalization and validation process of the supportive supervision schedule has been delayed because of a lack of coordination in people's availability.
- The supervision of PSPs has started later than expected because of the constraints mentioned above.

c) Leadership

- The funds allocated to the strategy's implementation remain insufficient. Therefore, the number of leadership training and follow-up sessions intended for providers in health districts cannot be increased.
- The ECD/ECR members' work overload has been a major constraint in meeting the deadlines set for the implementation of the leadership approach.
- The strategy's ownership by the MHMP still has to be improved.

Intervention area 5: Fight against Malaria (PMI)

Despite noticeable program achievements, various constraints were noted in the following areas:

- Institutional support to the PNL

- Delays in procuring registers, buckets, posters and management tools due to the drawn out negotiation process. Delays also occurred during revisions to the PNLN manual.
- Support of ICP advanced strategies in health huts.
- Principal constraints noted in the program strategy implementation were related to the delay in activities, absence of a program targeting certain health huts and the weak coordination/communication between various actors at the operational level
- Provider and laboratory technician training
- Calendar constraints led to training participants not being able to complete all of training activities or supervisions (several simultaneous activities were planned in the medical regions)
- Operational level supervision of providers was not regularly carried out
- Lack of agreement about per diem rates used by various partners led to a boycott of certain training sessions
- Delay in the delivery of the second batch of microscopes
- Free distribution of ITNs
- Insufficiency in IEC activity implementation by relays
- The CRD and CDD were not held in certain regions and districts
- Activity coordination at the operational level was not effective : daily supervision debriefing meetings were not always held at the regional and district levels
- Late MILDA implementation and an insufficiency of materials
- The time chosen for the JLS was not used due to the overlap with the rainy season and other conflicting activities at the health district level
- Weak involvement of local communities

V. Lessons learned from the program's implementation

Intervention area 1: Increased access to FP

- The private sector is willing to be integrated in health care delivery at the national level.
- The need to establish a partnership with the private sector and the different divisions and departments within the Ministry of Health is crucial in the effective integration of the private sector in the national health system and in the ownership of health policies by stakeholders from the private sector.
- Maintaining personal contacts with the main stakeholders within the private sector allows for a better implementation of action plans.
- The reinforcement of technical competencies and the improvement of ICP skills in FP counseling helps health posts play a crucial role in meeting FP objectives (as they are the most accessible structures for the population).
- The availability of IEC materials is a prerequisite to quality counseling sessions.
- FP counseling is a fundamental element in quality FP services and the strengthening of PPSs capacity to offer this service can contribute significantly to the increase in FP coverage.
- An effective counseling session helps a client understand the choices she has to make.
- The communication session is an effective channel for upfront dialogue between providers and clients regarding the quality of services.
- The involvement of ECD and ECR in the implementation of Siggil Jigéen's activities is crucial in order to meet the objectives included in the health program.

Intervention area 2: Strengthening the MNCH/FP service package

a) Implementation of the tutoring approach

- The revision of the training curriculum is essential in order to ensure a longer practical training.
- The availability of materials and equipments is crucial in order for providers to put their skills into practice right after the training sessions.
- The right supply in consumables in the sites hosting the internship helps create optimal conditions for practical training.
- The development of a joint work plan between the tutor and his/her supervisor improves the monitoring and evaluation of the tutoring approach.
- The involvement of the community from the very first stages of the process is necessary.
- The implication of district doctors in order to ensure the continuity of services during the absence of the tutors should be considered.
- The districts' financial support, particularly for health committees, is crucial in order to ensure the transportation of tutors from their workplace to the training sites, as well as the

smooth running and planning of on-site meetings. The implementation of the strategy becomes easier when these factors are taken into account.

b) AMTSL implementation

- The providers' orientation in the leadership and responsibility approach strategy before the AMTSL training sessions improves AMTSL implementation.
- The availability of basic resources for the implementation of AMTSL and essential newborn care before the beginning of the sessions is crucial in order to ensure that the training session will be effective.
- The involvement of local trainers helps strengthen the ownership of the approach at the local level and the follow-up of trained providers.
- The implementation of AMTSL and ENC has made it possible to strengthen the integration of the different programs and the RH services: Pregnancy surveillance and delivery plan (ANC), Prevention of Mother-To-Child transmission of HIV (PMTCT), post natal consultation (including FP, maternal breastfeeding, malaria prevention (MII) and inoculations).
- Introduction of AMTS permitted the improvement of service quality and in particular qualified assistance in birth and essential newborn care.

Intervention area 3: MNCH/FP services promotion and behavior change communication

- Collaboration with DANSE is necessary in order to validate the job aids.

Intervention area 4: Strengthening the health system in a decentralized environment

a) Health information system

- The RH data review meetings help reinforce the utilization of data in the monitoring of activities and improve the availability of RH information.
- The active collection of data remains crucial in order to ensure the completeness of reports.

b) Leadership

- It is vital to maintain the institutional collaboration with the MHMP in order to facilitate the adoption process by the DSR.
- The regular monitoring of ECR/ECD is necessary in order for the strategy's implementation to be effective.

Intervention area 5: Fight against malaria (PMI)

- Supervision allows for the strengthening of provider training and helps them to meet their goals.
- The coupled training of laboratory technicians and distribution of microscopes has been a greatly appreciated incentive.
- The series of training approach and the utilization of regional offices in the scheduling of activities have helped providers make progress during the sessions.

- The joint scheduling with the PNLN is a major asset in the implementation of the program and it should be maintained.
- The technical support provided by USAID/CDC in all activities has been appreciated and has helped implement the activities by creating a positive atmosphere through communication and mutual understanding.
- The joint supervision with the PNLN emphasized the relevance of the providers' training and the need to support job aids.
- The partnership between IntraHealth/UCAD/SLAP/ENDSS has helped improve the quality of the providers' training sessions. The initiative and the optimal working conditions were greatly appreciated. The Thiès' regional office has also been a great help in the area of logistical management.

VI. Year 3 Perspectives and Directions

Intervention area 1: Increased access to FP

- **Keep on strengthening the providers' skills in counseling and contraceptive technology:** 795 providers should be trained in these areas. This intervention will take place in 7 regions supported by USAID, especially Dakar (20% of Senegal's population). Emphasis will be put on long-acting and permanent methods (IUD, implants and tubal ligation).
- **Maintain efforts in securing the contraceptives and RH products procurement chain:** IntraHealth will keep on supporting the DSR in the management of contraceptive commodities and RH products through the yearly and half yearly review of the CPTS, the procurement of medical regions, as well as the supervision of RPP and district warehouses. During Year 3, special focus will be put on the effective integration of contraceptives in NPP and the implementation of a strategic plan in order to secure the procurement of RH products (SPSR).
- **Strengthening advocacy efforts for sustainable FP services** by supporting Siggil Jigéen's activities through the dissemination of advocacy tools (RAPID model, religious arguments), intensifying communication sessions at the district level and by advocating for FP during radio shows.
- **FP promotion:** Maintaining the national FP campaign, particularly through the implementation of regional communication plans, the production and the dissemination of media campaign tools and the organization of regional FP events.
- **Integration of adolescent reproductive health in schools:** In collaboration with the DSR and Siggil Jigéen, the Project will support the MHMP's School health control division (DCMS). The intervention in schools will include advocacy activities in order to integrate RH in the schools' curricula. Teachers' and providers' skills in School health centers will be strengthened.

Intervention area 2: Strengthening the MNCH/FP package

a) **Institutional support to the MSPM in:**

- The dissemination of PNP documents
- The reinforcement of providers' skills in the management of FGC
- The prevention and management of fistula
- The coordination, the planning, the monitoring and evaluation of RH activities

b) **Effective implementation of the tutoring approach:** monitoring and documentation of the approach in 68 PSP (42 health centers and 26 health posts) selected according to well-defined criteria. 450 providers will be trained with this on-site training approach.

c) **Strengthening providers' skills in PAC and AMTSL:** 65 providers will be trained in PAC and 22 will be trained in AMTSL and ENC.

d) **Strengthening nutrition services** through a subcontract with Helen Keller International. Training and communication tools will be developed in order to integrate nutrition in the MNCH/FP/Malaria package.

- e) **Development of job aids:** job aids will be developed or duplicated during the year in order to implement the MNCH package. They will include display stands for contraceptives to be used during FP counseling sessions, posters about newborn management, ISBC, the leadership and responsibility approach and logistics. A job aid intended for providers regarding mother/child management will be created along with a provider's guide for the logistical management of contraceptives.

Intervention area 3: Communication and Demand Creation

Future orientations will include:

- The implementation of the Mother to be care package in the PSPs. It will be implemented by providers working in health centers and health posts among women of reproductive age (Nioro, Ndoffane, Sédhiou and Vélingara).
- The further implementation and running of the Young Mothers clubs.

Intervention area 4: Strengthening the health system in a decentralized environment

During Year 3, the Project will work in close collaboration with the SNIS, the DSR and the PNL to ensure that the different levels of supervision are operational and that information is available for the data collection and review process. The Project will specifically support:

The reinforcement of the health information system through:

- Providers' training in the health information system and the filling-out of management tools in the regions and districts
- Technical and financial support given to integrated quarterly data review meetings, which create an appropriate information exchange framework in order to monitor the programs' performance in the regions. These meetings will provide a great opportunity to promote data utilization in programs by ECR/ECD.
- Regular supervision sessions and data audits to ensure a better management and quality of health information.
- Punctual financial support for the active collection of data in the "silent" zones within districts to ensure the completeness of the transferred data
- Regular monitoring of data transfer between the different levels of the health system through decentralized regional offices
- The creation of a data exchange system.

Strengthening supervision in order to improve the quality of services:

- Keep on orienting ECR/ECD in supportive supervision in order to make a pool of supervisor available at the regional and district level and supervise PSP providers on a regular basis.
- Supervision of medical regions by the central level. Districts will then be supervised by the medical regions. Health posts will finally be supervised by districts.
- Organization of half-yearly supportive supervision sessions in districts

- Creation of a database aimed at supervising and promoting data utilization during the performance monitoring process.

Strengthening the leadership and responsibility approach:

- Strengthening the ownership of the approach by the MHMP (DSR, quality program) by planning activities in a concerted manner, as well as the implementation and the monitoring of the strategy
- Monitoring, consolidation and implementation of the leadership approach in regions and districts
- Monitoring of benchmarks and the providers' expected level of performance
- Technical support in the performance recognition process by the districts and the medical regions in order to assess performance levels and rankings and to organize events.

Supporting the decentralized management system through:

- Technical support during decentralized planning and coordination meetings (Medical regions, districts, DSR)
- Participation of the different component managers and regional coordinators in these planning and management meetings

Integrate gender dimensions in the RH services package through the following activities:

- Maintaining the pilot experiment of gender integration in RH services in the region of Ziguinchor
- Sharing lessons learned from this experience with the MHMP

Intervention area 5: Fight against malaria (PMI)

Providers' and technicians' training

- Orientate cadre teams and train Dakar providers in malaria management and interpersonal communication
- Ensure the post-training follow-up on a sample of districts, in which providers have already been trained in malaria management
- Set up the new microscopes
- Finalize the last training session for laboratory technicians and plan a post-training follow-up visits
- Train biologists in different regions in order to have a pool of experts available for the microscopy quality control
- Finalize the decentralized training sessions in malaria management and interpersonal communication in Louga, Saint-Louis and Kolda
- Provide technical and financial support in the regular supportive supervision of providers in order to improve the quality of services.

Free distribution of ITN

- Develop a plan for the redeployment of the remaining ITNs

- Harmonize the coverage objective: “at least 85%” for Vitamin A supplementation, malaria treatment and ITN distribution
- Prepare for the JLS that will take place in December 2008
- Conduct an investigation regarding the coverage in Vitamin A supplementation, malaria treatment and ITN distribution
- Support the PNLP and DANSE in the organization of a free ITN distribution campaign planned in 2009.

Supporting the ICP advanced strategies at the health huts level

- Scale up the supporting program for advanced strategies, except in the Dakar region
- Make the coordination with other implementation agency more efficient (CCF, Net Mark)

Malaria communication campaign

- Increase and intensify communications efforts through the media by developing a communication package with community radio stations
- Support the medical regions of Dakar, Saint Louis, Louga, Kolda and Ziguinchor so that they adopt a regional communication plan.

Annex 1: Indicator Progress

Indicators		Target			Result	Year 2						Total Year 1 & 2	% Result Year 1 & 2
		Year 1	Year 2	Year 1 & 2	Year 1	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Result Year 2	% Year 2		
IR 12.1	Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USAID-supported programs	5000	8000	13 000	3 751	7 679	10 385	14515	15367	47 946	599%	51 697	398%
	Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs	7000	2000	9 000	1 349	1 078	1 826	2961	4726	10 591	530%	11 940	133%
Sub IR 12.1.1	Number of people trained in maternal/newborn health through USAID-supported programs	500	600	1 100	616	38	236	785	1290	2349	392%	2965	270%
IR 12.2	Number of newborns receiving essential newborn care through USAID-supported programs	20000	75000	95 000	5 552	45 109	39 517	39199	37709	161 534	215%	167 086	176%
	Number of postpartum/newborn visits within three days of birth in USAID-assisted programs		60783	60 783		8 662	17 865	23862	23477	73 866	122%	73 866	122%
IR 12.2	Number of antenatal care visits by skilled providers from USAID-assisted facilities	100000	200000	300 000	293 743	161 193	153 460	195126	175429	685 208	343%	978 951	326%
IR 12.2	Number of deliveries with a skilled birth attendant (SBA) in USAID-assisted programs	70000	75000	145 000	72 874	26 428	26 360	35624	32863	121 275	162%	194 149	134%

Indicators		Target			Result	Year 2						Total Year 1 & 2	% Result Year 1 & 2
		Year 1	Year 2	Year 1 & 2	Year 1	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Result Year 2	% Year 2		
Sub IR 12.1	Number of monitoring plans	1	1	1	1	1	1	1	1	1	100%	2	200%
IR 12.1	Number of new approaches successfully introduced through USAID-supported programs	5	6	6	4	5	5	6	6	6	100%	10	167%
Sub IR 12.1.1	Number of people trained in FP/RH with USAID funds	100	400	500	132	121	297	113	49	580	145%	712	142%
	Number of people trained in other strategic information management	50	25	75	0	0	44	68	157	269	1076%	269	359%
Sub IR 12.1.2	USG-assisted facilities' provider staff with a written performance appraisal	50	75	125	28	62	190	314	0	566	755%	594	475%
IR 12.2	Couple Years of Protection (CYP) in USG-supported programs	69000	195414	264414	177649	25700	37351	37593	33401	134 046	69%	311 695	118%
Sub IR 12.2.1	Number of counseling visits for Family Planning/Reproductive Health as a result of USAID assistance	300000	150000	450 000	112 352	218 441	226 879	288191	251921	985 432	657%	1097784	244%
Sub IR 12.2.1	Number of people that have seen or heard a specific USAID-supported FP/RH message	1500000	2000000	3 500 000	0	1 364 526	2 604 481	1721767	932355	6 623 129	331%	6623129	189%
Sub IR 12.2.1	Number of USAID program interventions providing services, counseling, and/or community-based awareness activities intended to respond to and/or reduce rates of gender-based	1	1	1	1	1	1	1	1	1	100%	2	200%

Indicators		Target			Result	Year 2						Total Year 1 & 2	% Result Year 1 & 2
		Year 1	Year 2	Year 1 & 2	Year 1	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Result Year 2	% Year 2		
	violence												
Sub IR 12.2.2	Number of USAID-assisted service delivery points providing Family Planning counseling or services	710	710	710	639	710	710	710	710	710	100%	1349	190%
	Number of people trained in monitoring and evaluation		10	10	0	0	0	8	8	8	80%	8	80%
	Number of people trained in malaria treatment or prevention with USG funds		960	960	0	38	44	585	1182	1849	193%	1849	193%

Annex 2: Explanation of Results

- a. **IR 12.1 Number of women receiving AMSTL through USAID-supported programs:** l'objectif fixé pour l'année 2 du projet était de 8000 accouchements sous GATPA. Les résultats enregistrés au cours de la période indiquent une évolution régulière de la couverture des accouchements à voie basse par la technique de la GATPA. De 7679 au 1^{er} trimestre, le nombre d'accouchements réalisés sous GATPA est passé à 10385 au 2nd trimestre, à 14 515 au 3^{ème} trimestre et à 15367 au 4^{ème} trimestre, ce qui donne un nombre total d'accouchement de 47 946 accouchements réalisés sous GATPA. Ainsi, le taux de réalisation par rapport à l'objectif initial reste très largement atteint. Celui-ci est de 599% pour l'an 2 et à 398% si l'on se réfère aux objectifs cumulés pour les 2 ns du projet. On observe par ailleurs que la part des accouchements réalisés sous GATPA par rapport aux accouchements réalisés dans la structure ne cesse d'augmenter ; ce pourcentage est passé de 29 % au premier trimestre à près de 41% au troisième trimestre. L'accélération des sessions de formation au cours de l'année (**504 prestataires** ont été formés), une amélioration de la collecte des données et l'adhésion des prestataires à cette technique ont contribué à l'atteinte de ces résultats qui indiquent une bonne application des acquis de la formation sur le terrain. Les visites de suivi post formation confirment de la bonne pratique de cette technique. Toutefois, l'insuffisance du matériel pour le nouveau-né constitue une contrainte réelle à la quelle une solution devra être trouvée. Compte tenu des résultats très satisfaisants réalisés, les objectifs de l'an 2 devront être réajustés. En effet, les objectifs fixés pour de l'an 2 étaient moins ambitieux du fait que c'était une approche innovatrice et la prudence avait guidé l'équipe dans l'exercice de planification.
- b. **IR 12.1 Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs:** le nombre de nouveau-nés infectés ayant bénéficié d'un traitement antibiotique a sensiblement augmenté; on observe un taux de réalisation de 133 % par rapport à l'objectif cumulé pour l'an 1 et l'an 2. L'observation correcte des procédures de prise en charge du nouveau-né malade et l'amélioration de notification des cas de nouveau-nés infectés pris en charge pourraient expliquer ces résultats.
- c. **IR 12.1.1 Number of people trained in maternal/newborn health through USAID programs (Project Monitoring):** on a noté une nette accélération du rythme des formations au cours de l'année, notamment entre le troisième et quatrième trimestre: 2349 prestataires ou membres d'équipe cadre ont eu à bénéficier d'une formation dans le domaine de la santé maternelle incluant la formation sur la GATPA, le tutorat, les SAA, la prise en charge du paludisme. Le taux de réalisation des activités de formation est actuellement de 392% si l'on se réfère aux objectifs ciblés pour l'an 2 du projet.
- d. **Number of newborns receiving essential newborn care through USAID- supported programs:** on observe également que le nombre de nouveau-né ayant bénéficié des soins essentiels de base (ou soins immédiats composés des trois composantes: soins du cordon, maintien de la température et mise au sein précoce) demeure important; le taux de réalisation de l'objectif est actuellement de 215%. Si l'on prend comme base les accouchements réalisés dans la structure, on observe que près de 85% des femmes qui accouchent au niveau des structures ont eu leur enfant qui a reçu les soins essentiels de base. L'intégration de la GATPA et des soins essentiels du nouveau-né dans la formation des prestataires a eu un effet positif sur l'application des procédures. On observe une bonne intégration de la GATPA et des soins essentiels du nouveau-né.
- e. **IR 12.2 Number of postpartum/newborn visits within 3 days of birth in USAID-aided programs:** le nombre de consultations postnatales réalisées durant les 3 premiers jours qui suivent l'accouchement a également évolué passant de 8 662 au 1er trimestre à **23.477** au 4ème

trimestre. On note actuellement un taux de réalisation de 122% de l'objectif ciblé. Le pourcentage d'accouchement réalisé dans la structure et ayant bénéficié de la consultation postnatale à j3 est passé de 15, 4% au 1^{er} trimestre à 36,5% au 2nd trimestre et à 51, 7% au troisième trimestre. Ceci indique un bon suivi des directives qui recommandent que le couple mère-enfant bénéficie au moins de la première consultation postnatale avant leur sortie de la maternité.

- f. **IR 12.2 Number of antenatal care visits by skilled providers in USAID-assisted facilities:** comme pour les accouchements et la consultation postnatale, on note une nette augmentation du nombre de CPN réalisé par un personnel qualifié; le niveau de réalisation de l'objectif est très largement dépassé (343%).
- g. **IR 12.2 Number of deliveries by a skilled birth attendant in USAID-assisted programs:** le nombre d'accouchement réalisé par un personnel qualifié demeure également important au regard des objectifs. Le taux de réalisation de l'objectif est de 162%. La part des accouchements réalisés par un personnel qualifié dans le total des accouchements réalisés dans la structure est passée de 46,9% au 1^{er} trimestre à 53,9% au 2nd trimestre et à 77,2% au 3^{ème} trimestre. L'introduction de la GATPA et l'intégration du leadership dans les formations cliniques sur la GATPA a renforcé la conscientisation des prestataires sur leur responsabilité dans la prise en charge des accouchements au niveau des structures, tâche qu'ils délaissaient aux matrones auparavant.
- h. **IR 12.2 Number of monitoring plans (Project Monitoring) :** le plan de monitoring a été développé et un plan de mise en œuvre du PMP de l'An 2 a été proposé.
- i. **Number of new approaches successfully introduced through USAID-supported programs:** les 6 approches proposées sont en cours d'expérimentation: il s'agit du leadership, du tutorat, de l'approche de formation basée sur la performance, du genre; des best pratiques en matière de PF, de la GATPA et des Soins essentiels du nouveau-né.
- j. **Sub IR 12.1.1 Number of people trained in FP/RH with USAID funds:** le niveau de réalisation de l'indicateur est largement atteint. Sur un objectif cumulé de 500 prestataires à former, le taux actuel de réalisation est de 145%. 580 prestataires ont été formés dans le domaine de la PF à ce jour.
- k. **IR 12.1.1 Number of people trained in other strategic information management:** dans le cadre des réunions de revue des données SR, les membres des ECR/ECD ont bénéficié de séances d'orientation sur la gestion des données (analyse et utilisation des données). Quatre séries de réunions trimestrielles regroupant les coordinatrices SR, les SSP et parfois les MCD ont été organisés dans les régions d'intervention. Au cours du quatrième trimestre, **157 prestataires** et membres des ECR/ECD ont été orientés sur le SIG et sur le remplissage des outils de gestion révisés.
- l. **IR 12.1.2 USG-assisted facilities' provider staff with a written performance appraisal:** au Niveau des 7 régions d'intervention les étapes 1 et 2 du cycle de responsabilisation ont été bouclées ; il s'agit de la définition des rôles et responsabilités et des performances attendues. A ce jour, les ateliers d'orientation des prestataires sur le cycle de responsabilisation ont permis de toucher 566 prestataires qui ont vu leur performance désirée définie. L'étape prochaine consistera à afficher ces performances au niveau des structures en vue d'une large diffusion au niveau de la communauté.
- m. **IR 12.2 Couple Years of Protection (CYP) in USG-supported programs:** le taux de réalisation de cet objectif demeure bas si l'on se réfère à l'objectif de l'an 2. le niveau de réalisation est de 69% même si l'on observe un taux de réalisation de 118% par rapport à l'objectif cumulé. En effet, au cours de l'an 2, la collecte des données pour documenter cet indicateur s'est référé au RTS (Registre Trimestriel de Stock) des PPS au lieu des RTS des dépôts des districts qui ne reflètent

pas le niveau de consommation réelle des produits PF. Les directives formulées indiquent qu'il faut désormais documenter cet indicateur à partir des RTS des PPS qui reflètent la consommation réelle des produits au niveau des structures.

- n. **Sub IR 12.2.1 Number of counseling visits for family planning/reproductive health as a result of USAID assistance** : cet indicateur intègre, entre autres, le nombre de nouvelles acceptantes de la PF, le nombre de clients CPN ayant bénéficié d'un counseling avant la proposition de test du VIH. Le taux de réalisation demeurent très en deçà de l'objectif fixé.
- o. **Sub IR 12.2.1 Number of people that have seen or heard a specific USAID-supported FP/RH message**: les activités du Réseau Siggil Jigéen à travers les sessions de dialogue, les foras et les émissions radios ont commencé à s'intensifier sur le terrain. De même le lancement de la campagne PF a été en fort moment de communication. Pour la documentation de cet indicateur, la dernière étude media a été acquise.
- p. **Sub IR 12.2.1 Number of USAID program interventions providing services, counseling, and/or community-based awareness activities intended to respond to and/or reduce rates of gender-based violence** : l'introduction de l'approche est en cours et est intégrée dans la formation des tuteurs. Les prestataires de la région de Ziguinchor ont été orientés.
- q. **Sub IR 12.2.2 Number of USAID-assisted service delivery points providing Family Planning counseling or services** : même si théoriquement tous les PPS sont censés fournir le paquet minimum de services SR le challenge réside dans l'amélioration de la qualité des services et dans le repositionnement de la PF au niveau opérationnel,.
- r. **Number of people trained in monitoring and evaluation of PMI** : huit agents du MSP ont bénéficié d'un cours sur le suivi et l'évaluation des programmes au CESAG
- s. **Number of people trained in malaria treatment or prevention with USG funds (PMI)**: 1849 prestataires ou membres des ECR/ECD ont été formés dans le domaine du traitement ou du diagnostic du paludisme. Le taux de réalisation de l'objectif est de 193%.

Annex 3: Financial Report

No.	Budget Categories	Current Budget	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Cumulative Total	Cumulative Total from start	Budget Remainder
1.2	Strengthen provider FP skills	91,000	1,100	10,194	29,313	34,063	61,687	63,376	27,624
1.3	Support FP services through SJ support	13,000	0	0	3,728	775	9,272	4,503	8,497
1.4	FP Promotion	7,500	0	0	64	21,690	7,436	21,754	-14,254
1.5	Secure the supply chain	27,600	0	14,225	3,991	13,021	23,609	17,012	10,588
1	Increased Access to FP	164,350	1,100	25,810	43,502	76,692	120,848	120,194	44,156
2.1	Institutional Support to the DSR	11,000	1,082	181	0	13,742	11,000	13,742	-2,742
2.2	Strengthening and Development of integrated MNCH services	107,000	68	20,593	41,782	7,258	65,218	49,039	57,961
2.3	Strengthen provider skills in AMTSL and ENC	37,000	0	33,141	31,929	59,691	5,071	91,620	-54,620
2.4	Develop job aids for the MNCH services package	37,000	0	390	5,019	9,816	31,981	14,835	22,165
2	Strengthen MNCH Services Package	192,000	1,150	54,305	78,730	90,507	113,270	169,237	22,763
3.1	Promote/Implement Mother to be care package	24,000	0	12,938	0	178	24,000	178	23,822
3.2	MNCH promotion in PPSs	12,000	0	0	0	0	12,000	0	12,000
3	Promote MNCH/FP services and Behavior Change Communication	36,000	0	12,938	0	178	36,000	178	35,822
4.1	Strengthen the information system	39,463	0	2,927	4,720	12,162	34,743	16,883	22,581

No.	Budget Categories	Current Budget	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Cumulative Total	Cumulative Total from start	Budget Remainder
4.2	Strengthen supervision system	40,500	0	0	7,764	21,724	32,736	29,488	11,012
4.3	Strengthen leadership and accountability among providers	38,200	1,327	8,345	14,955	11,718	23,245	26,673	11,527
4.4	Strengthen management in a decentralized system	7,500	155	2,257	2,426	0	5,074	2,426	5,074
4	Strengthen Health System in a decentralized environment	125,663	1,483	13,529	29,866	45,604	95,797	75,470	50,193
5.1	Increase access to quality services and information to treat and prevent cases of malaria	741,170	467	64,815	231,140	266,091	510,030	497,231	243,939
5.2	Increase provider and client knowledge in the treatment of malaria	490,330	6,359	6,607	58,707	188,500	431,623	247,207	243,123
5	Fight Against Malaria	1,231,500	6,827	71,423	289,847	454,591	941,653	744,438	487,062
6.1	Strengthen Staff Performance	2,000	0	0	0	0	2,000	0	2,000
6.2	Strengthen USAF performance	0	0	0	0	0	0	0	0
6.3	Set up a performance management system	0	0	0	0	0	0	0	0
6.4	Strengthen the internal communication and collaboration in the office	3,000	5,083	1,194	6,750	4,320	-3,750	11,069	-8,069
6.5	Strengthen external communications and collaborations	25,000	0	795	0	3,622	25,000	3,622	21,378
6	Program Management	30,000	5,083	1,989	6,750	7,941	23,250	14,691	15,309
7.1	Salaries	962,647	378,963	364,042	254,004	329,664	708,643	583,668	378,979

No.	Budget Categories	Current Budget	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Cumulative Total	Cumulative Total from start	Budget Remainder
7.2	Fringe Benefits/Leave	203,586	21,262	18,600	0	19,013	203,586	19,013	184,573
7.3	Allowances	42,837	17,311	27,736	16,326	42,491	26,511	58,817	-15,980
7.4	Consultants fees	19,726	4,500	5,697	0	0	19,726	0	19,726
7.5	Travel Transport & perdiem	216,060	58,571	64,563	1,778	75,301	214,282	77,079	138,981
7.6	Other direct costs	-67,727	111,183	-2,195	44,947	16,257	-112,674	61,204	-128,931
7.7	Equipment	243,876	68,349	0	95,517	0	148,359	95,517	148,359
7.8	Supplies	0	0	0	8,027	0	-8,027	8,027	-8,027
7	Other Direct Costs	1,621,005	660,139	478,443	420,600	482,726	1,200,405	903,326	717,679
8	Costs shared with Regional Offices	0	0	0	33,366	19,321	-33,366	52,687	-52,687
9.1	Siggil Jigeen	105,507	3,424	71,915	102,042	71,701	3,465	173,743	-68,236
9.2	Population Council	342,935	146,883	0	58,938	173,478	283,997	232,416	110,519
9.3	Not Yet Obligated	740,350	0	0	0	0	740,350	0	740,350
9	Subgrants	1,188,792	150,307	71,915	160,980	245,178	3,465	173,743	1,015,049
10	Indirect Costs	1,131,661	224,992	204,116	308,065	370,147	283,997	232,416	899,245
TOTAL		5,720,971	1,051,081	934,467	1,063,641	1,422,737	2,501,322	2,253,962	2,335,348

