

**PROSAF Transition Phase
Final Report**

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PERFORMANCE MONITORING PLAN

ACRONYM LIST

BCC	Behavior Change Communication
CAME	Essential Drug Purchasing Center
CBS	Community-Based Services
CBSA	Community-Based Services Agent
CHD	<i>Centre Hospitalier Départemental</i> (Departmental Hospital Center)
COGEA	<i>Comité de Gestion de l'Arrondissement</i> (Arrondissement Management Committee)
COGEC	<i>Comité de Gestion de la Commune</i> (Commune Management Committee)
COGES	Sub-Prefecture Health Management Committee
CSA	<i>Centre de Santé de l'Arrondissement</i> (Arrondissement Health Center)
CSC	<i>Centre de Santé de Commune</i> (Commune Health Center)
CVS	<i>Comité Villageois de Santé</i> (Village Health Committee)
DDSP	<i>Directeur Départemental de la Santé Publique</i> (Departmental Public Health Director)
ENIAB	<i>Ecole Nationale des Infirmiers and Infirmières du Bénin</i> (Benin National School of Nursing)
EONC	Emergency Obstetrical and Neonatal Care
ERPA	Rapid Health Worker Performance Assessment
FH	Family Health
FHS	Family Health Services
FHT	Family Health Team
HZ	Health Zone
HZMT	<i>Equipe d'Encadrement des Zones Sanitaires</i> (Health Zone Management Team)
IEC	Information, Education, Communication
IGA	Income generating activities
IMCI	Integrated Management of Childhood Illness
IOS	Integrated Offer of Services
KAP	Knowledge Attitudes and Practices
MCDI	Medical Care Development International
MCDZS	<i>Médecins Coordonateurs des Zones Sanitaires</i> (Health Zone Coordinating Physicians)
MOH	Ministry of Health
NGO	Non-Governmental Organization
OIS	<i>Offre intégrée des services de santé familiale</i> (Delivery of Integrated Family Health Services)
ORTB	<i>Office de Radiodiffusion and Télécommunications du Bénin</i> (Benin Radio Broadcasting and Telecommunications Bureau)
PMP	Performance Monitoring Plan
PNC	Prenatal Consultation
PROSAF	<i>Programme de Promotion Intégrée de Santé Familiale dans le Borgou and Alibori</i> (Benin Integrated Family Health Program)
PSS	<i>Projet Santé Suisse</i> (Swiss Health Project)
QA	Quality Assurance
SEPD	<i>Service d'Etude, Planification and Documentation</i> (Research, Planning and Documentation Service)
SM/BCC	Social Mobilization/Behavior Change Communication
SNIGS	<i>Système National d'Information d Gestion Sanitaire</i> (National System of Health Information and Management)
URC	University Research Co, LLC
USAID	United States Agency for International Development
VHC	Village Health Committee

1 INTRODUCTION

The mission of the Benin Integrated Family Health Program in the Borgou/Alibori (PROSAF) Transition Phase was to strengthen the accomplishments of the first five-year phase of the project, and to help make the key processes and the use of certain tools sustainable. The project developed a strategy to transfer skills and responsibilities to the health authorities while supporting new interventions. Emphasis was placed on the institutionalization of actions deemed essential to strengthen the health system in the two departments of Borgou and Alibori and to strengthen community participation.



This report documents the key actions carried out by the project over the twenty months of program implementation. The work of PROSAF Transition Phase focused on key components, or Intermediate Results: improved policy environment, increased access to health services and products, improved quality of services and increased demand for health services and prevention measures. The project was implemented by prime contractor, University Research Co, LLC (URC), in collaboration with the Benin Association for the Promotion of the Family (ABPF), the

Cooperative League of the USA (CLUSA) and the Program for Appropriate Technology in Health (PATH).

This final report documents the institutionalization process that guarantees the sustainability of the accomplishments; it also presents the key results, followed by a more detailed description of the approaches and results for each Intermediate Result.

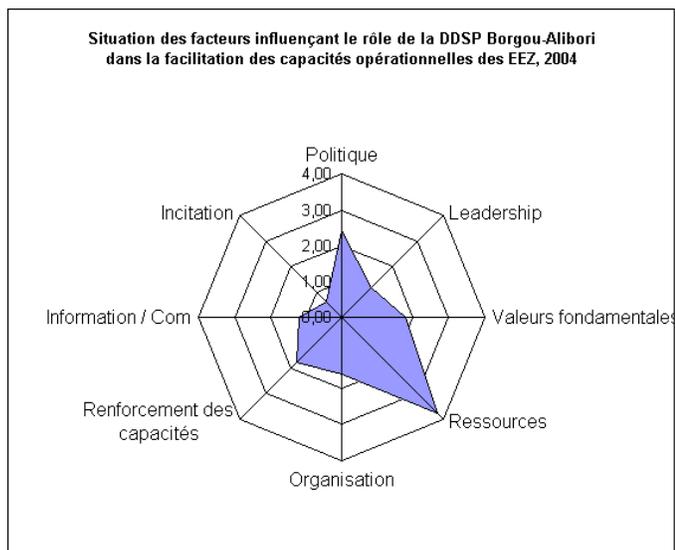
2 INSTITUTIONALIZATION APPROACH

The starting point for the PROSAF Transition Phase strategy was to seek to institutionalize all the processes, tools and approaches in use. The institutionalization strategy was developed in close cooperation with the counterparts at the department level and in the zones and validated by representatives of the central level. The strategy consisted of the following separate phases:

Analyze the lessons learned from the PROSAF institutionalization process.

Some of the strategy's key aspects include:

- Conduct discussions with the partners in the departments, the zones, the Ecole Nationale des Infirmiers et Infirmiers Adjoints du Bénin (ENIAB), and the Department Hospital Center, about their experiences and priorities;
- Make available the project technical documents to all the partners, translated into French if needed;
- Appoint a counterpart for each PROSAF technician at the DDSP and health zone levels with descriptions of each counterpart's responsibilities;
- Analyze the sustainability status of the different technical areas with the DDSP and the Health Zone Management Teams (HZMT);



- Prepare work plans that are integrated, with the counterparts as well as with the other partners, and with the Swiss Health Project (PSS) and MCDI.

Reflect on the institutionalization process and the establishment of priority actions

The sustainability of new practices, the use of the tools and the management approach can be achieved only through an institutionalization process. ¹ As a result of the discussions with the different partners, the critical areas identified were: (i) building the operational capacity of the health zones (HZ), (ii) the ascendant process for developing and implementing the strategic and operational plans, (iii) the partnership with the community, (iv) the integrated offer of the minimum package of family health services, (v) integrated formative supervision, and (vi) quality assurance (QA). For each of these areas, the progress of institutionalization was analyzed with the DDSF and the HZMTs. Identifying the themes to be strengthened was the basis for the planned actions in the project. An example of such an analysis is presented in the graphic above that illustrates the factors that influence the DDSF's role based on the HZs' analysis.

Recognizing the importance of the quality assurance approach

Quality assurance (QA) was the basis for implementing all PROSAF activities, including not just clinical activities, but also management, coordination and social mobilization activities. This approach consists of five elements:

- A systemic vision: The health workers understand the care system and the service processes. The system includes the clients (the populations) and their interests as well as the different health structures;
- Attempt to work according to the standards;
- Ask the employees to be accountable for their performance;
- Use the data for decision-making to improve performance;
- Teamwork.

Interim evaluation of the progress of the institutionalization and sustainability process

An internal evaluation was conducted after one year of implementation. This evaluation, participatory and consultative in nature, successfully identified progress and specific actions to be carried out, both by the health authorities and the project technical team.

¹ **Institutionalization:** a process by which all the activities and values of an approach or a strategy become an integral and lasting part of the system or organization and are part of daily activities and routines (the personnel has the skills and is committed to the subsequent actions; the organizational values and policies are aligned to support the goal to be achieved).

3 RESULTS

3.1 Data summarizing main achievements

TABLE I: KEY FAMILY HEALTH INDICATORS

Indicator	Baseline (%)	2005 (%)
Contraceptive prevalence rate	11	12
Exclusive breastfeeding 0-4 months	61	55
Fully vaccinated rate	56	30
Rate of use of ORT	61	69
Appropriate care or treatment for fever (malaria)	55	89
Knowledge of 3 modern family planning methods	25	38
Knowledge of 1 method of preventing diarrhea	76	82
Knowledge of STI symptoms	(H) 39 (F) 32	(H) 55 (F) 40
Knowledge of methods to reduce the risk of HIV infection	(H) 56 (F) 47	(H) 72 (F) 60
Knowledge of malaria prevention	(H) 76 (F) 59	(H) 81 (F) 79
Percent of health zones using the ascendant planning process for planning plans	2	100
Percent of public and private health centers offering the minimum package of family health services	50	94

4 MAIN ACHIEVEMENTS BY INTERMEDIATE RESULT

4.1 Intermediate Result 1: Improved Policy Environment

Through this result, the project sought to build management, planning and coordination capacity for health in the public and private sectors in the two departments with two purposes in mind: build health workers' management capacity and use data at every level; and increase civil society's involvement in the health sector. The project also aimed to support the activities of the Departmental Directorate of Public Health (DDSP) and strengthen its capacity to coordinate all project activities in the health sector in the Borgou/Alibori.

Strengthen management, including the use of data and the coordination of the health structures

The key components of the process of strengthening management and coordination are shown in the box to the right. Beginning with the first Management Assessment (MA), PROSAF helped Borgou/Alibori identify standards for management activities. PROSAF provided a series of training at the Health Zone Management Team (HZMT) and DDSP levels in

Strengthen management and coordinate the health structures

- Ascendant planning
- Computerization
- Periodic meetings
- Use data at the quarterly meetings
- Collect and analyze performance data
- Organize the HZ/DDSP
- Manage training curricula
- Set up logistics management systems (including the department warehouse)
- Set up financial management systems
- Set up data quality control systems
- Strengthen human resources management

logistics, teamwork, data quality control, etc. thereby building the health zones' operational capacity for autonomy as part of decentralization. From this perspective, the activities consisted of developing the skills of the HZMT members so that they would be able to:

- Prepare their strategic and operational action plans
- Implement the planned activities
- Conduct negotiations to raise funds and prepare partnership contracts
- Manage the funds delegated to them
- Provide quality care and services within a referral and counter-referral system
- Develop and implement an integrated formative supervision plan
- Manage human resources, including the ongoing improvement of personnel performance
- Monitor the key clinical and management indicators using a scoreboard

The table below illustrates the Borgou/Alibori health system's management performance.

TABLE N°2 : BORGOU/ALIBORI HEALTH SYSTEM'S MANAGEMENT PERFORMANCE

Indicator	2004	2005	Expected result
HZMT performance index by Borgou/Alibori health zones	86%	86%	80%
Performance index of HZMTs that use data at decision-making sessions by Borgou/Alibori health zones	100%	95%	65%
Performance index of health structures that correctly estimate and submit orders on time for key Family Health Products by Borgou-Alibori health zones	71%	98%	75%

Ascendant planning. The ascendant planning process for developing and implementing strategic and operational plans entails organizing planning activities so that the different key stages, such as the identification of problems and priority needs, setting the objectives, choosing the strategic components and actions, determining resources, scheduling, and preparing the scoreboard, are prepared from the most peripheral level of the socio-health system moving up to the high levels. This planning method fits in well with the decentralization objectives, according to which the communities should play an active role in planning and implementing the development activities that are initiated in their communities.



TABLE 3: HZMT PERFORMANCE INDEX IN THE USE OF THE ASCENDANT PLANNING PROCESS FOR DEVELOPING THEIR PLANS BY HEALTH ZONE IN BORGOU-ALIBORI

Period	Bembèrèkè Sinendé	Banikoara	Malanville Karimama	Parakou N'dali	Nikki Kalalé Pèrèrè	Kandi Gogounou Segbana	Tchaourou	Borgou-Alibori	Expected Result
2004	100%	100%	100%	100%	100%	100%	100%	100%	40%
2005	100%	100%	100%	100%	100%	100%	100%	100%	70%

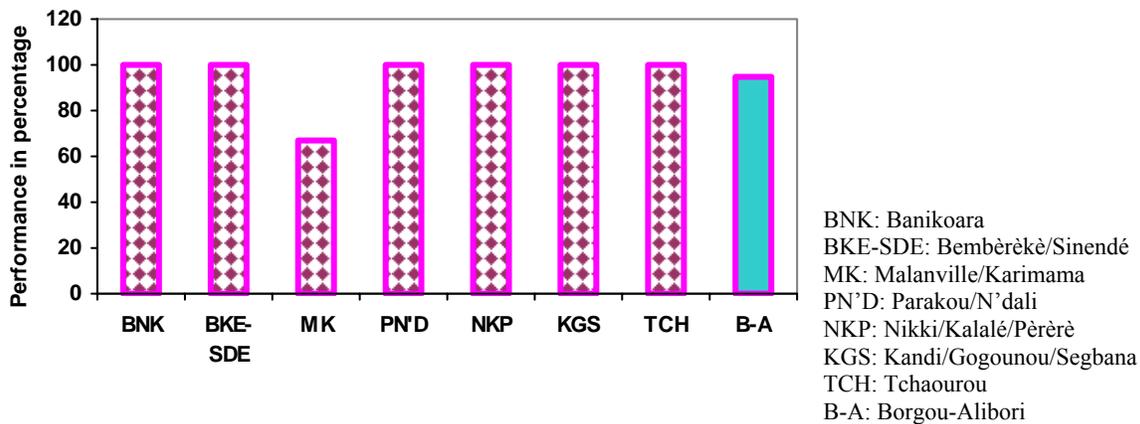
Hold regular meetings to strengthen teamwork and use data for monitoring and planning. In January 2002 PROSAF supported the organization by the DDSP of a department workshop on the management and use of SNIGS data. At this workshop, a consensus was reached between the public sector, represented by the DDSP and the health zones, and the owners of the private clinics or their representatives on the need to improve the processing of SNIGS by improving the collection, analysis and use of the data collected, especially at the peripheral level and finally, broader SNIGS coverage of the private sector. One of the key



results of this consensus workshop was the identification by structure and level (health center, zone hospital, zone office and DDSP), of the indicators that could enable the different stakeholders in the health services to make relevant decisions. These indicators were developed and strengthened in the form of scoreboards.

The strengthening of PROSAF accomplishments in terms of the use of data for decision-making, and by the HZMTs in particular, was achieved by 1) coaching the HZMTs in the periodic organization of quarterly activity and indicator review meetings; 2) in each health zone, setting up computerized scoreboards for tracking family health indicators; and 3) training all the MCDZSs, zone statisticians and officers in data quality control standards and procedures. This ongoing effort helped the seven (7) HZMTs reach and maintain a performance level between 95% and 100% since the first quarter of 2004. This success illustrates the effectiveness of coaching and how the culture of data use is becoming anchored in the health workers.

Graph 1: HZMT performance in the organization of at least four decision-making sessions per year using the data in Borgou and Alibori from January 1 to September 30, 2005



PROSAF supported the DDSP and the seven health zones in Borgou/Alibori to prepare their strategic plans and action plans by strengthening the skills of the HZMTs and the unit heads of the DDSP in budget planning and activity management. In cooperation with the Ministry of Finance and the Planning and Program Directorate of the Ministry of Health (MOH), PROSAF supported the training of HZMT members (including the health zone coordinating physicians) and the DDSP unit heads for preparing a program budget using the framework prepared by the MOH in 2002. Thus, all the health zones were able to prepare their 2003-2006 strategic plans and their 2004 action plans.

Starting in 2004, with the help of PROSAF Transition Phase, all of the HZMTs were trained in the processes of ascendant planning of action plans. Alongside the creation of COGECs in each health center, this new approach to planning could be used by all seven health zones with the technical support of PROSAF Transition Phase. This new approach prompted a needs assessment of the communities which, within the context of decentralization, must participate in the management of their health problems using their legal and organized structure, the COGECs.

Strengthen management

PROSAF Transition Phase provided technical and financial support to the DDSP to strengthen its health services management system based on the following stages:

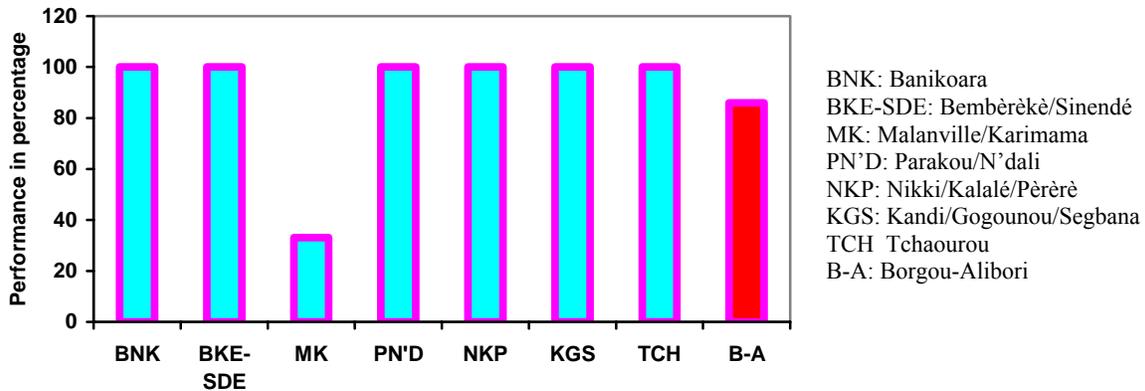


- Revise the logistics management system and train the health workers in the new management system that was developed
- Train the MCDZS and HZMT members to prepare the annual action plan and coach the HZMTs to implement these action plans
- Support the preparation of a DDSP management procedures manual and coach the DDSP to implement the manual
- Conduct the second edition of the MA and the third edition of the Rapid Evaluation of Health Worker Performance (ERPA) in 2004, to enable the monitoring of trends in

the management performance system in Borgou/Alibori and to take the appropriate corrective measures.

- Train the HZMT members (MCDZS and managers) in financing for health and budget management in a health zone.
- Train the officers from the DDSP, the health zones, the departmental hospital and the DDSP in financial and material management (SYSCOA/OHADA system), in human resources management and leadership.
- Provide technical support to the DDSP and health zones to prepare and implement a DDSP action plan to facilitate the implementation of decentralization by strengthening HZMT operational capacity.
- Train all the officers of the DDSPs, HZMTs, the departmental hospital and health zones in quality assurance and support them to prepare and implement a quality institutionalization plan, both at the management system level and the care level in Borgou/Alibori.
- Provide all the health zone offices with computers and train zone staff to use them for accounting and financial management. The computer tool facilitated the preparation of action plans in all the health zones as well as the monitoring of worker performance by facilitating the analysis and management of routine data and ad hoc surveys.
- Install the Internet in the zone offices in Kandi, Malanville and Banikoara to facilitate communication, research and information-sharing.

Figure 2: HZMT performance index (in the efficient management of human, financial, and material resources in Borgou/Alibori) as of March 31, 2005



This HZMT performance index, which is used to assess the level of efficiency in the management of the health zone and DDSP human, financial and material resources, indicates a performance level for management of 86%.

Setting up data quality control systems

Preparation of data quality control standards, procedures and tools for the data from the National Health Management Information System (SNIGS)

PROSAF analyzed the quality of the SNIGS data that the public and private health services collect. This analysis shows that the level of SNIGS data quality was low; this made the different DDSP unit heads aware of the need for more reliable data to support decisions related to health. Therefore, PROSAF supported them to obtain more reliable data. To this end, the SNIGS data quality control standards, procedures and tools were developed and formalized in the form of a training module on data quality control.

The data quality control process—through the use of procedures, standards and tools to evaluate the level of quality of SNIGS data, taught to the Health Zone Coordinating Physicians (MCDZS) and to the statistics management officers—consists of checking that there are no obvious errors in the sample of transmission media that were selected, to check that the logs for local use for the sample are correctly completed, and finally, to check the consistency of the successive compilations for the sample. To do so, the most appropriate method that has been taught is LQAS (Lot Quality Assurance Sampling). The way that it works has the advantage of being based on a random sampling of a small number of tools. In the specific case of the SNIGS data, and to achieve a 95% degree of quality, the maximum number is 19 tools completed. The study of these 19 tools will help decide, with an error risk of 7%, if the 95% quality level has been reached or not. Thus, for this 95% objective, the minimum number of error-free tools is 16 out of the 19 tools selected. The strategy proposed for the periodic quality evaluation is:

- Draw up an exhaustive list of the available tools;
- Take a random sampling of 19 tools;
- Make an exhaustive check of the cells for these tools and make a decision about quality.

Training of the MCDZS, zone nurses and midwives, zone statisticians and those of the Department Hospital Center in SNIGS data quality control

The module that was prepared on data quality control was subsequently used by the SEDP of the DDSP to train 23 workers, consisting of MCDZSs, zone office statisticians and zone hospitals in the Borgou health zones, including the Department Hospital Center, in SNIGS data quality control. This training was performed under the effective supervision of the DDSP. The knowledge acquired will enable the Borgou/Alibori health system to have quality data from this point forward and to set an example for the national level.

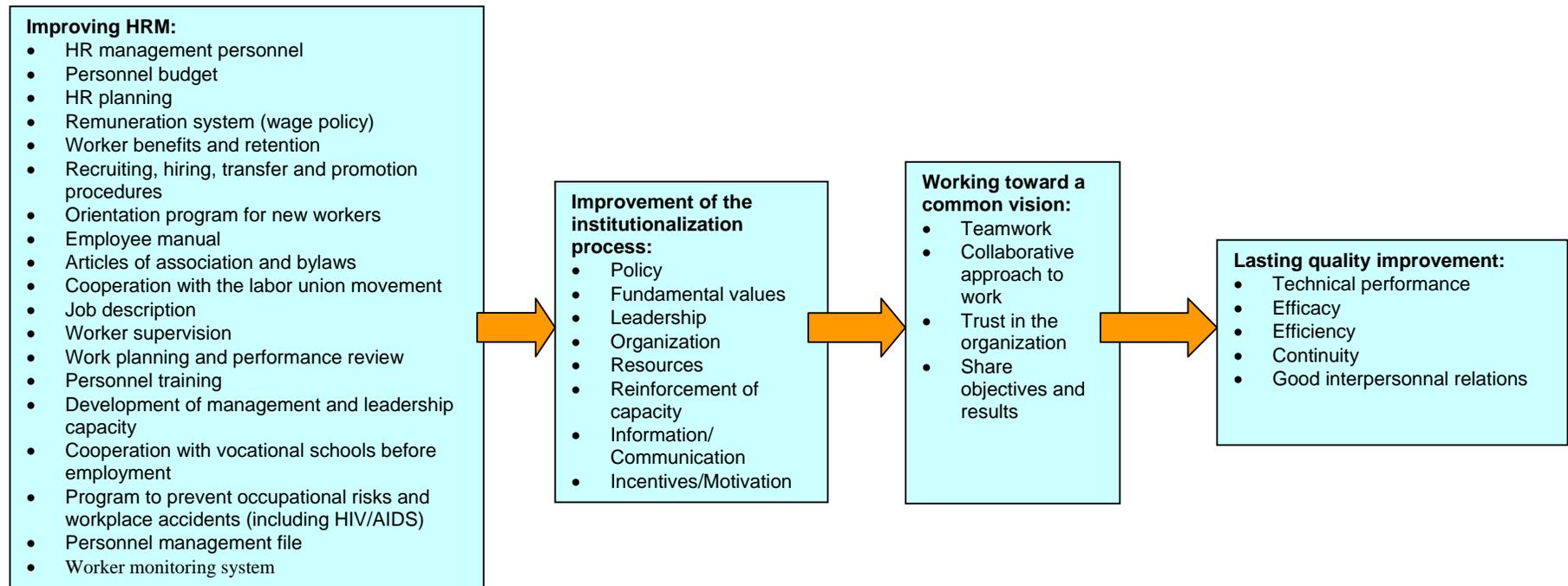
Moreover, this training strengthens the skills of the key stakeholders in the improvement networks that have been set up, especially in the zone hospitals, and for which reliable data collection for measurement and monitoring is crucial.

Strengthen human resources management

In July 2005, the process of extending basic quality assurance training to the health workers in the health centers (nurses and midwives), including zone hospital physicians who had not been trained in QA, was completed. This training took place according to an innovative model that combined QA and human resource management (HRM) training. This made it possible to point out the importance of quality in human resource management as a factor that influences provider motivation to ensure that their commitment to quality is a long-term commitment. A total of 313 health workers were trained.

Incentive programs were developed in some of the health zones, such as Banikoara, Tchaourou and Kandi-Gogounou-Segbana. These incentives were based on specific criteria that were identified and given to the workers in advance. Once workers met the criteria, they were awarded the incentive, which could be, for example, public recognition, or a certificate or congratulatory note for good service. These types of incentives seems to be sufficient to trigger a firm and lasting commitment to the application of behaviors that could result in client satisfaction and improving quality on an ongoing basis.

Integrated Approach to Quality Assurance (QA) – Human Resource Management (HRM) Training



Increase civil society's involvement in the health sector

True collaboration must exist between the communities and the CSAs. This collaboration is organized around specific activities in the plans prepared by the COGEAs and used by the health zones to prepare their plan and budget. These COGEAs, when they understand their role well, help orient the new workers assigned to the zone. It has even been observed that the COGEA members use the management skills acquired in CSA co-management in their other responsibilities in the local decentralized structures. The seven health zones in Borgou had 106 COGEAs/CSAs when the PROSAF Transition Phase began. Only the seven concentration zones were able to give their COGEAs operational plans for 2004. PROSAF Transition Phase support consisted of helping the COGEAs in the other zones to prepare an operational plan to cover the second half of 2004, and at the same time, the 2005 action plan. This support to the health zones was given based on the following stages:



- Train the social mobilization and behavior change communication officers
- Prepare a community mobilization plan in each health zone
- Incorporate social mobilization and behavior change communication activities into existing plans
- Self-analyze and prepare 2005 operational plans for the COGEAs/CSAs for the five non-concentration zones that had not yet received PROSAF support for community mobilization
- Due to their mastery of the process of preparing operational plans, the two concentration health zones also prepared their 2005 action plan

The following table shows the COGEAs that had an operational plan in the seven health zones of Borgou/Alibori as of March 31, 2005:

TABLE 4: COGEAs THAT HAVE OPERATIONAL PLANS

	Malanville/ Karimama	Kandi/ Gogounou/ Ségbana	Tchaourou	Bembereke/ Sinende	Banikoara	Nikki/ Kalalé/ Pèrèrè	Parakou/ N'Dali	Total
Number of COGEAs that have action plans ²	10	23	6	13	11	31	12	73
Total number of COGEAs/CSAs	10	23	6	13	11	31	12	106
Performance (the criterion is met)	100%	100%	100%	100%	100%	100%	100%	100%

Once the action plans have been prepared, the COGEAs are monitored and supported during their monthly meetings at which micro-planning is done and the report on the activities of the previous month is prepared. A checklist that the social mobilization and BCC team uses to monitor the components of an effective meeting is used during these meetings and doing so helps provide constructive feedback to the COGEA members.

The COGEAs and CSAs use their operational plans by carrying out a series of activities based on monthly micro-planning. The key activities are: holding monthly meetings, conducting awareness-raising field trips, organizing community outreach activities, and taking inventories.

² Including the arrondissements that have not implemented the community IMCI and EONC components

COGEA performance in terms of using operational plans is then measured based on the holding of monthly meetings, as these are an essential COGEA activity.

TABLE 5: COGEAS/COGECs THAT ORGANIZED MONTHLY TRAINING MEETINGS IN THE THIRD QUARTER OF 2005

	Bembèrèkè/ Sinendé	Banikoara	Malanville/ Karimama	Parakou/ N'dali	Nikki/ Kalalé/ Pèrèrè	Kandi/ Gogounou/ Segbana	Tchaourou	Total
Number of COGEAs/COGECs/COGES that organized a monthly training meeting	11	10	6	8	30	18	6	89
Total number of COGEAs/COGECs/COGES	13	11	10	12	31	23	6	106
Performance (the criterion is met)	85%	91%	60%	67%	97%	78%	100%	84%

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

The activities for this result focus on improving the supply system and product distribution system, improving the offer of integrated family health services, and increasing the availability of community-based products and services.

Improved supply system and product distribution system

The process of improving the supply and family health product distribution system continued as it did in previous years. This included building the capacities of the health workers to manage their inventory of drugs and contraceptives and to place orders on time and in the correct quantities. After supporting the creation of a family health product department warehouse in the preceding phase (PROSAF), PROSAF Transition Phase supported the expansion of warehouses at the zone level.

Introduction of the PIPELINE software in 2004



Orientation to PIPELINE software in Malanville

PROSAF supported the DDSP to install the PIPELINE software in its health structure. This software allows the managers and accountants in the health zones, the departmental hospital, and the DDSP to further computerize their management procedures, and especially to project their product needs. Seven health zone offices, six zone hospitals, three commune health centers, four DDSP units and the departmental hospital now have this management tool, and 22 managers in the commune health centers, health zones and zone offices spent two days being trained to use it.

Supported the DDSP and health zones to plan and mobilize resources to establish up zone distribution warehouses

Even with the existence of a department warehouse, there were difficulties in guaranteeing sufficient inventories of family health products for the departments. These difficulties caused the Banikoara and Kandi health zones to establish zone warehouses. The positive experience was the reason for the desire to expand these warehouses to all the zones. The following steps were taken to achieve this goal:

- Documentation of the experiences of the zone warehouses in Banikoara and Kandi, including field observation visits
- Coaching of an ad hoc committee set up by the DDSP to manage the process
- A partners meeting on funding for the zone warehouses to request support and financing. UNFPA, Swiss Cooperation, the PSS, CAME, MCDI, MOH and the DDSP, as well as five (5) health zone coordinating physicians attended. After this meeting, PROSAF helped each health zone coordinating physician prepare applications that are required for obtaining the funding, and to incorporate operational information from these applications into their 2005 action plans.
- Monitoring of the installation of the warehouses.



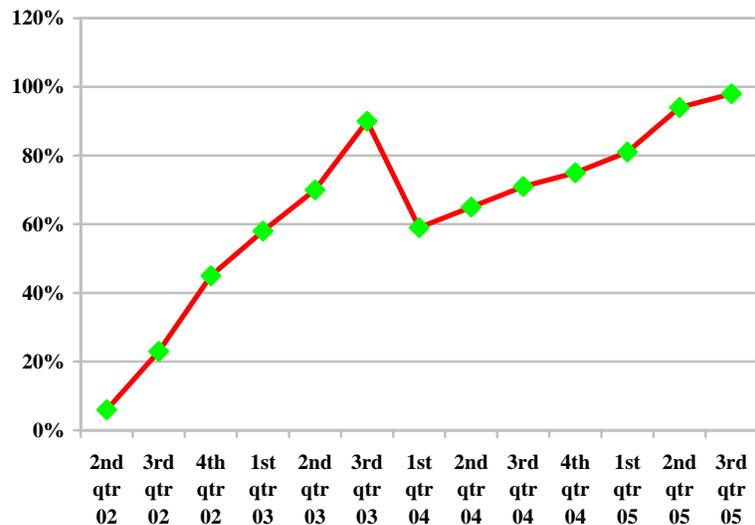
Discussion with the manager of the zone warehouse in Banikoara

Support for monitoring the management of family health product logistics consisted of three components:

- Holding a monitoring meeting. All the health zone coordinating physicians, zone managers, zone hospital directors and heads of DDSP units attended this meeting to assess the actions carried out since 2000 to improve logistics management and the supply of family health products; analyze the trends in the performance indicators such as availability rates of Essential Generic Drugs, product out-of-stock rates, etc.; and analyze the difficulties and the outlook for the future.
- Monthly HZMT coaching. Each HZMT had at least one monthly coaching visit to strengthen their ability to organize and manage the supply of family health products. Special emphasis was placed on the supervision of managers, health workers and others in the use and correct completion of the management tools, ordering products based on a correct estimate of quantities, meeting deadlines for the order, updating statistics and the use of PIPELINE. This approach helped to make continuing improvements in health zone performance in managing orders of family health products.
- Monitoring the performance of the health centers. The indicator for this achievement was a composite indicator with two criteria: i) the key family health product orders were correctly estimated, and ii) orders for key family health products were submitted on time.

The graph below shows the performance level achieved by the health centers for all of Borgou/Alibori.

FIGURE 3: TREND IN THE PERFORMANCE OF MANAGING ORDERS OF FAMILY HEALTH PRODUCTS IN BORGOU/ALIBORI (%) 2002-2005



Increase the offer of the minimum package of family health services

The integrated offer of the minimum package of family health services is a process through which the health workers provide system users, during a single contact and proactively, with all the preventive, curative and promotional services that meet their needs. During the first five years of PROSAF, the project strongly supported the DDSF to put in place the resources required to offer the minimum package of family health services by doing the following: i) providing the health centers with medical-technical equipment, including Norplant insertion/removal kits and renovating the sites, ii) training health zone tutors, trainers, and midwives in charge of maternity centers selected to start up Norplant in the organization and provision of the integrated offer of the minimum package of family health services. Also, to coordinate and monitor the integration activities, resource persons were appointed by the DDSF for each department to serve as focal points for integration. Through the steps above, the practice of integrated offer of the minimum package of family health services was effectively entrenched in the DDSF, the health zones and the health centers.

The current status of rooting this practice in Borgou and Alibori was evaluated so that it could be used as an input for the plan to institutionalize the integrated offer of the minimum package of family health services. All seven health zones and the DDSF in Borgou/Alibori completed this tool and analyzed the results, which were displayed on the radar graphic previously presented. Each zone also submitted a report that consisted of the following: a note on the methodology used, a brief description of the organization, the strengths, the weaknesses, actions that could improve the situation, and a scoreboard to monitor these actions.

PROSAF *Transition Phase* has strengthened the offer of the minimum package of family health services by:

- Implementing a plan in each health zone to institutionalize the integrated offer of the minimum package of family health services and continuous evaluation of health center performance in this area;
- Training all the nurses, midwives and nurse's assistants in the seven health zones in the integrated offer of the minimum package of family health services, combined with the use of the revised

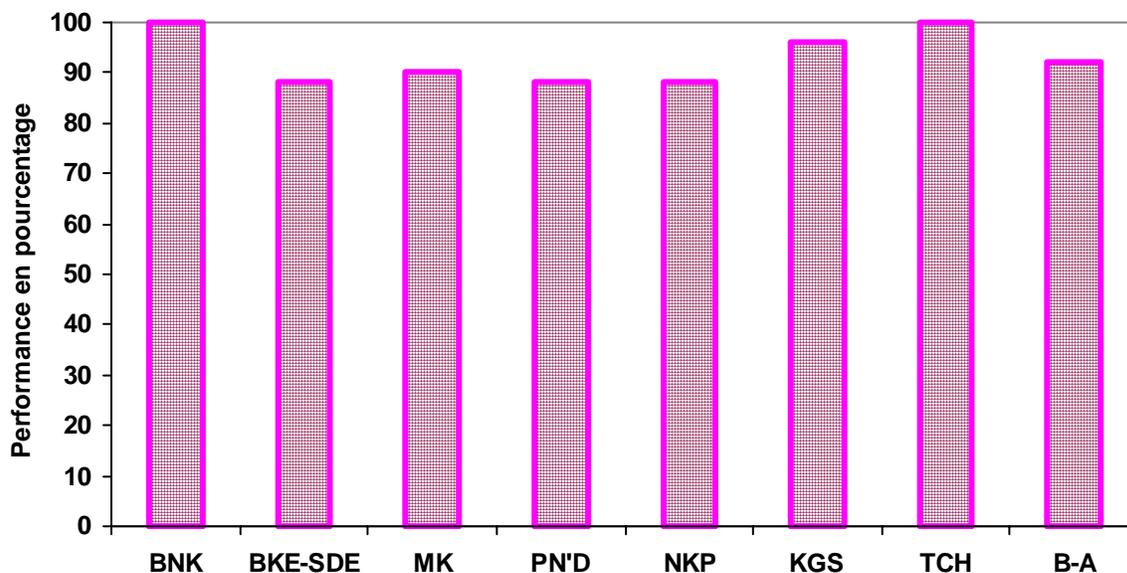
family health protocols. From September to December 2004, 664 health workers (nurses, midwives and nurse's assistants) in the seven health zones received practical training in integrated service delivery combined with the use of the revised family health protocols. All the training sessions were carried out by the teams of trainers from the health zones. This was the first time in Benin that nurse's assistants have been trained in the standards for the delivery of clinical care along with the skilled workers.

- Implementing tools for strengthening performance and institutionalizing integrated service delivery. PROSAF supported the DDSF in the preparation, validation and dissemination in the health zones of a plan to institutionalize the practice of integrated service delivery. This plan emphasizes specific actions to be carried out to strengthen areas such as leadership, policies, incentives and motivation for the health workers, organization, and resources.
- Developing a grid for continuous evaluation of excellence in the integrated offer of the minimum package of family health services. The goal is to evaluate the performance of all the health centers in implementing integrated service delivery standards and identify the center with the best performance, which will serve as a center of reference and practical training for all workers newly assigned to a health zone.
- Adding new integrated service delivery standards to the basic training in the École Nationale des Infirmiers et Infirmiers Adjoints de Bénin (ENIAB). One major achievement was the integration of new integrated service delivery modules into the ENIAB curriculum. This was accomplished through a training workshop that included four modules: (1) organization of integrated service delivery, (2) interpersonal communication, (3) management of nursing care and integrated service delivery, (4) evaluation of integrated service delivery. Following a test by third-year students, the curriculum was integrated. It included group work, case studies, a reference manual and student monitoring during their practical training in the field.



The graph shows by health zone the level of performance achieved by the public and private health centers that were evaluated on integrated offer of the minimum packages of family health services.

Performance des zones sanitaires en offre du paquet minimum de services intégrés de Santé Familiale (% des CS publiques et privés qui offrent le PMSISF) dans le Borgou et Alibori de Janvier04-Janvier05



BNK : Banikoara
 BKE-SDE : Bembèrèkè/Sinendé
 MK : Malanville/Karimama
 PN'D : Parakou/N'dali
 NKP : Nikki/Kalalé/Pèrèrè
 KGS : Kandi/Gogounou/Segbana
 TCH : Tchaourou
 B-A : Borgou-Alibori

Increase the availability of family health products at the community level

This component includes two important components of intervention: the implementation of community-based services and the institutionalization of their supervision by the HZMTs.

Extend the coverage of community-based services

In the first phase of PROSAF, community activities took place only in two zones, which were called the concentration zones. In this second phase, the goal was to expand community activities to the other five health zones by strengthening the arrondissement management committees (COGEAs) and by setting up community-based services (CBS). The different steps in both cases resulted in the preparation of an agreement that identified the roles and responsibilities of both the communities and the health system at the local level. These steps are:

- Setting up teams of community facilitators: Based on each zone’s social mobilization plan, the social mobilization and behavior change communication (BCC) teams, PROSAF’s Technical Assistant and his/her counterpart, set up teams of community facilitators consisting of arrondissement health center staff, nongovernmental organization (NGO) staff, and staff from other development institutions that work in the locality. Once these teams were in place in each arrondissement, they were trained and coached to lead the next two steps.
- Negotiating partnership with the communities through a series of meetings at both the

arrondissement and village levels. During these meetings, the goals, rules, content, mechanisms for action, and what can be done and what cannot be done, are presented to the communities by zone community facilitators with technical support from PROSAF. Based on the information, the communities made an official commitment as to whether or not they will take part in the program.

- Participatory community assessment (PCA) is then scheduled with a community once it agrees to be part of the program. Through several workshops held at the arrondissement and village level, the assessment results in a survey of difficulties with which the different health facilities are confronted, the assets they have, and the role that each partner should play to ensure proper operation.
- Signing the memorandum of understanding. At the end of the participatory community assessment, each village that has taken part in the process with the COGEA's support prepares an action plan. This action plan includes all of the actions to be carried out by all the stakeholders to achieve the health goals that were identified for the locality, as well as the roles and responsibilities of the health centers and community organizations. The roles and responsibilities of the different stakeholders are detailed in a document that is signed both by the health center manager and the community representatives. This document is the memorandum of understanding between the health center and the villages in the health area.
- Assigning the community-based health workers. The health zones and the arrondissement health centers were supported to expand community-based services in the five non-concentration health zones, while strengthening the network already set up in the first phase in the health zones of Banikoara and Bembéréké-Sinendé. 60% of the populations (villages) of the non-concentration zones now have a trained and equipped community-based service agents (CBSA) to distribute essential family health products. The coverage of these CBSAs for all of these zones is as follows:

TABLE 6: VILLAGES COVERED BY COMMUNITY-BASED AGENTS WHO OFFER THE MINIMUM PACKAGE OF FAMILY HEALTH PRODUCTS AND SERVICES IN THE NON-CONCENTRATION ZONES

COVERAGE IN COMMUNITY BASED SERVICES						
	Malanville Karimama	Parako u N'dali	Nikki Kalalé Pèrèrè	Kandi Gogouno u Segbana	Tchaouro u	Total
Number of villages in the non-concentration zones covered by the CBSAs	59	60	85	44	41	289
Total number of villages surveyed in the non-concentration zones	68	99	148	126	41	482
Performance	87%	61%	34%	35%	100%	60%

With the expansion of community-based services, 542 CBSAs are trained and equipped with family health products and provide coverage throughout all the health zones in Borgou/Alibori.

Institutionalization of community-based supervision services

The PROSAF Transition Phase placed special emphasis on strengthening and institutionalizing the key achievements in increased community participation in health system management and in more extensive community-based services in the health system. Community-based activities work properly only if the HZMTs supervise the health workers and ask them to be accountable for supervision. Key activities included changes to the supervision and monitoring tools through memos that created the desired reforms.

Each health zone monitors its own implementation of actions through quarterly supervision visits, quarterly meetings and twice-yearly performance monitoring visits carried out by the HZMTs. All the zones were able to carry out these steps and implement them.

4.3 Intermediate Result 3: Improved Quality of Services

The activities in this result included improving health worker performance at every level through training, formative supervision and coaching, and the institutionalization of quality assurance.

Institutionalization of Quality Assurance

PROSAF Transition Phase worked to reinforce the accomplishments of the implementation of quality assurance in the health zones of Banikoara and Bembèrèkè-Sinendé in the phase carried out from 1999 to 2003 and to expand it to the other remaining health zones. This expansion included, in particular, the zone hospitals and the department hospital in Parakou. All the health workers in the seven zones received basic quality assurance training, including the zone hospital physicians. The table below shows the workers that were trained. This training was provided according to an innovative model that combined with quality assurance with human resource management training (see IR 1.1). This made it possible to highlight the importance of quality human resource management as a factor that affects the motivation of providers to make a long-term commitment to quality. In total, 313 health workers were trained, thereby adding to the achievements of the 1999-2003 period.

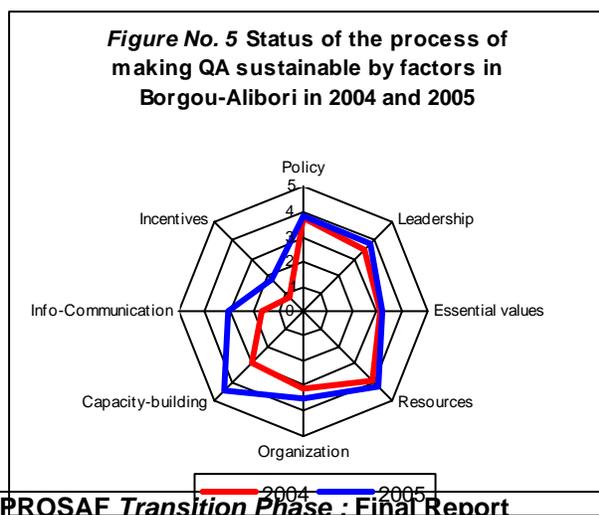
TABLE 7: BREAKDOWN OF WORKERS TRAINED IN QA IN 2005

Localities	2000 to 2002	2005	Total
Banikoara	100	39	139
Kandi-Gogounou-Segbana		53	
Malanville-Karimama		18	
Bembèrèkè-Sinendé	112	38	150
Nikki-Kalalè-Pèrè		79	
Parakou N'Dali		45	
Tchaourou		31	
Other zones	71		
Departmental hospital	69	8	77
DDSP	14	2	16
Grand Total	366	313	679

A plan to institutionalize Quality Assurance was prepared with the DDSP and the health zone management teams to support the process of making the achievements sustainable. The preparation of this plan was based on the results of an evaluation of the initial situation performed in March 2004 to evaluate the level of the departments of Borgou and Alibori. In March 2005 another evaluation was performed to

measure the progress after one year of implementing the institutionalization plan.

The methodology used in the self-evaluation is built around a frame of analysis that includes: 1) policy, 2)



leadership, 3) fundamental values, 4) resources, 5) organization, 6) capacity-building, 7) information and communication, 8) incentives/motivation. The stages of institutionalization are: i) the initial situation (level 0), ii) awareness-raising (level 1), iii) experimentation (level 2), iv) expansion (level 3), v) consolidation (level 4), vi) maturity (level 5). The summary of results illustrated the performances by factors in 2004 and 2005, presented in Figure No. 5. The figure highlights progress since 2004 in terms of improving the factors that influence the process of making quality assurance sustainable in the departments of Borgou and Alibori. Thus the major weaknesses identified

in 2004 with regard to the incentive system for employees in terms of QA, promoting investment and communication among the health system's components and stakeholders, and building QA capacities, the 2005 results show a significant trend toward improving these three critical factors. The participants in the workshop on planning activities to make sustainable the accomplishments/methods/tools that were developed with PROSAF's contribution, which was held in May 2004 in Parakou, identified incentives, information and communication, and the essential values as the most critical factors that slow the sustainability process throughout the entire health system in Borgou-Alibori, not to mention all the development sectors in Benin.

Clinical capacity-building for health workers

A comprehensive strategy was used to build the clinical capacity of health workers. Training is one of several interventions that had a positive impact on improving the quality of care. Training is selected as an appropriate intervention for improving the skills of the health workers only when the initial analysis reveals gaps in the knowledge the health service providers have. Due to the fact that the Ministry has introduced new

Clinical capacity-building

- Create teams of trainers at the zone and DDSP levels
- Provide the curricula
- Create coaching and tutoring processes
- Incorporate new standards into basic training at the ENIAB
- Formative supervision

family health standards, it was important not only to update the health workers' knowledge, but also to ensure that the organization of services enabled them to implement the new knowledge through monitoring immediately after the training in the work sites. Finally, the establishment of a regular supervision system that promotes the same teamwork and problem-solving principles was completed. With a view to strengthening the capacities of the zones and the DDSP to carry out training in the future, a team of trainers was established; the team has mastered the clinical content, the principles of education for adults, and the organization of training sessions.

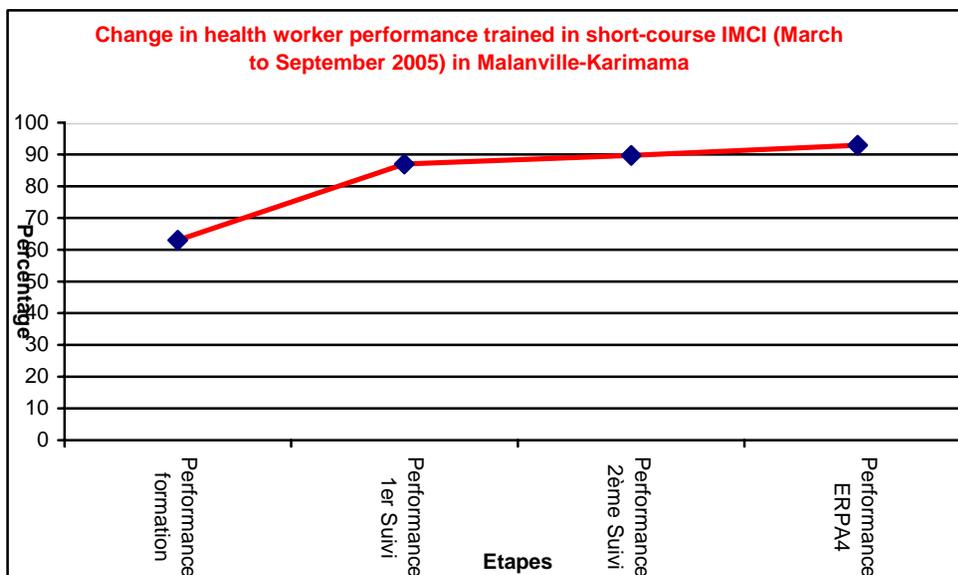
Dissemination of new standards

PROSAF Transition Phase disseminated revised standards and protocols that were prepared by the Ministry of Health. This was the prerequisite for sustainably supporting the implementation of Quality assurance at every level of the health system. For this reason, planning work was done with the staff to be trained with the DDSP and the health zones. This work identified the staff by health zone whose profiles include physicians, nurses, midwives and nurse's assistants. Three-day workshops were organized to ensure a practical communication of standards and protocols according to the integrated offer of family health services approach.

Once the standards and protocols were communicated and understood by the providers, a set of strategies to measure acceptance of these standards must be developed and implemented to identify deviations on an ongoing basis and to trigger approaches to improve the situation.

Development of a shorter IMCI training model

Begun in Benin in 2001 in the departments of Ouémè/plateau, IMCI also has been introduced in the departments of Borgou/Alibori. PROSAF supported the process by taking charge of planning the training, including the training of a full team of trainers, and preparing a complete training kit. PROSAF funded six initial sessions in addition to the training of trainers that covered all of the pilot zones. Subsequently, the other partners, UNICEF and the Swiss Health Project (PSS) in particular, made a commitment in the expansion phase to cover the health zones of Bembèrèkè-Sinendé and Nikki-Kalalé-Pèrèrè. But very quickly the necessity emerged of reviewing the training program, whose costs were deemed exorbitant by all the partners, in order to shorten training time from eleven days to six days. PROSAF Transition Phase took the lead in this review process and, in March 2005, with the trainers from Borgou/Alibori, and with the approval of the MOH, organized a brainstorming workshop on the shorter model. To this end, six trainers, including the DDSP's director of IMCI, and the course director, worked for three days to develop



Strengthen formative supervision.

Formative supervision is the process that involves managing and supporting health workers so that they are able to assume their responsibilities according to care and management standards and protocols. The formative supervision process seeks to improve worker performance by acting not just on skills, but also on motivation and the health workers' working environment, and while care is being provided. Formative supervision places emphasis on immediate feedback on observed behaviors and on the deficiencies observed in mastering the task or a series of procedures that comprise the task. To support strengthening the achievements and making them sustainable, PROSAF Transition Phase worked with the DDSP to prepare an institutionalization plan that seeks to improve the factors that affect this process, which are policy commitment, leadership, essential values, organization, resources, capacity-building, information, communication and incentives. The progress assessment of the implementation of this plan showed that there has been significant progress toward making the accomplishments effectively sustainable in the two departments of Borgou and Alibori.

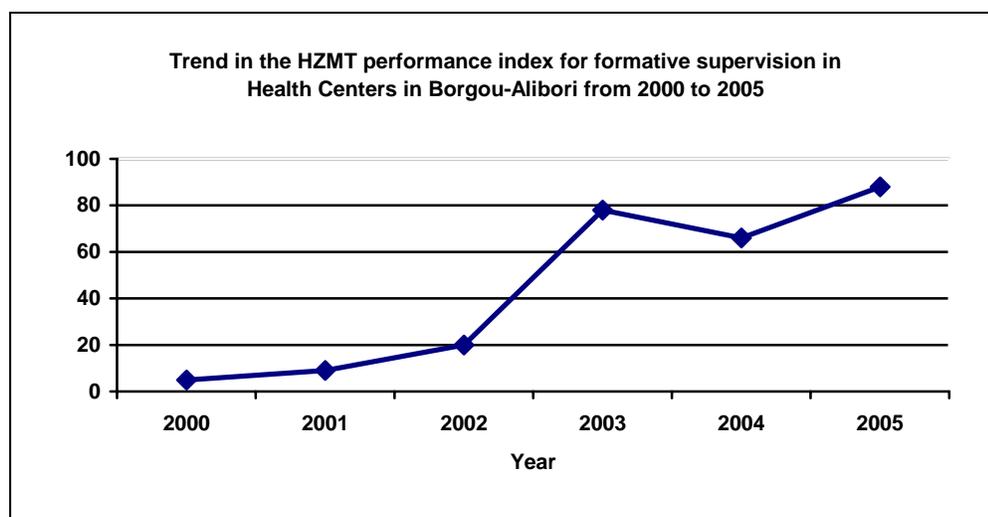
Formative supervision includes the following main successive stages: identification of workers and areas to be supervised, setting up a supervision team and preparing data collection tools, direct observation of the delivery of priority care, document analysis, discussion and feedback to the health workers, and using the results of the last visit, including solving problems identified in cooperation with the people being supervised.

It is considered that each health center received a formative supervision visit when the following five criteria are met:

- The recommendations from the last visit are being followed
- The delivery of services is observed (at least three client-provider PNC and/or family planning and/or IMCI meetings)
- The documents are analyzed
- There is feedback with the health workers (observations & document analysis)
- There is discussion with the health workers on attempting to solve problems

The analysis of the quarterly data collected from 2000 to 2005 shows compelling results in terms of the trend toward making formative supervision sustainable in the departments of Borgou and Alibori. These results show significant and constant progress in the performance index of the HZMTs in formative supervision for the Health Centers. This index was 5% in 2000 and rose to 88% in 2005. The fact that the index was kept above 65% during 2003, 2004, and 2005, suggests effective ownership of this activity to

support the quality of health care and services.



This figure shows a clear improvement in the performance index between 2000 and 2005. The fall observed in 2004 is explained by interferences caused by the epidemic periods during two quarters in the Nikki-Kalalé-Pèrère health zone, which alone accounts for

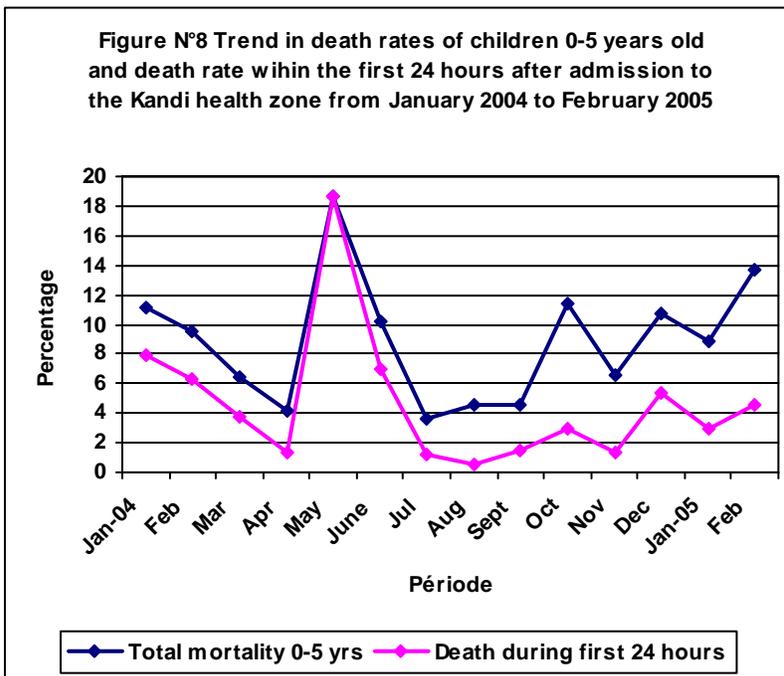
almost one-third of the health facilities in the two departments combined. This table shows that the overall performance of the departments of Borgou and Alibori in formative supervision reached 90%. All the health zones made progress.

Improve the quality of care

The collaborative model was chosen as the approach to accelerate the trend of the clinical indicators toward improvement, particularly in the area of care for obstetric emergency cases, pediatric emergencies and the control of nosocomial infections. Improvement networks for these clinical areas were set up in the two departments of Borgou and Alibori. To facilitate implementation, PROSAF Transition Phase assisted the DDSP team in charge of quality assurance to master the process of monitoring and documenting the experiments carried out by these networks.

The results of the different strategies to measure quality, expressed using monitoring indicators, serve as the starting point for the improvement activities. Following the analysis of the traditional approach for rapid problem-solving, tested from 2000 to 2003 in the health zones of Banikoara and Bembèrèkè-Sinendé, developed essentially around the use of the services, PROSAF introduced the collaborative approach to improvement in April 2003 to improve the gaps observed by reporting the results of the EGGSS2. In May 2004, PROSAF Transition Phase reached an agreement with the support of the central officers of the Ministry of Health and the Borgou / Alibori DDSP to expand the improvement experiments to the zone hospitals and the departmental hospital in Parakou. The collaborative approach was restructured to adopt a network improvement approach according to a continuum that takes into account the structures that comprise the health system from the community level up to the department reference hospital. The areas selected were identified around the Ministry of Health's priorities, which are emergency pediatric care and IMCI, emergency obstetric and neonatal care, and nosocomial infections, all with client satisfaction in mind.

FIGURE 7. CONTINUUM FOR IMPROVING THE HEALTH SYSTEM

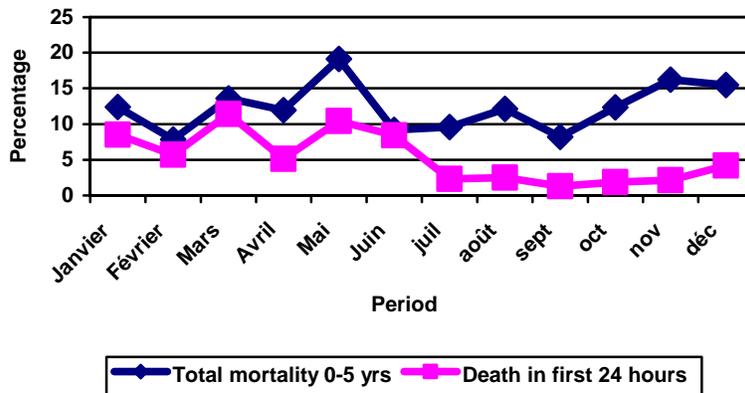


Emergency Pediatric Care Network

In view of the high death rate observed among children from 0 to 5 years old in the first twenty-four hours after they are admitted to the hospital, the hospitals of the seven health zones and the departmental hospital in Parakou chose the death rate of children in this age group in the first twenty-four hours and afterwards as one of the relevant indicators for this network. The goal was to lower this rate by at least half within twelve months after introducing the changes and monitoring. After the June 2004 planning workshop, the teams were made

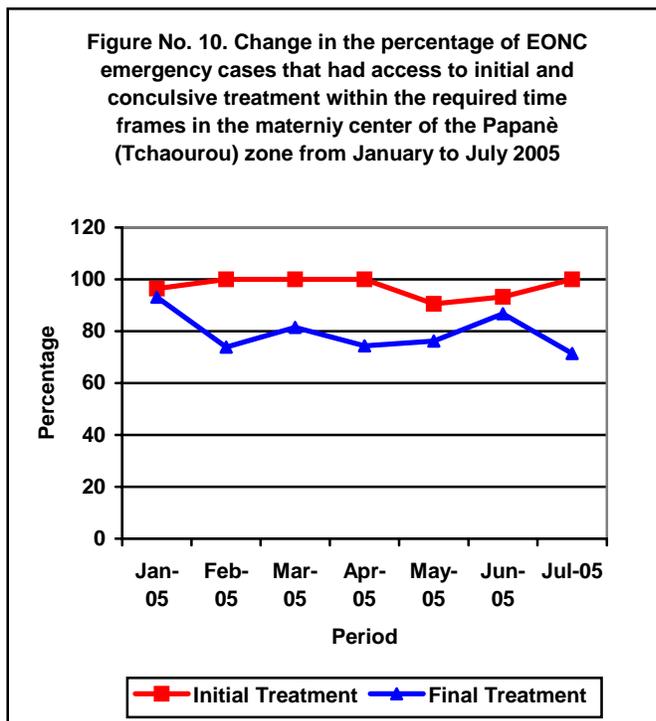
aware of the challenge and most of them launched the change initiatives. Training in Triage, Evaluation and Treatment of Pediatric Emergencies (TEPTE), conducted in October 2004, made it possible to better understand the most relevant types of changes. The organization of on-call shifts for the physicians was instituted, for example, in the Kandi zone hospital, while other zone hospitals provided oxygenation kit equipment, followed by the training of all the personnel in the operation of this equipment. The changes that were made quickly brought about improvements, and this made a difference in the death curve for children within the first twenty-four hours relative to the curve for all deaths of children from 0 to 5 years old observed for the period. Figures No. 8 and No. 9 below give an example of this.

Figure No. 9 Trend in death rates of children from 0 to 5 years old and death rate within the first 24 hours after admission to the Bembereke HZ from January to December 2004

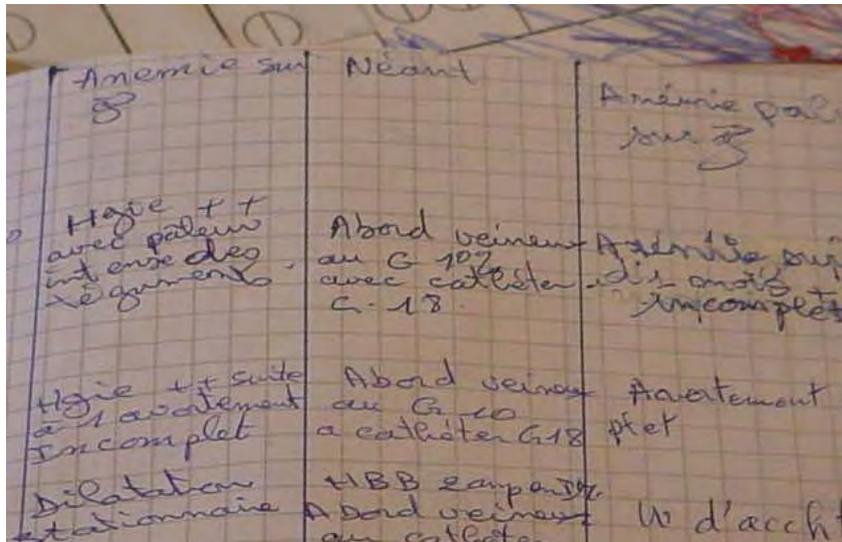


The Pediatric Emergency Care Network is being expanded to the health centers that are organized as “collaborators” around the IMCI indicators. The improvement goal of the health center collaborative teams is to increase the percentage of children from 0 to 5 years old who receive care in accordance with IMCI standards. To achieve this goal, PROSAF supported the coverage of all the IMCI providers and, very recently, in May-June 2005, total coverage of basic QA training. The introduction of community IMCI through community-based services completes the system in the care continuum. Community IMCI is based on the ability of families to adopt practices that promote children’s health and to go to the health center immediately when certain signs of severity appear. Support structures are set up in the villages that are experimenting with community IMCI in order to eliminate the financial barrier of access to care.

Obstetric and Neonatal Emergency Care Network

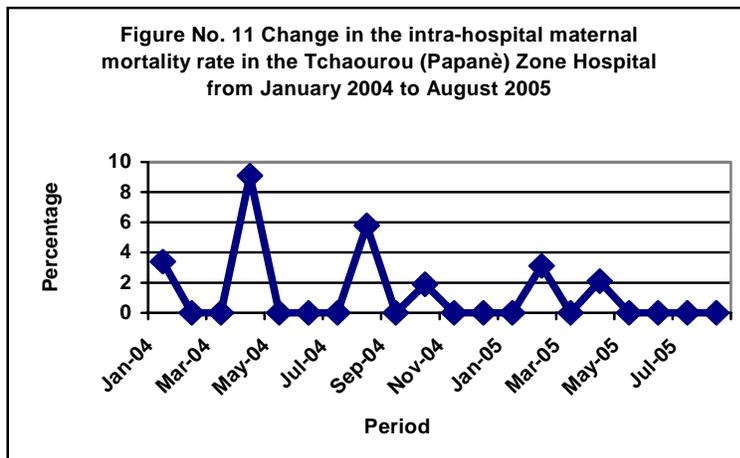


Among the causes found for maternal mortality, there are mainly hemorrhage, eclampsia, dystocia and post-partum infections. Nonetheless, regardless of the causes, deaths occur in most cases due to delays in making the decision to seek care and referral to an equipped health structure and the quality of care offered by the health team. For these reasons, the EONC network selected as an indicator for monitoring improvements the percentage of women who come in as emergency cases and that have initial treatment no later than the first fifteen (15) minutes after admission and conclusive treatment (a cesarean, for example) no later than two (2) hours after admission.



A page from the EONC register

One of the important changes introduced involves reconfiguring the maternity log so that there are columns for collecting information that is used in calculating these time frames. Time frame measurement has become a genuine monitoring instrument for most of the zone hospitals. Figure No. 10 shows an almost continuous improvement in initial care, the percentage of which has stabilized at around 100% in the Papanè (Tchaourou) zone hospital. Moreover, several health zone coordinating physicians have decided to decrease the costs of obstetric emergency health transportation to reduce the time that elapses before referral as much as possible. Ambulances with full tanks of gas are pre-positioned seven days a week for emergency transportation.



The second indicator adopted and monitored by the EONC network is the death rate among women referred or admitted for obstetric emergencies. This indicator seeks to measure on a continuous basis the effectiveness of emergency care management. The national maternal death rate is about 3% according to the EONC survey conducted in 2003. Figure No. 11 shows an improving trend between January 2004 and August 2005 when the most recent data were collected.

Nonetheless, the persistence of the variations is obvious and is explained in part by the severity of the cases taken in due to the delay in decision-making and referral to the equipped center and the quality of care provided. The existence of the variations also is caused by variations in applying the EONC standards from one provider to another. Some of the activities carried out in the PROSAF Transition Phase to improve compliance with the care management standards in the referral maternity center included providers trained in EONC with emphasis on active management of the third stage of labor. This training included two (2) providers from the referral maternity from each health zone for a total of fourteen (14) midwives.

One of the useful results of this experiment is the fact that, at this time, there is a medical audit of all maternal deaths and the maternity center health teams are beginning to systematically collect and analyze

data of this type. Some under-performances have a connection with the under-equipment of the referral maternity centers, and especially in terms of EONC kits that include a complete oxygenation system.



Example of a ready ambulance pre-positioned at the Kandi hospital for emergency evacuations to CHD in Parakou

For the health centers, specific indicators were identified in order to improve the quality of management for complications from pregnancy, delivery and the post-partum period. Three indicators were adopted, namely: (i) the percentage of complicated cases referred, (ii) the percentage of complicated cases referred with IV access, (iii) the percentage of villages that have a support committee and funding and/or a solidarity system (this indicator measures the effectiveness of community participation in community EONC).

In the EONC network, at the health centers, initiatives were noted. For example, the Bembèrèkè-Sinendé Health Zone Management Team prepared a program on “lifesaving procedures” for training midwives and nurses that work at the peripheral level based on deficiencies identified during the supervision visits. In the Tchaourou health zone, a motivation system was set up that establishes “rewards” for the health team based on the continuing improvement in its performances of providing care for delivery complications.

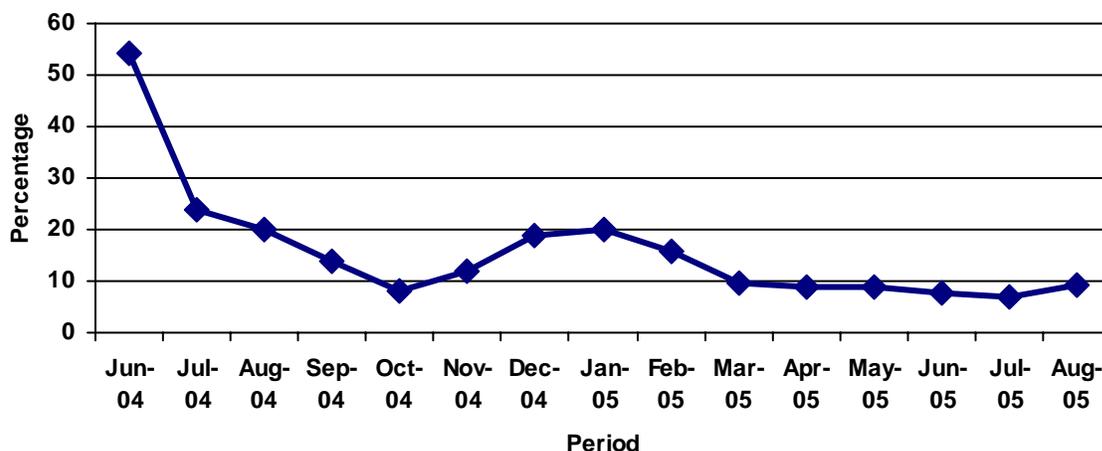
In the villages that have support committees, memorandums of understanding (MOU) were drawn up between the community and transportation companies to facilitate the transportation of complicated cases from the villages to the health centers. These memorandums of understanding brought about a significant decrease in the cost of transportation, up to 50% in some cases.

Example of cost reduction of Banikoara transport
Four CSA (4) of the eight have already established contracts with local transportation providers :
Igrigou 3500 F by motorbike
Toura Taxi from 15000 F to 5000F
Founogo Taxi from 25000 F to 15000F
Goumori Taxi from 25000 F to 7000F

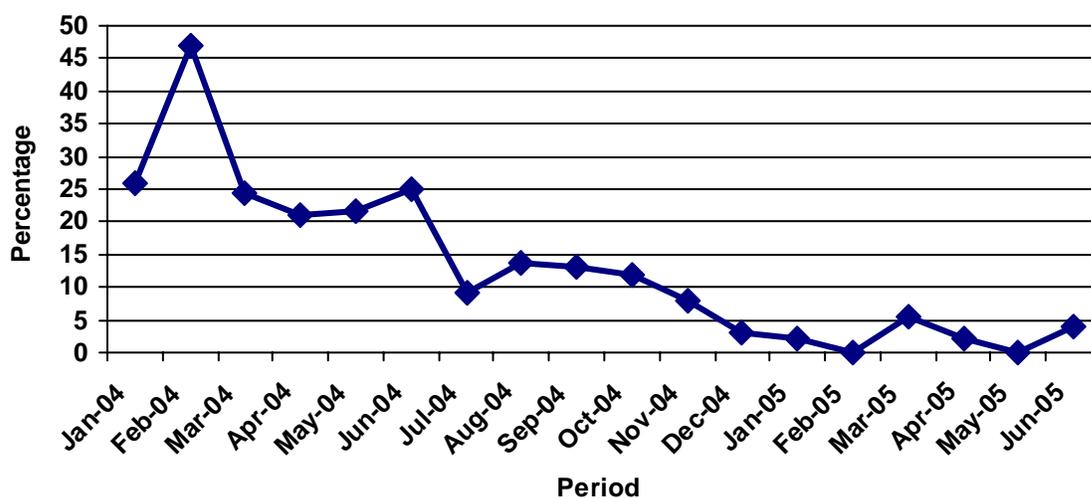
Nosocomial infections, a new priority for hospital services worldwide, are an even higher priority for hospitals in developing countries. Several factors are related to the hospital environment, and especially its microbial ecology, the food chain, the water supply system, the system for managing biomedical and household waste as well as wastewater, and practices of health professionals and other practices of patients or family members who support them. In the context of the nosocomial infection control network, the health zone hospitals selected as an objective a further decrease in the rate of surgical site infections and, as a monitoring indicator, the rate of surgical site infections (measured using the existence of suppuration based on the type of surgical procedure). The changes that have been introduced group actions together, such as training the personnel in hospital hygiene measures, allocating specific inputs to ensure

strict asepsis during all stages of providing patient care, establishing strict rules on accessing treatment rooms and hospitalization wards, including people that get close to patients, regulating visiting hours for parents, and managing hospital space. Significant results were recorded in at least four of the seven zone hospitals in Borgou/Alibori. As Figures No. 12 and No. 13 illustrate the types of significant results that have been achieved.

**Trend in surgical site infection rate in the Parakou N'Dali HZ (Boko)
June 2004 to August 2005**



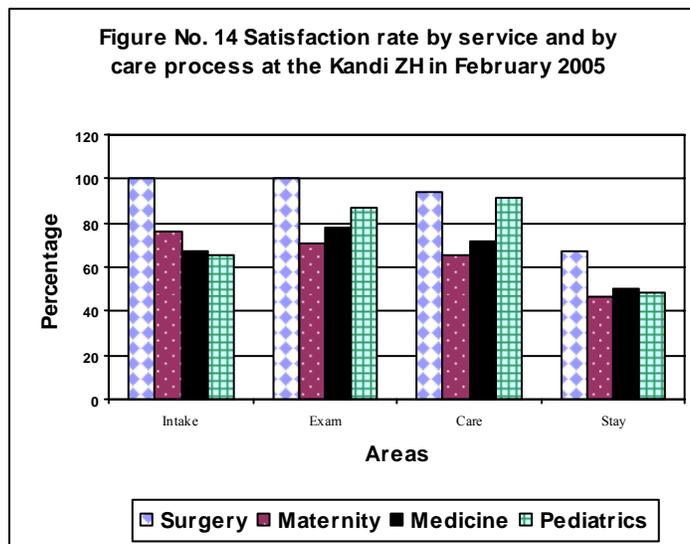
**Trend in surgical site infection rate in the Tchaourou HZ (Papanè)
from January 2004 to June 2005**



Client Satisfaction Network

Client satisfaction is the unifying goal of all the improvement networks. Participants at the network establishment workshop, held in May 2004, decided to establish a client satisfaction network to create the conditions for better sharing of experiences among the health zones. The Banikoara health zone, which

had already acquired experience in this area because it started the client satisfaction surveys in 2000 and conducted the survey in each subsequent year, was used as the startup example. Methodological questions were asked, and some of the participants opted for the qualitative approach, while others advocated the quantitative method. In practice, both methods were tested and presentations were made about them. There were experiments with the qualitative method with the support of the Swiss Health Project (PSS) in the departments of Zou and Collines³. This method, called the social mediation process to improve the quality of care, was tested in the Dassa hospital. It is based on a participatory socio-anthropological survey characterized by the collection and analysis of qualitative data interspersed with sessions on feedback and training and mini-workshops for planning activities that help better satisfy clients inside and outside the health system. The resulting model is one that resolves conflicts/divergences by developing a social mediation scenario, with the reorganization of services as the base, training and motivation as the two pillars, and good interpersonal communication as the roof. The center is represented by adequate equipment.



The quantitative method is based on measuring client perception using a list of variables according to the stages in the hospital care process: (i) intake, (ii) examination, (iii) care, and (iv) stay. The questionnaires are administered by the units: Surgery, Maternity, and Pediatrics. The data are entered in Access and processed as tables. Figure No. 14 shows the results of this client satisfaction assessment in the Kandi zone hospital. To collect this type of information, the Boko zone hospital experimented with a simple method known as “two faces,” one of which depicts a happy face while the other one shows a sad face. The hospital clients put a check mark under the face that reflects their perception of the quality of the service according to the service used. The hospital team goes through the results and critiques itself based on the results.

Hospital Services	July 19, 2004			July 22, 2004			Overall		
	☺	☹	Total	☺	☹	Total	☺	☹	Total
Pharmacy	3	1	4	33	4	37	36	5	41
Maternity	3	0	3	7	1	8	10	1	11
Pediatric	3	0	3	0	0	0	3	0	3
Consultation	19	0	19	20	4	24	39	4	43
TOTAL	28	1	29	60	9	69	88	10	98

Transfer skills to the DDSP for implementing health system performance monitoring

³ The health zones in the departments of Zou and Collines and the Abomey Health Center joined the networking experiment for the four areas (Emergency Pediatric Care, EONC, Nosocomial Infection Control and Client Satisfaction) with the departments of Borgou and Alibori.

Improvements in the quality of services can continue only if there is ongoing support for monitoring and planning the improvements. As support has been implemented over seven years in PROSAF and PROSAF Transition Phase, a series of practical measures has been put in place to enable the DDSP and the HZMTs to closely monitor system performance. The list below summarizes the performance measurement methods developed in the department of Borgou/Alibori, independently of the partners involved in the process of designing or providing technical and financial assistance for implementing them. The new methods that PROSAF has introduced are as follows:

- The Management Assessment (MA), which was PROSAF's major activity when it began in 1999 (1st edition), and made it possible to analyze the strength and weaknesses of the Borgou/Alibori health system, such as clinical performance and the performance of the different support subsystems. The MA made it possible for the different health zones to prepare action plans to improve performance at every level of the Borgou/Alibori health system. There was a second edition of the MA in 2002 which took a critical look at performances achieved since the first edition. The unit heads of the DDSP, the health zone coordinating physicians and the central level (the Planning and Program Directorate) were heavily involved in these two editions, and the second edition was carried out almost entirely by the stakeholders of the Borgou/Alibori health system, in which they revised the data collection tools and collected and analyzed the data.
- The Knowledge, Attitudes, and Practices surveys (KAP and mini-KAP), the first edition of which took place in 2000, measured the level of knowledge of the populations of Borgou/Alibori in family health, their attitude toward health issues, and the practices of individuals and families in seeking curative or preventive care. The next editions took place in 2002 and 2005 and made it possible to observe the clear improvement in the populations' knowledge and practice in the area of family health.
- The Rapid Health Worker Performance Assessment (ERPA), which is a mini-MA, collects, analyzes and interprets the data in compliance with the essential standards of family health care and services based on the direct observation of a small sample of cases managed by the providers, exit interviews with clients and verifying the availability of the minimum package of family health services. The first edition in Borgou/Alibori was carried out in 2002 by the health zone coordinating physicians and the DDSP unit heads. The second edition, conducted in December 2003, was run entirely by the HZMTs, some of which paid for a portion of the implementation expenses, thereby demonstrating the fact that they had mastered the methodology and the financial feasibility, which is within their reach.
- The quarterly performance of the health zones was determined by the indicators of PROSAF's Performance Monitoring Plan (PMP), calculated using data collected quarterly by the health zone statisticians under the technical supervision of the Research, Planning and Documentation Service (SEPD), the DDSP and PROSAF. These are process indicators that determine the areas of the support subsystem that show weaknesses so that the appropriate solutions can be identified, such as formative supervision, management of orders for family health products, etc. Even though this activity is funded by PROSAF, data is collected entirely by the health zones and support from PROSAF is merely in the form of technical support for data synthesis and calculation and financial support, consisting of per diem and fuel for the collection field trips. But these activities can be paid for entirely out of the delegated funds (national budget) which created a budget line item for fuel and per diem for supervision. Now that the HZMTs and the SEPD have done a good job of mastering the methodology, all that remains is for the DDSP to decide to adopt the PMP indicators as one of the means to monitor health system performance in Borgou/Alibori on a quarterly basis.
- Integrated formative supervision was developed by PROSAF based on traditional supervision which, instead of being an opportunity for learning and coaching, was actually "policing" and it discouraged the beneficiaries. Formative supervision is very much accepted by the workers who

receive it and the supervisors take advantage of it to communicate the standards to the workers. This activity is carried out entirely by the HZMTs each quarter at the health zone level, and the HZMTs pay for all the inherent expenses.

- Post-training monitoring, or tutoring, was introduced. Tutoring is often done one month after each training session and is for the trained workers. Although technically speaking, the trainers from the DDSP and the HZMTs are experienced in practicing this, this activity is carried out by PROSAF (or any other partner) each time.

Practical measures for monitoring health system performance by the DDSP

TABLE 9: PRACTICAL MEASURES AND ACTIONS REQUIRED FOR MONITORING HEALTH SYSTEM PERFORMANCE BY THE DDSP

Measures	<i>Required actions</i>	Levels / structures involved	
Decide to involve all the stakeholders of the health system method of performance-based management.	Acceptance at the central level through directives that clearly reflect the orientation of the strategic objectives on the overall performance of the DDSP's leadership system.	MOH DDSP	September 2004
In the MCs, set up a committee to monitor health system performance.	Acceptance at the central level through instructions along these lines, including the terms of reference for these committees.	MOH DDSP	September 2004
Have goals for improving system performance: inputs, processes, and results.	Make the most of the quarterly and annual planning documents to deduce the expected performances from them.	DDSP	October 2004
Prepare a list of key indicators grouped into monitoring scoreboards. The definition of the indicators should be clear enough to limit variations from one health structure to the next.	Consensus workshop to identify the key indicators based on the objectives identified in the action plans and interventions in progress in the health zones. Make the use of scoreboards widespread for monitoring performance at each level of the health system.	DDSP Partners	October 2004
Prepare a list of key monitoring indicators, indicating the frequency of data collection and analysis for monitoring the performance of the systemic components.	Decision-making and clear instructions for the appropriate units at the DDSP level.	DDSP Partners	November 2004
Prepare a table for obtaining data that includes the sources of the data (numerator and denominator), the method and the collection tools to be used.	Decision-making and clear instructions for the appropriate units at the DDSP level. Incorporate the monitoring and ERPA tools. Systematize data collection on key indicators during the integrated formative supervisions.	DDSP Partners	November 2004
Create a mechanism / procedure for systematic feedback on performance with workers involved in implementing clinical and management activities.	Make decisions and have clear instructions for the appropriate units at the DDSP level. Identify the practical procedures for this feedback.	DDSP Partners	November 2004
Connect the performance monitoring system with the	Decision-making. Identify practical procedures for using the	DDSP Partners	October 2004

Measures	<i>Required actions</i>	Levels / structures involved	
continuous training system in order to use the results of the measurements to introduce / adjust the required training activities.	performance monitoring data to trigger a training process on worker skills.		
Implement the integrated performance monitoring model.	Decision-making.	MOH DDSP	Starting in January 2005
Document the experience to learn the key lessons from it.	Consensus on a basis of documentation.	DDSP Partners	January 2006

4.4 Intermediate Result 4: Increased demand for family health services and prevention measures

The activities in this result include: improving knowledge and attitudes toward prevention measures and appropriate behaviors of the populations and improving the socio-cultural environment fostering the use of services and prevention measures.

Changing the behavior of the population and health workers is an important aspect of improving health. The actions carried out focused on establishing partnerships between the community and the health workers, and on strengthening the population's knowledge to promote good habits and to make certain that the population seeks care promptly when needed. PROSAF initiated collaboration

Strengthening knowledge and behavior

IEC/BCC Curriculum
IEC materials
Disseminate information about health using job aids
Use traditional popular media
Build the capacities of local radio stations
Deploy IEC/BCC officers at the zone level

with the popular traditional media such as theatrical companies and griots. Radio stations, with large audiences in the zones, participated and have begun to develop their own broadcasts about health.

To influence the results indicators established by USAID, PROSAF designed a communication strategy with several components, including training health workers, setting up a network of community liaisons and broadcasting multimedia campaigns. This included the distribution of printed materials, broadcasting spots on the radio, and tours of theatrical companies in the targeted zones. Campaigns were carried out on the themes of child health and reproductive health. The BCC multimedia campaigns contributed significantly to achieving the results indicators.

Training Curriculum In Information, Education And Communication (IEC)/

Behavior Change Communication (BCC)



A KAP survey in progress

To strengthen the capacities of the different stakeholders in the Borgou-Alibori health system, a series of training sessions was organized, based on the BCC training curriculum developed by PROSAF.⁴ The curriculum consists of five parts: the introduction; the introduction to facilitation; BCC facilitation comprised of nine modules; reproductive health, comprised of four modules; and children's health, comprised of six modules. The modules are

subdivided into sessions. For each session, the objective, period, materials to be used, and the activities to be carried out are indicated, such as: awareness-raising game, group chat, use of IEC materials, role plays, mimes, skits, songs, etc. The module plan and the flexible and coherent sequencing of the different sessions and activities make the users' task easier. The different activities are prepared in such a way as to enable illiterate people to also be able to understand the content and use the messages to advantage.

The curriculum was prepared during the workshops with the DDSF Borgou-Alibori workers and the health zones, zone coordinators, and the zone nurses from ABPF, NGO representatives, PROSAF Technical Assistants for the health zones, and PROSAF's BCC team. The curriculum was pre-tested at the training of trainers and was validated at this workshop. Comments and remarks made by the users in the field were circulated during this workshop and made it possible to improve the curriculum. At the end of the project, the curriculum was disseminated to all the zones of Borgou/Alibori.

Preparation and use Of IEC materials

Information, education and communication (IEC) materials make a substantial contribution to performing BCC activities and making them sustainable, by serving as repertoires for health messages and inducements for discussion and reflection sessions.

Over the seven years of the project, PROSAF and its partners prepared and widely distributed many IEC materials. The IEC materials made available to the public include the following:

- Printed materials such as posters, leaflets and brochures with illustrated messages on the various family health themes;
- Audiovisual materials such as cassettes, videos and theatrical CDs/DVDs, works by griots and chorale groups, and media advertising spots;
- Practice models as well: a phallus made of wood to demonstrate correct condom use, and chloroquine tablets made of art paper to check the dose for treating malaria.

⁴ BCC training curriculum by PROSAF/DDSP Borgou-Alibori. PROSAF, Parakou, 2005.

Sustainability of IEC media

Through these BCC activities, PROSAF used a participatory approach of “entertainment education.” A griot teaches community members entertaining activities that convey health messages at the same time. The messages conveyed relate back to popular songs. Based on well-known tunes, the health messages with words. Short poems are also recited, accompanied by gestures. Interactive games are also played with body movements. All of these participatory activities make excellent communication materials to help people learn new information and adopt sound behaviors. They repeat them during their daily activities and come to own the songs and messages. Through this community ownership, entertainment education contributes to sustainability.

Dissemination of health information through job aids

A key to increasing health worker capacity to comply with standards and manage health services is the availability of support materials that assist them in performing newly learned, not frequently used, or complicated tasks. One such type of support material is the job aid. URC has a wealth of experience developing job aids using a variety of approaches and methodologies. With an eye toward modifying or adapting existing job aids to benefit priority health programs in the Borgou/Alibori, meetings were held with PROSAF managers, DDSP staff, and feedback was obtained from health workers who might benefit from the use of these job aids.

Emergency obstetric and neonatal care (EONC), integrated management of childhood illness (IMCI), and infection prevention in the health facility setting were identified as priority areas to address during the PROSAF Transition Phase. Consequently, job aids were developed to prevent infection in the health centers and hospitals, EONC, health care for newborn babies, and maternity danger signs.

Materials prepared with funds and technical assistance from PROSAF are now being used or adapted by the partners to ensure their sustainability.



Job aid discussion, Kandi.

For example, the Ministry of Health reprinted and distributed four of the counseling cards on malaria. The PROLIPO Project by Africare, an NGO, has begun to use several images taken from these counseling cards in a leaflet and plans to use more of the images in the future. MCDI has directly incorporated entire chapters of the PROSAF/DDSP Borgou-Alibori BCC Training Curriculum into its training materials, such as the chapters on malaria and diarrhea. MCDI is also in the process of contributing to making several entertainment education activities sustainable, including the Vaccination Hand, the recitation of Sick Child Danger Signs, and the lullaby

about exclusive breastfeeding.

Use of popular media

For the purpose of making the BCC activities sustainable PROSAF strengthened stakeholder capacities in the community through the use of popular and traditional media, such as the theater, griots, and women’s folklore groups, as well as local radio stations. Often, capacity-building activities were carried out in cooperation with the DDSP and other NGO partners such as PSS or MCDI. Capacity-building activities include:

- Training popular and traditional media workers in the area of family health;

- Preparing IEC materials such as songs, spots and theatrical plays; and
- Giving these workers greater creative abilities through practice and experience.

Throughout the seven years of PROSAF, theatrical companies and *griots* were used as vectors to disseminate health messages. With technical assistance from PROSAF, the Bio Guerra company developed four theatrical plays: Let's Space Births Using Modern Methods (*Espaces les Naissances avec les Méthodes Modernes*), Let's Not Reject Saka (*Ne Rejetons Pas Saka*), on how to prevent HIV/AIDS, and its adaptation to a film for television entitled If I Had Known (*Si Je Savais*).



An actor administering a pre-test

During one multimedia campaign, the women's theatrical company *l'Oeil du Septentrion* wrote a theatrical play with assistance from PROSAF technicians entitled Let's Control Malaria (*Luttons contre le paludisme*). The company presented the play in 76 villages in Borgou-Alibori, with audiences of around 250 in each village.

At the end of the plays, discussions were held based on age group with the actors to give more explanations and answer audience concerns. To reinforce the educational messages sent by the theater and the community workers, radio spots were broadcast on the same themes.

To better expand campaign activities on the theme of emergency obstetric and neonatal care (EONC) and family planning, in 2004 PROSAF also sponsored the tour of the Bio Guerra company with the theatrical play entitled Let's Protect Our Mothers and Children (*Protégeons nos Mères et Enfants*). This play was presented before 20,000 spectators in 58 Bariba villages in two health zones. Another play, Let's Control HIV/AIDS (*Luttons contre le VIH/SIDA*), was put on tour for 30,000 spectators in 73 villages and 16 secondary schools. The pre- and post-test analyses showed a clear improvement in knowledge of contraception methods and the willingness to use them with a sex partner.



Griots playing at a local radio station

The project gives the communication actors the opportunity to practice and to have many experiences in their respective fields. This makes them more professional by strengthening their capacity, their talent and their know-how. The theatrical companies, for example, write their theatrical plays themselves and analyze the quantitative data that are collected. With repetition,

the actors become much more effective and improve their communication with the populations. The *griots* improve their shows and attract larger and larger audiences. They easily introduce health themes into their traditional rhythms. For example, one of the *griots* enjoys singing about family planning because it gives him a chance to tease men with who have many children about their weaknesses while making them think about their sexual behaviors.

Strengthening the capacities of local radio stations

PROSAF has worked extensively with radio hosts on programming and the preparation of spots, and this began a sustainability process because other stakeholders and partners will use the skills that PROSAF has given to the local stakeholders. And when MCDI wanted to prepare for a workshop to develop spots on IMCI, they invited the radio host from Bembéréké, who had been trained and recommended by PROSAF. This host helped them prepare for their workshop. With the participatory approach, at the first session, the popular and traditional media partners observed and learned. In a subsequent workshop, they are involved and become facilitators of games, demonstrations or a health theme based on their level. This gives them the capacities, skills and a certain assurance. For example, griot Tamborou was on the radio in Bembéréké one day for a program for the general public. The fact that he was accustomed to the hosts of this radio station allowed him to take the microphone and host without difficulty.

Placement of the IEC/BCC officers at the zone level

In 2004, a training workshop on the BCc Curriculum was organized for the Social Mobilization and BCC Officers, the zone coordinators, zone nurses and NGO representatives. The participants at this training workshop acted as trainers of trainers. In this regard, they trained the health workers that subsequently trained the CBSAs and COGEA/C members with the support of the zone coordinators and zone nurses. Some of the training for the health workers was monitored to better assess curriculum content and to assimilate the techniques used to get the messages across. These monitorings improved curriculum content and the techniques to be used to get the messages across. The monitorings at the CBSA training level and the discussions with the trainers showed the necessity of preparing modules on the essential activities that the CBSAs must carry out. These modules were prepared and they clearly and simply summarize most of the activities of the CBSAs.

Strengthening community participation
Deploy the community-based health workers
Curricula available for the CBSAs, COGEA and the COGECs
Income generating activities
IMCI and EONC activities
System for the supervision of the CBSAs by the CSAs
Motivation of the Community-Based Health Agents
Set up the social mobilization teams in the zones

Strengthening community participation

PROSAF contributed a social mobilization approach, originally in two zones, Bembéréké-Sinendé and Banikoara, that has now been expanded to the other zones. The approach emphasizes improving access to priority health services, including family planning, emergency obstetric and neonatal care (EONC), and the Community Integrated Management of Childhood Illnesses (IMCI) by community workers; and the effective co-management of health services between the communities and the health workers. After seven years of action, the components now in place and used regularly are presented in the box and some of them are described in greater detail below.

Deployment of the Community-Based Health Workers (CBSA)

Choosing the CBSAs was one of the first activities in the offer of services that is one of the three parts of the conceptual framework for implementing the IMCI community component. As the community participatory assessments and village action plans were carried out, the different structures that implement the community-based services are set up.

The CBSAs and health workers conducted education and interpersonal communication sessions using counseling cards and folders on malaria and diarrhea.

Curricula for the CBSAs, COGEAs and COGECs:

To make the CBSAs operational so that they can implement community-based services, training sessions were carried out for health workers and some resource persons and community stakeholders that were to provide training for the CBSAs. These workers were selected to train the CBSAs in their health zones because of the activities they perform. The general objective of this training is to familiarize the participants with facilitation techniques and supervision methodology, both of which will enable them to train and monitor the CBSAs in the field.

A total of 145 trainers were trained in all of the five non-concentration (5) health zones.

Based on COGEC actions that revealed the needs to be covered in terms of CBS using the participatory community self-assessment, the CBSAs from the health area in each CSA were identified with the full participation of the populations using the criteria identified and approved by everyone.

The purpose of training the CBSAs is to make them capable of offering health promotion services in their different health areas. Specifically, the purpose was to familiarize themselves with themes on:

- The community-based services concept
- Health promotion leadership techniques
- Integrated Management of Childhood Illnesses (IMCI)
- Family planning
- Sexually transmitted diseases (STD) and HIV/AIDS
- Management of community-based service activities

Several interactive methods and techniques were used, such as tests, micro-teaching, demonstrations, songs, simulations, etc. The trainers are CSA health workers supervised by the mobilization officer in each health zone and the community mobilization Technical Assistant that PROSAF Transition Phase placed in each HZMT to support the capacity-building of the health zones.

A total of 321 CBSAs had been trained in the five non-concentration health zones as of June 30, 2005.



Income Generating Activities (IGA)

Each of the seven pilot arrondissement health centers in the health zones of Banikoara and Bembèrèkè-Sinendé, and the Toura health center, which was added, received several support

visits from the social mobilization and behavior change communication officers and PROSAF Technical Assistants. The IGA carried out in these centers are the Village Boutique in Ina, Oil Marketing (which accounts for 50% of IGAs) in Kokey, Founougo, Ounet and Toura, the production and marketing of ice cream and lollipops in Sèkèrè, the cafeteria in Fo-Bouré and the “Bush Taxi” in Gamia. The communities contributed 33% of all the funding requirements to implement these activities. One IGA—the one in Toura—was financed in its entirety from internal funds raised in the arrondissement of Toura, a decentralized structure of the commune of Banikoara. Four (4) IGAs were co-financed between the communities and PROSAF, and three (3) were financed entirely by PROSAF.

The startup of the activities in the first seven centers coincides with the end of PROSAF. At this time, six out of eight IGAs are operating normally. They could achieve optimum profitability with a little more systematized supervision and management control. The IGAs in the other two health centers are experiencing difficulties and have had to suspend operations to better define them. The main difficulties found are failure to strictly apply the management rules and procedures, a lack of supervision by the HZMTs in the health zone of Bembéréké-Sinendé, and the irregular supply of petroleum products by SONCOP in the health zone of Banikoara. After the supervision visits, a certain number of recommendations were made: Everyone should re-read the IGA management procedures; IGAs should be incorporated into health center management supervision; non-performing committees should be restructured; and reimbursement plans should be effectively implemented.

Community IMCI and EONC:

PROSAF and the other community IMCI stakeholders (MCDI and PSS), and the EONC stakeholder (IntraHealth International), held various meetings to harmonize approaches to implement these strategies. In each health zone, the following activities were implemented with the technical and/or financial assistance of these different partners:

- Prepare an implementation protocol;
- Identify health centers for implementing each of the strategies;
- Identify persons who are to play the role of community facilitators (CFs);
- Train the community facilitators;
- Negotiate the partnership with the communities;
- Community participatory assessment.

Each health zone identified health centers in which the above-mentioned actions were developed on a pilot basis. In the Malanville/Karimama health zone, the community EONCs (c-EONC) covered the villages of six CSA health areas, while the health zones of NikKi/Kalalé/Pèrèrè (six CSAs), Kandi/Gogounou/Segbana (three CSAs), Parakou/N’Dali (two CSAs) and Tchaourou (three CSAs), implemented community IMCI (c-IMCI). A total of four CSAs implemented community EONC AND 14 CSAs implemented c-IMCI.

To support the implementation of the process in these health facilities, and in accordance with the multisectoral platform recommended for implementing community IMCI, 18 teams of Community Facilitators, consisting of 97 people, were set up. These teams are comprised in general of the unit head nurse, the midwife,



workers from the CARDER, community leaders, local NGO coordinators and ABPF zone coordinators. These teams were trained using an iterative system for conducting all the stages in the process. During this year, the key stages that have been carried out are negotiating the partnership with the community and the community participatory assessment.

5 CONCLUSION

During the period of its implementation, PROSAF Transition Phase put into operation the solutions that were proposed for the challenges identified at the end of the first phase of PROSAF. Plans to institutionalize the strengthening of health zone operational capacity, ascendant planning, the integrated formative supervision of the health workers, coordination and supervision of community-based activities, the integrated offer of the minimum package of family health in the private and public health facilities in Borgou/Alibori, and Quality Assurance, were prepared and successfully implemented.

Management capacities were strengthened at every level of the Borgou/Alibori health system, and the health workers mastered the tools to assess the system's performance and to manage the quality data. Innovative experiments, such as the introduction of the shorter six-day formula for clinical IMCI, the orientation (at a practical training session) for the newly assigned health workers, and training of nurse's assistants in FH protocols, have been successfully implemented and deserve to be scaled up.

The partnership between the health centers and the communities has become standard practice in all the health zones, with the goal of deploying the CBSAs. The popular and traditional media have become powerful vectors for getting across educational messages on family health in Borgou/Alibori. This is demonstrated by this region's contraceptive prevalence rate, which rose from 3.6% in 1999 to 12.3% in 2005.

Even with all these success stories, challenges remain in terms of strengthening these accomplishments in Borgou/Alibori without obscuring—most fortunately—the many opportunities.

It is important to pay special attention to two challenges that seem major. They are: i) leadership in the Borgou-Alibori DDSP to maintain and reinforce the accomplishments and ii) the departure from Borgou-Alibori of most of the physicians and other officers trained in various areas during this project. These two challenges alone could jeopardize the survival of the accomplishments made over the past seven years of PROSAF implementation.

The table below summarizes the potential challenges and opportunities which, if taken into account, could help the MOH continue strengthening family health services in Benin.

Challenge	Opportunities
Leadership at the DDSP level to maintain and strengthen the accomplishments	Make the DDSP officers that played the role of counterparts aware and motivate them DDSP vision to serve as role model at the national level for the various experiments conducted in Borgou/Alibori Include Borgou/Alibori in the POPFAM intervention zones
Keep a few of the officers that took part in implementing the PROSAF experiments (the departure en masse of the former MCDZs may jeopardize the accomplishments in some of the HZs)	There are HZMT members who are capable and motivated to continue strengthening the accomplishments Ownership of the tools and good practices by the new MCDZSs

Challenge	Opportunities
	<p>Include Borgou/Alibori in the POPFAM intervention zones</p> <p>Support the other partners who have come to own the PROSAF tools and approaches, such as PSS and MCDI</p>
Staff mobility	<p>Decentralize the management of health workers assigned to each HZ by the MCDZ (MOH Order of November 8, 2005)</p> <p>The MCDZs are responsible for permission for absence and administrative leave under (same Order of November 8, 2005)</p>
Continue to manage human, financial and material resources effectively	<p>Many health workers are trained in human resources and financial management</p> <p>New MOH Orders (No. 10196/MSP of October 19, 2005) establishing the duties of the Health Committee and setting the benefits to be paid out of community finances in the peripheral health units and facilities (Order No. 10277/MSP of October 21, 2005)</p>
Permanent availability of FH products, including contraceptives, at the different levels of the peripheral health system, including at the community level (CBSAs)	<p>Health workers trained in drug management and PIPEPLINE</p> <p>The will of the MCDZs to continue setting up zone warehouses with support from partners</p> <p>Political will to strengthen the CAME's technical and operational capacity</p>
Strengthen the partnership between the health center and the community and finance activities that promote health	<p>Each HZ has technical skills to carry out the process that is to culminate in the realization of the partnership</p> <p>Training the COGECs is an administrative requirement of the MOH for each MCDZ</p> <p>Many local elected officials are increasingly involved in the health issues for their populations</p> <p>Develop mutual health organizations</p> <p>BCC and community mobilization tools exist and the stakeholders are experienced (PTM)</p>
Continue the activities of the quality assurance collaborative	<p>Firm commitment by certain network team leaders, such as the team leader for the Prevention of Infections</p> <p>MOH commitment to effectively implement quality of care in Benin</p> <p>Potential pressure/demand from growing mutual health organization groups in Borgou/Alibori for better quality of care in the health facilities that offer health care services</p>
Periodically evaluate worker and health system performance	<p>There are tools that all the MCDZs and unit heads in the DDSP/BA have mastered</p> <p>Availability of certain partners such as the PSS to support this activity</p>
Validate and adopt the shorter six-day formula for clinical IMCI training	<p>Experiment carried out by nationals (physicians) who have been able to measure its benefits in terms of</p>

Challenge	Opportunities
	<p>quality (good learner performance) and in terms of costs (less costly than the eleven-day formula)</p> <p>Already adopted by the PSS, which uses it to train the HWs in Nikki-Kalalé-Pèrèrè</p> <p>Highly appreciated by USAID, which may support its national validation for use by POPFAM</p>

6 FINANCIAL REPORT

Period: January 10, 2004 to October 31, 2005

Contract No: 680-C-00-04-00039-00

Contract Cost	\$3,638,687
Fixed Fee	\$190,472
Total Contract	\$3,829,159
Obligation	\$3,829,159

Expenditures to Date by Line Item

Contract Line Item	Total Estimated Cost	Cumulative Expenditures to Date*	Remaining Funds
IR 1: Improved Policy Environment	\$797,346	\$738,988	\$58,358
IR 2: Increased Access to Family Health Services and Products	\$777,860	\$695,831	\$82,029
IR 3: Improved Quality of Services	\$732,008	\$705,522	\$26,486
IR 4: Increased Demand for Health Services and Prevention Measures	\$1,521,945	\$1,449,509	\$72,436
Total	\$3,829,159	\$3,589,850	\$239,309

Total Expensed Funds	\$3,589,850
Total Obligated Funds	\$3,829,159
% Obligated Funds Expensed	93.75%
Total Obligated Funds Remaining	\$239,309

Total Fee	\$190,472
Total Fee Billed	\$173,543
Fee Remaining to be Billed	\$16,929

Expenditures To Date by Funding Source

Fund Source	Obligation	Cumulative Expenditures to Date*
CLIN 001		
CSMH	\$282,612	\$261,602
ID	\$161,631	\$150,015
HIV/AIDS	\$85,114	\$79,072
POP	\$267,989	\$248,300
CLIN 002		
CSMH	\$269,200	\$240,758
ID	\$250,380	\$224,058
HIV/AID	\$19,242	\$17,396
POP	\$239,038	\$213,620
CLIN 003		
CSMH	\$257,560	\$248,344
ID	\$85,269	\$81,841
HIV/AID	\$116,255	\$112,178
POP	\$272,924	\$263,160
CLIN 004		
CSMH	\$442,673	\$421,807
ID	\$447,520	\$423,386
HIV/AID	\$184,926	\$176,840
POP	\$446,826	\$427,476

* Report does not include October 2005 field expenses; billing for Milestones 5, 14 and 20; or trailing costs.

**Annex 1:
Performance Monitoring Plan**

Annex: PROSAF Transition Phase Performance Management Plan

Results (Sub-IRs)	Achievements per Result	Indicator	Baseline	Target	Achievement 2005	Data source
IR 1: Improved Policy Environment						
<u>sub-IR 1.1 Improved health policies and strategies, and mechanisms for their implementation</u>	Achievement 1: Capacity to more efficiently manage human, financial, and material resources is increased at DDS and health zone levels.	1.1.1 Performance index for health zone team	57%	80%	86%	HZ Activity Reports
	Achievement 2: DDS and all seven health zones monitor and report data for family health indicators more accurately and regularly.	1.1.2 Percentage of health zones compiling quarterly data in scoreboard	86%	100%	86%	HZ Quarterly Monitoring Reports
	Achievement 3: Collected data are used for decision-making at all levels of the health system, public and private in Borgou/Alibori.	1.1.3 Percentage of HZMTs who have organized at least 4 decision-making sessions using data, per year	N/A	65%	95%	HZMT quarterly reports
<u>sub-IR 1.2 Strengthened management, planning and coordination capacity at all levels of the health system</u>	Achievement 1: DDS and all seven health zones improve implementation of strategic plans and annual operational action plans.	1.2.1 At least one annual plan review session organized by each HZMT and the DDS	2	7	7	HZ and the DDS Activity Reports
	Achievement 2: The ascending process of designing and implementing strategic and operational plans is institutionalized.	1.2.2 Percentage of health zones using ascendant planning process to develop their plans	28%	70%	100%	HZ Activity Reports
<u>sub-IR 1.3 Increased participation of civil society in the health sector</u>	Achievement 1: Monthly formative meetings are held by the health centers and COGECs/COGES.	1.3.1 Percentage of COGECs/COGES who are organizing monthly formative meetings	N/A	60%	87%	COGECs/COGES activity reports
	Achievement 2: Data collection procedures for family health indicators are improved at public and private sector facilities.	1.3.2 Percentage of public and private sector health facilities reporting data to HZMT	N/A	15%	94	Reports from HZMTs and DDS
	Achievement 3: A mechanism is institutionalized at the DDS and all seven health zones to plan, coordinate and supervise community-based services.	1.3.3 Percentage of HZMTs that, on a quarterly basis, include community-based services in their supervision tool and in the job descriptions of health workers	0%	80%	100%	HZMT activity reports
	Achievement 4: Increase percentage of communities in non-concentration zones that have COGECs trained to advocate for health issues including prevention measures.	1.3.4 Percentage of COGEC in non-concentration zones trained in advocacy for health	0%	60%	76%	Training reports
	Achievement 5: Partnership between health centers and communities reinforced.	1.3.5 Percentage of health zones who implement institutionalization plan for coordination and supervision of community-based activities	0%	80%	100%	HZMT activity reports

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Results (Sub-IRs)	Achievements per Result	Indicator	Baseline	Target	Achievement 2005	Data source
IR 2: Increased Access to Family Health Services and Products						
<u>sub-IR 2.1 Improved supply and commodity distribution system</u>	Achievement 1: Increase the delivery points that submit correct and timely orders for family health products (including contraceptives and selected essential drugs) over previous 12 months.	2.1.1 Family Health Product Order Management Index	70%	75%	98%	SNIGS and supervision report review
<u>sub-IR 2.2 Improved integrated family health service delivery</u>	Achievement 1: Increase number of public and private sector clinics offering the minimum package of family health services.	2.2.1 Percentage of public and private health facilities offering the minimum package of family health services in an integrated manner	50%	85%	94%	ERPA
	Achievement 2: Increase the contraceptive prevalence rate in Borgou/Alibori.	2.2.2 Contraceptive Prevalence Rate	11.2%	13%	12%	KAP survey 2005
<u>sub-IR 2.3 Increased community-based services and products distribution</u>	Achievement 1: Increase the number of communities in non-concentration zones that have MOUs with health centers defining roles of community-level organizations in the delivery of health services, commodities, and prevention measures.	2.3.1 Percent of communities that have a signed MOU with health centers in non-concentration zones	0%	25%	85%	MOUs signed
	Achievement 2: Increased percentage of populations in non-concentration zones that have access to community-based distribution of essential family health products.	2.3.2 Proportion of communities served by community-based agents offering a minimum package of family health products and services	0%	45%	39%	CBSA Activity Reports
	Achievement 3: COGEC perform outreach activities (vaccination, growth monitoring, IEC, etc.) once a month in selected communities.	2.3.3 Percentage of COGEC performing monthly outreach activities	N/A	57%	66%	COGEC Activity Reports

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Results (Sub-IRs)	Achievements per Result	Indicator	Baseline	Target	Achievement 2005	Data source
IR 3: Improved Quality of Services						
<u>sub-IR 3.1 Increased health worker capacity to manage health services</u>	Achievement 1: Quality Assurance culture is institutionalized at all levels of the health system in Borgou and Alibori.	3.1.1 Percentage of health care providers complying with essential norms for IMCI, FP, and prenatal care	IMCI: 19% FP: 4% PNC: 10%	IMCI: 30% FP: 30% PNC: 30%	IMCI: 9% FP: 0% PNC: 5%	ERPA
	Achievement 2: Transfer capacity to DDS and health zones through training and follow-up on management of human, material and financial resources.	3.1.2 Percent of health workers in the seven health zones trained in management of human, material, and financial resource management	0%	80%	Fin/Mat: 96% HR: 98%	Health zones and PROSAF training database
	Achievement 3: Increase the percentage of health workers in the seven zones trained in integrated family health services.	3.1.3 Percentage of health workers trained in integrated family health service delivery	7%	75%	87%	Health zones and PROSAF training database
	Achievement 4: Increase the number of midwives and nurses responsible for maternal care in non-concentration zones and trained in the management of obstetric and neonatal emergencies.	3.1.4 Percentage of midwives and nurses trained in neonatal and obstetric emergencies	25%	70%	100%	Health zones and PROSAF training database
	Achievement 5: Increase the number of health workers trained in IMCI in the four remaining zones.	3.1.5 Percentage of health workers in the four remaining zones trained in IMCI	0%	80%	124%	Health zones and PROSAF training database
	Achievement 6: Increase the number of health centers receiving four formative supervisory visits per year.	3.1.6 Percentage of health centers receiving at least one supervisory visit per quarter	76%	80%	88%	HZ and HC supervision report review
<u>sub-IR 3.2 Improved performance of health care workers</u>	Achievement 1: Increase the percent of service providers complying accurately with IMCI norms.	3.2.1 Percentage of health care providers complying with essential norms for IMCI	21%	55%	9%	ERPA
	Achievement 2: Increase the percent of children aged 12-23 months who are fully immunized before their first birthday.	3.2.2 Fully vaccinated rate	56%	75%	30%	KAP survey 2005
	Achievement 3: Assist the DDS to organize health performance assessment and follow-up.	3.2.3 Percentage of health centers receiving at least one health performance assessment per year	35%	60%	49%	ERPA report
	Achievement 4: Family health protocols and norms disseminated with PRIME II collaboration.	3.2.4 Percentage of health workers trained in the use of family health protocols and norms	70%	80%	86.7%	Health zones and PROSAF training database

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Results (Sub-IRs)	Achievements per Result	Indicator	Baseline	Target	Achievement 2005	Data source
IR 4: Increased Demand for Health Services and Prevention Measures						
		4 (a) ORT Rehydration Therapy Use Rate	61%	75%	69%	KAP survey 2005
		4 (b) Home Treatment/Care Seeking for Fever (Malaria)	55%	75%	89%	KAP survey 2005
<u>sub-IR 4.1 Improved knowledge of and attitudes favoring prevention measures and appropriate behaviors</u>	Achievement 1: Increase capacity of actors' communication (health workers, COGEC, CVS).	4.1.1 Proportion actors (workers, COGEC, CVS) trained in communication	28%	60%	66%	HZ and PROSAF II training database
	Achievement 2: Increase the percent of adults who can cite, without prompting, mosquito nets as a means of preventing malaria.	4.1.2 Proportion of people aged 15 years and over who cite, without prompting, mosquito nets as a means of preventing malaria	W 59% M 76%	70%	W 79% M 81%	KAP survey 2005
	Achievement 3: Increase the percent of women in union, aged 15-49, who can name, without prompting, at least three modern methods of contraception.	4.1.3 Proportion of women aged 15-49 in union who can name without prompting at least 3 modern methods of contraception	25%	50%	38%	KAP survey 2005
	Achievement 4: Increase the percent of adults who can cite, without prompting, two or more correct methods for reducing risk of HIV infection.	4.1.4 Proportion of people aged 15 years and over who cite, without prompting, two or more correct methods for reducing risk of HIV infection	W 47% M 56%	W:60% M: 65%	W 60% M 72%	KAP survey 2005
	Achievement 5: Increase the percent of men who can cite, without prompting, two or more symptoms of STIs.	4.1.5 Proportion of men aged 15-49 who can identify, without prompting, two or more STI symptoms for their own gender	39%	50%	55%	KAP survey 2005
	Achievement 6: Increase the percent of women who can cite, without prompting, two or more symptoms of STIs.	4.1.6 Proportion of women aged 15-49 who can identify, without prompting, two or more STI symptoms for their own gender	32%	45%	40%	KAP survey 2005

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Results (Sub-IRs)	Achievements per Result	Indicator	Baseline	Target	Achievement 2005	Data source
	Achievement 7: Increase the percent of mothers who can describe three behaviors related to preventing diarrhea.	4.1.7 Proportion of women aged 15-49 who cite, without prompting, at least 3 correct methods for preventing infant diarrhea	14%	20%	36%	KAP survey 2005
<u>sub-IR 4.2 Improved socio-cultural environment favoring the use of services and prevention measures</u>	Achievement 1: Increase the percent of children under three years of age with diarrhea in the past two weeks who were treated with ORT.	4.2.1 Proportion of children under 3 years of age with diarrhea in the past two weeks who were treated with ORT	61%	75%	69%	KAP survey 2005
	Achievement 2: Increase the percent of infants who are exclusively breastfed for the first four months of life.	4.2.2 Proportion of all infants 0-3 months of age who are exclusively breastfed	61%	70%	55%	KAP survey 2005
	Achievement 3: Increase the percent of married women of reproductive age who are using (or have a partner who is using) a modern contraceptive method at the time of the survey.	4.2.3 Proportion of married women of reproductive age who are using (or have a partner who is using) a modern contraceptive method at the time of the survey	11.2%	17%	12%	KAP survey 2005
	Achievement 4: Increase the percent of mothers who state that they would seek assistance from a provider if their child exhibits the signs and symptoms of acute respiratory infection (ARI).	4.2.4 Proportion of mothers or caretakers of children under 3 years of age who state that they would seek assistance from a provider if their child exhibits signs and symptoms of acute respiratory infection	68%	85%	66%	KAP survey 2005
	Achievement 5: Increase the percent of children under five years of age who had a fever episode in the past two weeks and were treated at home or were taken to a health center for treatment within 48 hours of onset of fever.	4.2.5 Proportion of children under 5 years of age who had a fever episode in the past two weeks and were treated at home or were taken to a health center for treatment within 48 hours of onset of fever	55%	75%	89%	KAP survey 2005
	Achievement 6: Innovative proposals related to IGAs received from trained COGECs for the provision of family health services and commodities at the community level.	4.2.6 Number of innovative proposals for income generating activities	7	25	22	COGEC proposals