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Senegal Projet de Réduction de la Mortalité et de la Morbidité Maternelle (PREMOMA) Annual Report, 2005



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Senegal Project:
Annual Report 2005

*Projet de Réduction de
la Mortalité et de la
Morbidity Maternelle
PREMOMA*



MANAGEMENT SCIENCES for HEALTH
strengthening health programs worldwide



a project of USAID
managed by
Management Sciences for Health and The Futures Group International



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ACRONYMS

ADEMAS	Agence pour le Développement du Marketing Social (Social Marketing Development Agency)
ANAFA	Association Nationale pour l'Alphabétisation et la Formation des Adultes (National Association for Adult Training and Literacy)
ANIOS	Association Nationale des Imans et Oulémas du Sénégal
ARPV	Association de Relais Polyvalents (Association of Multifocus Agents)
ASBEF	Association Sénégalaise pour le Bien Etre Familial (Senegalese Association for Family Well-being)
BCC	behavior change communication
CCF	Christian Children's Fund
CEFOREP	training center
CGO	gynecology-obstetrics clinic
COPE	Client Oriented Provider Efficient
CPN	prenatal consultation
CYP	couple year(s) of protection
DLSI	Division de la Lutte contre le Sida et des IST (Division to Fight AIDS and STDs)
DOT	directly observed treatment
DSR	Division de la Santé de la Reproduction (Reproductive Health Division)
ECD	Equipe Cadre District (District Executive Team)
ECR	Equipe Cadre Régional (Regional Executive Team)
EDS	Enquête Démographique et de Santé
EM	essential medicine
FP	family planning
GE	goutte épaisse (thick smear)
GPF	Groupement pour la Promotion des Femmes (Association for Women's Advancement)
ICP	head nurse of a health post (Infirmier Chef de Poste)
IEC	information, education and communication
IMAT	Inventory Management Assessment Tool
IPT	intermittent preventive treatment
IRH	Institute of Reproductive Health
IUD	intra-uterine device
JICA	Japanese Cooperation Agency
MSH	Management Sciences for Health
NGO	non-governmental organization
PNA	National Pharmacy (Pharmacie Nationale d'Approvisionnement)

PNLP	National Program to Fight Malaria
PRA	Regional Pharmacy (Pharmacie Régionale d'Approvisionnement)
PREMOMA	Maternal Morbidity and Mortality Reduction Project
PSM/PF	Projet Santé Maternelle et Planification Familiale (Maternal Health and Family Planning Project)
RH	reproductive health
RIP	Réseau de l'Islam et Population (Islam and Population Network)
RM	Région Médicale (medical region)
SANFAM	Family Health (NGO)
SDP	service delivery point (point de prestation de services, PPS)
SO3	Strategic Objective 3
SP	sulfadoxine-pyrimethamine
STD/HIV	sexually transmitted disease/human immunodeficiency virus
TACS	contraceptive procurement table (Tableau d'Acquisition des Contraceptifs au Sénégal)
UCAD	Cheikh Anta Diop University
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
USP/DQI	United States Pharmacopeia/Drug Quality Information
WHO	World Health Organization

EXECUTIVE SUMMARY

The USAID project for maternal health and family planning in Senegal, known as the *Projet de Réduction de la Mortalité et de la Morbidité Maternelle (PREMOMA)* and administered by Management Sciences for Health and the Futures Group International, started in November 2004. PREMOMA is the follow-on to the USAID Senegal Maternal Health and Family Planning Project (2000–2004). PREMOMA has made a significant contribution to the efforts of the government of Senegal and local non-governmental organizations in improving maternal health, reducing maternal mortality and increasing awareness of family planning. Two key intermediate results illustrate major accomplishments by PREMOMA thus far:

- ❖ **Improve access to prenatal services, assisted birth, post-natal monitoring and family planning by through integration and decentralization of services:** In the previous project, MSH achieved the following results:
 - The strengthening of service providers' technical skills related to maternal health, in particular the skills of nurses, who are present mostly in rural areas (80% of service providers trained were head nurses at health posts);
 - The decentralization of post-abortion care up to the health center level;
 - The design and implementation of an original community-based supervisory training approach in 197 service delivery points in 16 districts;
 - The development and implementation of a new policy for the prevention of malaria among pregnant women through IPT using sulfadoxine-pyrimethamine during prenatal care;
 - The implementation of an effective contraceptive supply system that reduces the occurrence of stock-outs attributable to depot managers, in order to accelerate progress in the CYP for contraceptives financed by USAID.

- ❖ **Increase demand for services.** Certain achievements warrant mention:

- The strengthening of resources for action of the maternal health/family planning program with the advent of the workers of the Association de Relais Polyvalents (ARPV);
- A model for communities to appropriate funds for reproductive health promotional activities implemented by the community health promoters (*persuadeurs communitaires*);
- The commitment of policy makers and opinion leaders in Senegal, as exemplified by the introduction of reproductive health content and skills into the Ecoles de Formations d'Instituteurs (EFI) and by the determined involvement of lawmakers in the National Assembly for the adoption of a law regarding reproductive health;
- The effective collaboration in the Kaolack District between the public and private sectors in health (nursing practices in particular), by regularly sharing periodic reports and by expanding training sessions and refresher training sessions for private personnel.

PREMOMA continues to use the strategies developed by the Maternal Health and Family Planning Project to achieve further positive results. PREMOMA activities are based on the following four strategies:

1. Improving the skills of health care agents;
2. Increasing the availability and quality of maternal health services;
3. Increasing the availability of contraceptives;
4. Improving knowledge and acceptance of and demand for reproductive health services.

These strategies are employed at 432 service delivery points in 25 health districts, in 5 of the 11 medical regions of Senegal, as follows:

- ❖ Maternal health and family planning activities in 22 districts;
- ❖ Family planning activities in the 3 districts of the Dakar region.

This report focuses primarily on the last four months of 2005. It reviews the activities conducted and results obtained from September through December 2005. The report also provides a summary of the progress achieved and the constraints noted during the life of the project so far—13 months of activity (November 2004 through December 2005).

The strategies developed by PREMOMA from September through December 2005 have achieved measurable results in the following four areas.

Strategy 1: Improving the skills of health care agents

The efforts implemented by the Maternal Health and Family Planning Project to strengthen the skills of service providers achieved satisfactory coverage in the training of health post head nurses (ICPs) and midwives in the fields of prenatal care, family planning and emergency obstetrics care. During the last four-month period, however, PREMOMA sought to strengthen the skills of service providers and stimulated the following levels of enhanced coverage:

- ✚ 61% of the 117 head nurses at health posts targeted were trained in post-abortion care. The percentage of service delivery points with at least one provider trained in post-abortion care increased from 39% to 100% in the health care centers and from 0% to 72% in the health posts;
- ✚ 37% of the 200 midwives involved in family planning services received refresher training on IUDs;
- ✚ 46% of the districts saw their providers trained to manage the third phase of labor, in order to prevent hemorrhage during childbirth, the primary cause of maternal deaths in Senegal.

Strategy 2: Increasing the availability and quality of maternal health and family planning services

- ✚ **Increased availability of post-abortion care:** By December 2005, emergency post-abortion care was available 24 hours a day at all health care centers covered by the REMOMA project. The percentage of patients treated by manual intra-uterine vacuum aspiration at the 23 health care centers had increased from 38% in 2003 to an average of 66% in 2004. In 2004, 84% of post-abortion care patients were given counseling before leaving the service delivery point. Among them, the proportion of patients that chose and received a method of family planning before leaving the health facility increased from 31% in 2003 to 53% in 2004.
- ✚ **Expansion of family planning services in Senegal** with the introduction of a new natural family planning method called the *fixed interval method* or the *cycle beads method*. In the 8 target districts, 124 providers were trained in 2 months. The beads are available at service delivery points that have a trained provider.
- ✚ **Repositioning of IUDs among methods of contraception:** After the start-up of the refresher training for midwives, specifically focused on counseling and IUD insertion and removal, monitoring showed that the average number of IUD insertions by government midwives who had undergone refresher training was 4 (0–18). Overall, out of the 995 new family planning clients (from October 1 through December 12, 2005), 91, or 9%, chose the IUD;
- ✚ **Sustained improvement in the quality of reproductive health services:** After a first round of supervisory visits in the 25 districts between 2003 and 2004, service delivery points in 5 districts received a second supervisory visit, including 3 districts (Kebemer, Louga and Linguere) between September and December 2005. In these 3 districts, the percentage of service providers complying with standards and protocols increased in the following areas: prenatal care (+4%), family planning (+8%), family planning counseling (+16%) and prevention of infections (+24%). All the service delivery points in these 3 districts implemented

COPE after its introduction during the first supervisory visit. These trends had already been observed during the second supervisory visit at Tivaouane and Khombole reported in the previous report. These results demonstrate the relevance of the formative supervision approach. From these results, PREMOMA can expect major positive changes in the quality of reproductive health services that truly contribute to better family health.

Strategy 3: Increasing the availability of methods of contraception

The purpose of PREMOMA is first to make contraceptive products available throughout the health care system while reducing stock-outs to the greatest extent possible. The project's goal is also to improve the management of essential medicines in order to facilitate their subsequent integration into a single distribution system with the National Pharmacy.

All districts in the USAID intervention zones were supplied with inventory levels that correspond to the established guidelines for the system. The percentage of SDP depots where basic methods (pills, injectables, condoms and spermicides) were available 90% of the time in the last six-month period was 87%. At 59% of these service delivery points there has been no stock-out of contraceptives during the past six months. The CYP in USAID zones increased by at least 18% between 2003 (53,645) and 2004 (63,694). During the first six-month period of 2005, CYP reached 76,458 at the national level.

These encouraging results are the product of:

- ✚ better control over the process for estimating needs and the process of ordering supplies with the use of contraceptive procurement tables, an activity managed by PREMOMA and coordinating all partner organizations donating contraceptives;
- ✚ a regular supply sent to district warehouses by the DSR (Reproductive Health Division) with a buffer inventory at regional levels;

- ✚ the training of warehouse personnel and the regular supervision of the district warehouses and the SDPs. All managers of SDP depots were trained to manage inventories.

With regard to the involvement and appropriation process used by the government, significant progress has been achieved. The plan to transfer logistical management of contraceptives to the Reproductive Health Division is in progress. The experience from integrating contraceptives into the logistics system of the National Pharmacy at Kaolack is currently being documented so it can be implemented at the national level. Finally, efforts by the Government of Senegal to lobby the partners for better contraceptive security are beginning to show success, with the establishment of a budget line item for the purchase of contraceptives, currently set at 90 million.

Strategy 4: Improving knowledge and acceptance of and demand for reproductive health services

Notable, yet still somewhat tentative, results are being realized in the area of services used by the community, based on the analysis of data from the 2005 EDS by comparing the intervention zones of the project to the national-level results. In the regions supported by the project, the prevalence of contraceptives is 14%, compared to 6% for the rest of Senegal. Ninety-four percent of women consulted a health professional during pregnancy, compared to 89% at the national level (this trend is confirmed by supervision of the 5 districts that received a second visit, where the rate of completion of three prenatal consultations is 51%, while it was 35% during the first supervision visit). We can conclude that the level achieved by these indicators at the national scale is due, to a large extent, to the efforts carried out in USAID intervention zones.

These results were obtained by behavior change communication activities that were intended to:

- ✚ promote the creation of a sociocultural environment favorable to the fight against maternal mortality through advocacy;
- ✚ reinforce the skills of community members in combating maternal mortality.

To get leaders and decision-makers to become more involved in maternal health issues, the promotion of awareness among religious leaders using the REDUCE model was continued, and 72 new leaders were oriented. Among them, 41% carried out promotion activities in the form of sermons during prayers and meetings with women. To go beyond the promotion of awareness as is currently done using the REDUCE model, and to help leaders make appropriate decisions to improve reproductive health, the project is introducing a model called “Safe Motherhood” for assistance in effective decision-making.

To strengthen the skills of the community to fight maternal mortality, two groups of community activists are used by the project through complementary approaches: Associations de Relais Polyvalents (ARPVs, or multifocus agents) and community health promoters.

- ✚ The multifocus agents, designated by their communities and organized into 123 associations, carry out informal talks, integrated or targeted home visits, and social mobilization activities. After an implementation period of one year, an evaluation of the skills of the ARPVs was conducted to show the areas of competence as well as any gaps in skills. To close these gaps, a pilot remote training program of multifocus agents began in December 2005. This program uses radio broadcasts focusing on maternal health, child survival, family planning, adolescent health, STDs/HIV and communication as a means of changing behavior. The first components for monitoring after broadcast of the first 5 episodes demonstrates an improvement of knowledge in monitoring of pregnancy from 28% to 56.9%, for malaria from 76% to 89% and for home care for malaria from 39 to 56%.

✚ The Community Health Promoter program is an approach that contributes to the establishment of monitoring during pregnancy, birth and post-partum care, and more continued use of family planning in the selected locations. After a pilot phase during the Maternal Health and Family Planning Project, the extension of this approach has been implemented in 4 districts since the previous four-month period. Within two months of implementation, 594 pregnant women were recruited in 2 months by 80 community health promoters, or an average of 7 pregnant women per promoter. Among those who gave birth, the family planning rates after birth were 17%.

To address acceptance of and demand for care, community involvement in the search for post-abortion care was a significant activity carried out during the four-month period in question. A community survey allowed us to evaluate the perception and attitudes of the population vis-à-vis the problems posed by post-abortion care. These communities were then invited to prepare action plans to promote better post-abortion care.

A few constraints were discovered as these activities were carried out:

✚ The uptake of formative supervision by the district teams is insufficient. This explains the insufficient frequency of supervision and therefore the difficulties in ensuring monitoring of the quality of services via indicators from the supervision grid;

✚ The program to strengthen leadership skills among upper-level executives from the Ministry of Health was not able to be continued during this four-month period, due to participants being unavailable, since they were occupied with priority activities at the level of the Health Management Office (Direction de la Santé), such as management of the cholera epidemic and floods;

- ✚ Introduction of the accreditation process for service quality was delayed by the desire of the Ministry to integrate this approach into the quality process currently being prepared;
- ✚ Information about the implementation of the prevention of mother-child transmission of HIV/AIDS activities is difficult to report due to lack of coordination of these activities among the DSR, the AIDS Division and the partners.

Despite these constraints, the project contributed to increasing the availability and use of RH services, in particular in the area of post-abortion care as well as acceptability and demand for services.

To strengthen progress and improve weaknesses, efforts should focus on:

- ✚ improvement of the quality of services, with target activities such as experimentation with accreditation in pilot zones and the continued implementation of formative supervision;
- ✚ better availability of family planning services through the implementation, in the long term, of a true community-based system of services using the operational device of the Association de Relais Polyvalents;
- ✚ consolidation of the introduction of intermittent preventive treatment against malaria among pregnant women by implementation of a plan to encourage IPT, in collaboration with the National Program to Fight Malaria;
- ✚ re-activation of activities to prevent mother-to-child transmission of HIV/AIDS, thanks to more effective collaboration among the various participants: PREMOMA will continue its efforts directed at achieving better synergy with the Ministry and with partners;

- ✚ continued pursuit of decentralization of emergency obstetrics care, including post-abortion care;
- ✚ continued pursuit of activities to integrate private service providers in health districts, while reinforcing the experience at Kaolack and initiating the same process in Dakar;
- ✚ participation and support of the community by strengthening the skills of ARPVs through formative supervision and remote training; continued extension of the experience of community health promoters, and the introduction of the Safe Motherhood model;
- ✚ improvement of monitoring of reproductive health indicators by establishing a tool for collecting these data. This measure will circumvent the problem of collecting indicators via supervision, and it has the benefit of allowing reproductive health coordinators from the districts to regularly share their results.

**SECTION A: PRIMARY ACTIVITIES CONDUCTED BETWEEN MAY AND
SEPTEMBER 2005**

CLINICAL ACTIVITIES

This section deals with activities related to the **services offered**, i.e. the **availability** and **quality** of maternal health and family planning services.

I. Availability of Maternal Health and Family Planning Services

A. Prevention of malaria among pregnant women

Intermittent preventive treatment with sulfadoxine-pyrimethamine (SP) was adopted during the consensus conference in June 2003. It is an important aspect of USAID's support for PNLP carried out by MSH.

The NGOs that participated at the community level and at the medical parasitology laboratory of UCAD responsible for quality control of the SP and the monitoring of SP effectiveness and tolerance at the level of the sentinel sites also participate in the implementation of the strategy at the operational level.

Objectives

The efforts carried out in the context of drug-based prevention of malaria among pregnant women must contribute to:

- increasing access to and use of prenatal services including the prevention of malaria among pregnant women;
- improvement of the quality of services offered.

Expected Results

- Prenatal consultation services are accessible and provide a package of prenatal care including the prevention of malaria among pregnant women.
- Research activities contributing to improving the quality of services offered are regularly carried out.

Strategies

The strategies to be carried out are listed below:

- Facilitation of the performance of activities at the central level
- Formative supervision and collection of data on prenatal care and intermittent preventive treatment
- Training of service providers in intermittent preventive treatment
- IEC regarding malaria among pregnant women
- Research into the quality of the SP
- Research regarding tolerance and the effectiveness of SP.

Activities Carried Out

1. Technical assistance to strengthen malaria prevention among pregnant women

Facilitation of the SP artesunate protocol validation among pregnant women

The meeting took place on January 26, 2005 with the members of the research committee, USAID representatives, PNLP personnel and a representative of the Reproductive Health Division (DSR). This protocol describes, on the one hand, alternative strategies for intermittent preventive treatment with SP (SP + artesunate) and on the other hand, dual therapy at the community level. It was validated and sent to WHO/AFRO by the WHO Dakar office for mobilization of 2005 research funds.

Facilitation of the preparation of the IPT Circular

During the formative supervision by MSH, frequent stock-outs of SP were observed in most of the facilities visited. These shortages reportedly occurred when inventories of SP from the telethon ran out, and there were no local initiatives, which risked compromising the correct administration of IPT.

So an informational report about this situation was submitted to the PNLP coordinator in order to strengthen prevention of malaria using SP among pregnant women. This report allowed the PNLP to propose national directives that summarize the actions to be taken in order to ensure that the SP is free, that

inventories of SP are renewed from funds allocated each year by the government to the various districts, and that SP is administered during prenatal care following the principle of directly observed treatment.

Preparation of the IPT data collection grid

To better consider the IPT aspect during formative supervision carried out by MSH, an addition was proposed to the various teams, that is, collecting data on IPT and treated mosquito nets at the service delivery points where visits were conducted.

Preparation of an IPT reactivation plan

In the context of strengthening preventive medication for malaria among pregnant women, a plan to revive IPT was proposed to the PNL and the Reproductive Health Division (DSR). This plan is intended to:

- strengthen the skills of providers of prenatal care in relation to preventive medication for malaria among pregnant women;
- collect information from service providers regarding the implementation of IPT in the various district;
- collect data regarding coverage of pregnant women with SP/IPT;
- collect information from SDP managers about the management of material resources (availability of SP, costs of SP, etc.) and the training of personnel in IPT;
- survey problems limiting the application of IPT in the district;
- prepare a plan to resolve the problems discovered with officials from the districts where visits were carried out.

It includes two phases: (1) an intensive phase involving supervision and collection of data on prenatal consultation and IPT at 15 service delivery points, which requires a commitment from the central, regional and operational levels; and (2) a phase involving consolidation or monitoring of IPT on a quarterly basis by the teams of officials from districts and regions.

Oversight of the technical performance of this plan will be provided by a monitoring committee comprising representatives of the PNLP, DSR and MSH/USAID. The start-up of the plan is scheduled for January 2006.

Results of Interventions

1. Coverage of pregnant women with SP/IPT

Table 1 presents the results obtained at the operational level. Overall, coverage with two doses of SP exceeds 80% within the various participants and intervention regions for the NGOs. Application of directly observed treatment is not, however, in effect at all service delivery points.

Table 1: SP coverage status of pregnant women

STRUCTURES	DESCRIPTION OF ACTIVITIES CARRIED OUT
AFRICARE (Ziguinchor Region)	In 2005, 6,954 pregnant women received two doses of sulfadoxine-pyrimethamine for IPT. Six hundred cases of malaria related to pregnancy were noted during this year.
PLAN (Nioro, Louga and Khombole Districts)	According to the mid-point survey of the Child Survival Project carried out in December 2005 at the district level, significant coverage rates were obtained: <ul style="list-style-type: none"> • Nioro: 87% of mothers received sulfadoxine-pyrimethamine. • Louga: 89% of mothers received SP.
CCF CANAH (Districts of Thiadiaye, Joal, Mbour and Popenguine)	27,286 pregnant women had prenatal consultations at the health care facilities in the districts of Thiadiaye, Joal, Mbour and Popenguine, which comprise the intervention area of CAMAT. In all four health districts, 39.73% of women coming in for prenatal consultations received a dose of IPT, and 30.67% received two doses during the period Jan.-Sept. 2005. According to the program evaluation carried out in Nov.–Dec. 2005 at the commune level in Mbour, the proportion of pregnant women who received prenatal examination services and who received at least two doses of SP was 96.8%.
MSH	530 service providers have already been trained in IPT in all of the intervention districts of USAID. During formative supervision carried out by MSH at 19 SDPs, the data on IPT were collected based on a specific grid. The following observations were made: <ul style="list-style-type: none"> • SP was sold at certain SDPs of the district for between 100F and 480F. • Most of the providers specify the status of the pregnancy but do not ask about any allergy related to sulfonamides.

	<ul style="list-style-type: none"> • Directly observed treatment is not used by service providers at most of the SDPs. • In the 19 health structures visited, 2,351 women received SP1 and 1,920 received SP2 in a 6-month period. This brings the effective rate of IPT to 77%. The same observation was made in the logistics survey, regarding PNL, AIDS and TB. • SP was reportedly out of stock at 42% of the facilities visited and directly observed treatment was reportedly only used by 46% of the persons interviewed.
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2. Monitoring of the quality of anti-malarials, including SP

In the context of support provided by USAID/USP to the PNL, a study on quality control of anti-malarial medicines was conducted at the sentinel site level by the medical parasitology laboratory of UCAD. The methodology used and the results obtained in 2005 are described below.

Study sites. Five regions of Senegal, including the peri-urban area of Guédiawaye (Dakar region) and four rural areas (Kaolack, Touba, Richard-toll and Velingara), were targeted in the first phase. These zones include sentinel sites under ongoing epidemiological monitoring and at this level regular monitoring of chemical resistance to plasmodium is carried out.

Sampling. The lots of anti-malarial medications were sampled at the level of the five target sites for the study. For a given molecule, the various lots available in the field, all of mixed origins, were collected, in a proportion of at least three lots per molecule.

For this study, samples of chloroquine, amodiaquine, sulfadoxine-pyrimethamine and derivatives of artemisinin were collected from public health services, private pharmacies and from the informal market. To this end, the sample data collection sheet prepared by USP/DQI was used.

Research methods. The samples and analyses were carried out by teams of students in their 6th year or graduates in Pharmacy, who had all undergone organized training coordinated by an expert from USP/DQI regarding standard operating procedures related to all activities carried out in the context of quality control for anti-malarial medicines.

All samples were tested by GPHF-Minilab at the level of the various sentinel sites to determine identity, breakdown time and the approximate dosage of active ingredients. The tests were carried out in accordance with the specifications of the Minilab. All products which presented a defect upon visual inspection or a non-standard breakdown test, or products for which the active ingredient presented during thin section chromatography a spot diameter less than that of the reference substance at 80% of nominal concentration, were considered to be of poor quality.

Sampling results. Sampling results for the five sites appear in Table 2.

Table 2: Sampling results

Regions	Total No. of Samples	No. of Samples from the Legal Sector		No. of Samples from the Informal Sector
		Private Sector	Public Sector	
Dakar	73	30	18	25
Velingara	63	29	15	19
Touba	91	16	11	64
Richard Toll	79	40	29	10
Kaolack	99	58	15	26
Total	405	173	88	144
Percentage	100	42.72	21.73	35.56

Quality of sulfadoxine-pyrimethamine. Table 3 shows the distribution of samples by site according to the results of the physical and visual inspection. Table 4 shows the results based on the flaking test. In Table 5, the results of testing for the amount of active ingredients are shown.

Table 3: Quality of samples, based on physical and visual inspection

Sentinel Sites	Sulfadoxine –Pyrimethamine	
	Adherence to Quality Standards	
	Met Standards	Did Not Meet Standards
Touba	16	6
Richard Toll	15	0
Kaolack	16	6
Dakar	11	5
Velingara	9	9
Total	67	26
Percentage not meeting standards	27.96	

Table 4: Quality of samples, based on the flaking test

Sentinel Sites	Sulfadoxine –Pyrimethamine	
	Met Standards	Did Not Meet Standards
Touba	22	0
Richard Toll	15	0
Kaolack	21	1
Dakar	16	0
Velingara	18	0
Total	92	1
Percentage not meeting standards	1.08	

Table 5: Quality of samples in relation to active ingredient content

Sentinel Sites	Sulfadoxine –Pyrimethamine	
	Met Standards	Did Not Meet Standards
Touba	17	5
Richard Toll	14	1
Kaolack	19	3
Dakar	13	3
Velingara	16	2
Total	79	14
Percentage not meeting standards	15.05	

In total, 31 samples out of 91 tested, or 34.1%, did not meet quality standards.

During the period of the study, 113 samples out of 405 analyzed, i.e., 27.9%, did not meet standards, for all the tests considered. We noted, however, that the majority of quality problems involved:

- non-compliance with good manufacturing practices (absence of manufacturer names and addresses, notices of usage, defective secondary packaging, etc.), which comprised 18.27% of cases;
- low active ingredient content, representing 11.85% of cases.

Among the target molecules, chloroquine is most affected (60 samples out of 104, or 57.7%), followed by sulfadoxine-pyrimethamine (31 out of 91 samples, or 34.1%) and amodiaquine (17 samples out of 82, or 20.7%). The lowest percentages of failure to meet standards were observed with quinine (1 out of 65 samples, or 1.54%) and derivatives of artemisinin, in particular artesunate (4 out of 63, or 6.35).

Evaluation of the rate of non-conformity with standards by site shows that the Velingara site ranks first, with 25.4% (physical inspection), 20.63% (dosage) and 15.8% (flaking) non-conformity, respectively, followed by the Touba and Dakar sites. The explanation

rests in the anarchic proliferation of fake pharmacies and non-standard depots in these three locations, in particular the Ocas market in Touba, the Diaobé market in Velingara, and "Keur serigne" in Dakar. Heavy trading between local populations and their Guinean and Gambian neighbors is a significant source of poor-quality medications and knock-offs.

Of the 113 samples overall that did not meet quality standards, 72, or 63.71% came from the informal sector, 24 or 21.62% came from the private sector, and 17 or 15.04% came from the public sector. This high percentage of non-conformity with standards from the informal sector again shows the urgent need to implement effective strategies to fight this illegal market for medicines, the proliferation of which seriously affects the attainment of goals to fight malaria.

Sixty samples of chloroquine were observed out of the 113 poor-quality samples, or approximately 53.09%. The SP, amodiaquine, quinine and artemisinin derivatives followed, with 7.45%, 15.04%, 0.88% and 3.54%, respectively.

3. Monitoring of Tolerance and Effectiveness of Anti-malarials

Tolerance of SP/IPT. With support from USAID, the medical parasitology laboratory carried out a study of the tolerance of SP among 196 pregnant women at the maternity ward of the Roi Baudouin health care center at Guediawaye. The analysis of data collected consisted of measuring and comparing the incidence of secondary clinical effects and the incidence of secondary biological effects in the two groups: anemia, thrombopenia, hypercreatininemia for serum creatinine level, elevated transaminases, and hyperbilirubinemia for serum bilirubin levels. The results are shown in Table 6.

Table 6: Frequency of complaints by patients after administration of SP

One month after administration of SP1			One month after administration of SP1		
Complaints	Number	Frequency (%)	Complaints	Number	Frequency (%)
Abdominal-pelvic pain	23	12.1	Abdominal-pelvic pain	21	12.6
Headaches	11	5.8	Headaches	10	6
Vertigo	5	2.6	Vertigo	2	1.2
Vomiting	2	1.1	Vomiting	3	1.8
Threat of early birth	2	1.1	Threat of early birth (prevalence) [?]	1	0.6
Fever	1	0.5	Fever	1	0.6
Cutaneous eruption	1	0.5	HTA	3	1.8
			Side pain	2	1.2
			Pharyngitis	1	0.6
			Hemorrhoids	1	0.6
			Metrorrhagia	1	0.6

This study has confirmed that SP used in IPT among pregnant women is well tolerated. No serious side effects such as Lyell's syndrome or Stevens Johnson syndrome have been noted.

The secondary cutaneous effects are minor: They involve two cases of cutaneous eruption, one of which was reported by the midwife as being an allergy to SP, which led the patient to stop treatment.

Clinical tolerance was found from biological analysis, with a low incidence of leucopenia (see Table 7). In regards to thrombopenia, a slight increase in incidence was noted before treatment and the second dose; however, the difference was not statistically significant.

Renal and hepatic tolerance of SP in the study cohort was satisfactory. Elevations in creatininemia, bilirubinemia, and transanimases were rare and were at levels near values considered to be normal.

Table 7: Biological data, 1 month after SP treatment

CATEGORIES/indicators	Before treatment	1 month after 1 st treatment	1 month after 2 nd treatment	P
Number	104	98	92	
Average hemoglobin rate (g/dl)	10.7	10.8	10.9	0.87
Percentage of anemia (< 7.5 g/dl)	1	0	0	–
Percentage of moderate anemia (7.5 – 10.5 g/dl)	37.5%	39.8%	30.4%	0.37
Leucopenia	2.9%	2%	2.4%	0.91
Thrombopenia (< 150,000)	4.8%	7.1%	8.7%	0.55
Average transanimase value (UI/l)	22.8	21.5	23	
Elevated transanimase levels (> 41 UI/l)	1 (1%)	1 (1%)	0	-
Average creatininemia value (mg/dl)	0.70	0.71	0.72	
Elevated creatininemia (> 0.9 mg/dl)	1 (1%)	0	1 (1.1%)	-
Average bilirubinemia value (mg/dl)	0.74	0.73	0.77	
Elevated bilirubinemia level	3 (2.9%)	0	0	-

Clinical tolerance was found from biological analysis, with a low incidence of leucopenia. In regards to thrombopenia, a slight increase in incidence was noted between the study's start and the second dose; however the difference was not statistically significant.

Renal and hepatic tolerance of SP in the study cohort was satisfactory. Elevations in creatininemia, bilirubinemia, and transanimases were rare and were at levels near values considered to be normal.

With regard to the fetus, results do not show any increase in morbidity and mortality compared to the data collected from the Roi Baudouin Center maternity activity report in 2002.

Effectiveness of sulfadoxine-pyrimethamine. The study was carried out by the medical parasitology laboratory of UCAD; it involved two cohorts recruited in the maternity clinics of Guediawaye (150 women) and Richard-Toll (128 women). It involved indicators related to pregnancy and delivery:

- prevalence of malarial infection and anemia at the start of the study;
- monthly incidence of episodes of malaria;
- monthly evolution of the average hematocrit value (based on each individual's report) using a T test for matched samples;
- frequency of malarial episodes during emergency consultations;
- proportion of women receiving 2 SP treatments;
- prevalence of placental infection;
- prevalence of birth weight < 2,500 grams;
- frequency of miscarriages, still-births and premature births.

Preliminary descriptive analyses have allowed us to observe that among the women monitored regularly from inclusion in the study to delivery, who have thus received the 2 specified SP treatments, there was:

- a **low incidence of malarial episodes**: 3.3 out of 100 women during the 6-month malarial transmission period at Guediawaye and 0.8 out of 100 women during 6 months at Richard Toll;
- an **improvement in hematocrit**, with an average increase between inclusion and delivery of 4.3 points at Richard Toll and 5.2 points at Guediawaye.

It must, however, be noted that at Guediawaye, the four episodes of malaria occurred more than one month after the first SP treatment. This seems to indicate that it is necessary for the SP/IPT be combined with the use of individual protection means such as materials treated with insecticide. In contrast, it was surprising to discover at Richard Toll a positive GE (thick smear) in the month following administration of SP.

Furthermore, it seems that iron supplements provided a clear benefit in relation to anemia. Treatment with SP alone cannot explain the changes in hematocrit during monitoring, in particular since the women had negative GE (thick smear) results.

It must be noted that at Guediawaye, of the 150 women included, only 121 (80.1%) actually had two SP treatments. For Richard Toll, data regarding the proportion of pregnant women actually receiving the two treatments were not yet available. This SP2 coverage rate at Guediawaye seems low for us, to the extent that the patients had free access to care and they were regularly motivated by telephone contact by a social worker.

Evaluation of the link between artesunate and SP for IPT among pregnant women. The study was conducted by the Medical Parasitology Laboratory, under the auspices of USAID support to PNLN, in conjunction with the maternity center at Ndiareme located at the Ndiareme market at Guediawaye. The study's goal is to evaluate the effectiveness and tolerance of intermittent preventive treatment of malaria among pregnant women with sulfadoxine-pyrimethamine associated with artesunate. The first stage or inclusion in the study occurred from October 12 through November 30, 2005. It involved the selection of women meeting the study criteria. In total, in 29 days, 50 women were included in this study, which is in progress. The results may be available in the first half of 2006.

Constraints

- The low level of coordination between the Reproductive Health Division (DSR) and the National Program to Fight Malaria (PNLN) limits the preparation and implementation of the agreed-upon action plan for prevention of malaria among pregnant women.
- Sulfadoxine-pyrimethamine is presented in blister packs of three doses. This presentation is used both by pregnant women who receive it free for IPT during a prenatal visit and by patients who buy it for combined treatment of simple malaria.

- There are therefore two types of management of a single product intended for different target audiences. This situation did not favor good availability of SP/IPT and could even limit the impact of communication on IPT.
- The coverage of pregnant women with SP/PI is not known in all health care facilities due to non-standard data collection methods.
- The IPT supervision grid, which allows better evaluation of the implementation of the strategy and regular collection of data about IPT and prenatal consultations, has not yet been adopted and used by the PNL and DSR.

Lessons Learned

- Research conducted by the Medical Parasitology Laboratory of UCAD at the level of the sentinel sites allows the quality, tolerance and effectiveness of SP to be monitored and guides strategies.
- The various quality control studies of anti-malarials conducted since 2003 at the sentinel sites chosen in Senegal have shown a high percentage of non-conformity to standards resulting from poor-quality medicines from the informal sector, primarily involving chloroquine, followed by SP and amodiaquine.
- The involvement of NGOs in activities related to IPT facilitates monitoring of pregnant women at the community level and the collection of data regarding IPT and prenatal consultations.
- Formative supervision allows better evaluation of the level of application of the strategy by the service providers and regular monitoring of IPT among pregnant women.

Next Stages

- Continue to monitor the effectiveness and tolerance of sulfadoxine-pyrimethamine used for intermittent preventive treatment.
- Continue monitoring SP quality at the level of sentinel sites.
- Implement the plan to reactivate IPT among 15 service delivery points.
- Supervise NGOs participating in conducting action plans involving IPT at the operational level.

- Facilitate the organization of quarterly supervisory and data collection visits regarding prenatal care and IPT at the district level by NGOs and regional and district executive teams.

Recommendations

- Implement a framework for multi-sector cooperation to strengthen malaria prevention among pregnant women.
- Develop a specific presentation of SP intended for pregnant women
- Monitor the application of directly observed treatment and the free provision of SP.
- Standardize the data collection tools for prenatal care and IPT.
- Collect and regularly analyze data regarding IPT.

B. Prevention of hemorrhage during delivery

This is one of the essential components of the project to improve maternal health. Post-partum hemorrhage is the primary cause of the death of mothers and its prevention can have a far-reaching impact in reducing maternal mortality. The project supported the Reproductive Health Division (DSR) in reviewing policies, standards and protocols for reproductive health services comprising active management of the third phase of labor. Intervention at the level of service delivery points consisted of strengthening skills of qualified personnel through orientation sessions that are also an opportunity to recall and discuss standards and norms regarding the storage and use of oxytocin and the primary role of qualified personnel in preventing hemorrhage during delivery. These instruction sessions are monitored and carried out during formative supervision visits.

For this period of September through December 2004:

- **service providers in 6 health districts were involved, which brings to 10 (i.e., 42%) the number of health districts with qualified personnel who have received this instruction;**

- 204 participants were trained, of which 86% were providers (101 government midwives, or SFEs, and 76 health post nurses) and 14% were members of district and regional executive teams.

The use of the technique by care providers who have been trained will be evaluated during upcoming formative supervision visits.

C. Post-abortion care

Improvement of post-abortion care at the service delivery points of the 23 health districts covered by the project requires strengthening skills of care providers and the availability of the equipment necessary for quality treatment of incomplete abortions. Care providers at all levels must have the skills to offer appropriate and quality counseling to patients after an abortion (before, during and after treatment), to identify any complications, treat them or refer them to a higher level according to the standards and protocols for post-abortion care.

Training

During this period of the report, the efforts undertaken during the previous months to strengthen the skills of care providers in post-abortion care were continued, as follows:

- After development of a training curriculum for post-abortion counseling, a pool of trainers selected from the District Executive Teams and Regional Executive Teams was established for each of the four medical regions (Thies, Ziguinchor, Kaolack, Louga). Each regional pool includes 15 trainers, with at least 2 trainers per health district. A training session for trainers was held in each region (Kaolack, October 20-25; Thies, November 21-25; and Ziguinchor, December 19-23, 2005). Upon completion of each session, the participants planned the training of counselors for their respective districts.
- **Training of health post nurses in post-abortion care** for better accessibility of services was the subject of a sub-contract with CEFOREP. Three sessions of the

nine covered by the contract took place in Thies (November 2-3, 2005; December 1-3, 2005 and January 4-6, 2006). Thus, in the Thies region all service delivery points (regional health centers, 8 district health centers and the 103 urban and rural health posts) currently offer post-abortion care services.

Monitoring

The support provided by the project to DSR since 2003 for dissemination of the results of operational research into post-abortion care, strengthening skills of care providers, material support, and formative supervision fostered a corresponding improvement in post-abortion care at the level of the 23 health districts.

Access to post-abortion care services. The percentage of service delivery points with at least one provider trained in post-abortion care has increased dramatically, from 39 to 100% for all health centers and from 0 to 72% for health posts. (See Figure 1.) Post-abortion care services are available 24 hours a day at the 23 district health centers.

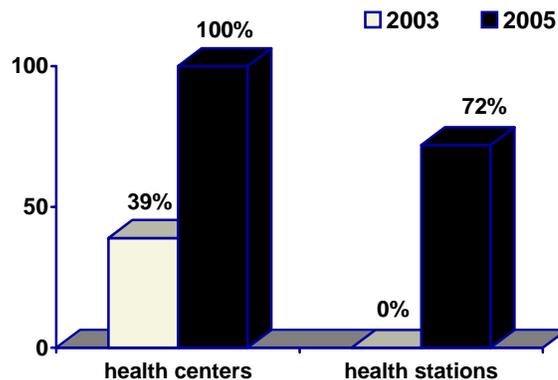


Figure 1: Percentage of service delivery points (health centers and health posts) that offer post-abortion care, 2003 and 2005

Utilization of post-abortion care services. The number of patients seen for post-abortion care in the 23 district health centers doubled (1,203 patients in 2003 and 2,390 patients in 2004).

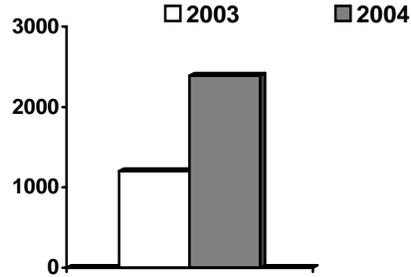


Figure 2: Number of patients seen for post-abortion care at the 23 health centers in 2003 and 2004

Of course, the availability of post-abortion care at the level of the 23 health centers could explain the significant increase in post-abortion patients seen at certain service delivery points between 2003 and 2004. However, certain other explanations may be proposed, in particular:

- the establishment of the post-abortion care register, allowing care providers to better record information about abortions;
- trained health post nurses who refer more cases of abortion with an indication of manual intra-uterine vacuum aspiration at the level of the health centers;
- integration of the prevention of abortion and the corresponding complications into informal talks held through the service delivery points;
- inclusion of post-abortion care in the activities of community health promoters at the level of certain health districts.

Manual intra-uterine vacuum aspiration for evacuation of the uterus is the preferred treatment for post-abortion care. It is as effective as D&C but it is less costly and more accessible (can be performed by a midwife or a trained nurse) and involves fewer complications. **The percentage of patients treated using manual intra-uterine vacuum aspiration at the 23 health centers increased from 38% in 2003 to an average of 66% in 2004.**

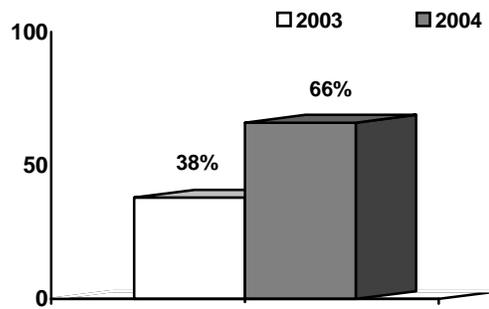


Figure 3: Percentage of patients treated using manual intra-uterine vacuum aspiration at the level of the 23 health centers in 2003 and 2004

Any woman, after an abortion, must receive information about post-abortion family planning and available family planning methods, and screening and treatment for STDs/AIDS through quality counseling. In 2004, **84% of post-abortion patients received counseling before leaving the service delivery point.** These data are not available for 2003. Among patients who received counseling, the proportion of **patients who chose and received a method of family planning before leaving the health facility increased from 31% in 2003 to 53% in 2004.**

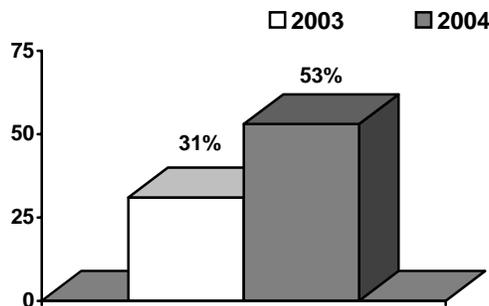


Figure 4: Percentage of post-abortion patients who received a method of family planning before leaving the maternity clinic in 2003 and 2004

However, the changes in these indicators are not the same for all health centers. The challenge is to maintain gains and strengthen counseling and family planning after abortions even more, as well as Component 4 of post-abortion care (connection to other

reproductive health services, in particular prevention and treatment of STDs/HIV/AIDS). Screening and treatment for STDs as well as the proposal for voluntary HIV screening for post-abortion patients may be a goal for the next monitoring visit for post-abortion care at certain targeted service delivery points.

1. Increases in the choice of contraceptive methods

In the context of the support provided to the **plan to encourage the use of IUDs**, initiated by DSR, the following activities were carried out during the latest four-month period.

- ✚ Dissemination of the results of studies on the use of IUDs for members of the district executive teams and regional executive teams, and care providers, was linked to instruction on management of the third phase of labor.
- ✚ The refresher training program for midwives was carried out through a sub-contract with CEFOREP.
- ✚ A meeting to standardize training tools was held on August 26, 2005 at the facilities of CEFOREP. It brought together all trainers (DSR, CGO, consultants, PREMOMA) and facilitated standardization of the methods and contents of the training program.
- ✚ Eight of the 20 sessions planned took place during the last four-month period. Six training reports were received: 73 government midwives received refresher training regarding IUDs (IEC, placement and removal techniques, family planning services). The average number of insertions and removals per participant during training were 3 and 1, respectively.
- ✚ Thirty government midwives received refresher training in the medical regions of Thies, Louga and Kaolack, and they received a supervision/coaching visit approximately three months after receiving training. A supervision grid was prepared for this purpose, in particular showing the availability of equipment, observation of skills followed by feedback (counseling, insertion and removal of the IUD following IP guidelines), application of skills (proportion of new family planning clients choosing and using the IUD after training).

These results came from these early monitoring visits:

- The average number of IUD insertions after training per government midwife who received refresher training was 4 (0 - 18).
- The average number of IUD removals after training per government midwife who received refresher training was 1 (0 -5).
- Overall, out of the 995 new family planning clients (from October 1 through December 12, 2005), 91, or 9%, chose the IUD.

The primary constraints encountered in the field were insufficient supplies required to insert or remove the IUD as well as lack of IEC materials at the SDP level, and insufficient IUD awareness activities.

Recommendations were made by the supervision teams to the district executive teams, the DSR and PREMOMA to enable the care providers who were trained to better use the skills they had acquired.

D. Introduction of the Fixed Days Method

In spite of efforts to increase access to family planning in Senegal, the prevalence of contraceptives is low, at 10.3%. The fixed days method, a new, modern family planning method developed and tested by Georgetown University, is a simple and natural method based on the woman's menstrual cycle. With a colored set of "cycle beads," the woman avoids pregnancy by abstaining from unprotected sexual relations during her fertile days. Used correctly, the fixed days method is 95% effective in preventing pregnancy. The fixed days method is also affordable: the cost of each set of beads is less than one US dollar. The fixed days method is a method that helps to meet the unmet family planning needs that still exist in Senegal (35%).

It also meets the need for a natural method that may easily be added to the range of contraceptive methods already available. In the context of Senegal, the fixed days method offers a simple, effective and affordable opportunity to increase the prevalence of contraception among women of reproductive age. In September 2005, MSH, the

primary collaborator of the Reproductive Health Division for family planning, launched the first phase of introduction of the fixed days method in Senegal, with the following goals.

Goals

- Introduce the fixed days method into the range of methods available in Senegal.
- Collaborate with NGOs and community-based organizations that offer natural family planning to provide and promote the fixed days method.
- Promote the fixed days method as a method for couples, by focusing on the involvement of men.

Expected Results

- A cadre of care providers trained to offer the fixed days method;
- An increase in the use of family planning among women who have never used family planning;
- Partnerships with NGOs and community organizations to supply and promote the method within the community.

Strategies

Goal 1: Introduce the fixed days method into the range of methods available in Senegal

- A total of three regions and 8 districts were chosen for intervention: In Dakar, the 3 districts of Mbao, Rufisque and Guediawaye were chosen, as well as Catholic facilities (10) in the city of Dakar. In Thies, the 4 districts of Joal, Popenguine, Thadiaye and Mbour were chosen, as well as the Thies Medical Region. A single district, Ziguinchor, was chosen in the region of Ziguinchor due to the commitment of the medical team to reproductive health activities.
- Training of trainers took place and involved personnel from the DSR, PREMOMA, the National Health and Social Development School (ENDSS), the Obstetrics and Gynecology Clinic at Chu A. Le Dantec, and the Senegalese Association for Family Planning (ASPF), as well as the regional executive teams, except for the

Ziguinchor region. In the intervention zones, the reproductive health services providers were trained to offer the fixed days method. In the districts of Guediawaye, Joal and Popenguine, the providers at health centers, reference health centers and health posts were trained. In the other districts targeted by this phase of introduction (Mbao, Rufisque, Mbour and Thiadiaye), only the service providers from health centers and reference centers were trained.

- A monitoring and evaluation plan was developed. The registration of women using the fixed days method will be included in the existing management tools at the health care facilities. The tools for collecting data and supervision were developed and shared during the service provider training sessions. A coaching system was prepared to support the service providers during the first months of providing these services. Ideally, the coaching will be included in the supervision activities at the district levels.
- A coaching visit was carried out in the Joal district, and 5 service providers were supervised.

Goal 2: Collaborate with NGOs and community-based organizations to offer and promote the fixed days method in the community

- Collaboration was established with the Christian Children's Fund (CCF) to conduct community promotion of the fixed days method in the 4 districts of Thies involved in the intervention. The promoters and coordinators from CCF received training on December 21 and 22 on community awareness.
- An ASPF representative was trained during the training session for trainers. A meeting with the director of ASPF took place on December 14 to discuss integration of the fixed days method into the activities of the ASPF. A training of trainers for their supervisors is planned for February 1, 2006.
- Collaboration was established with the Association of Private Catholic Dispensaries in Dakar to offer and promote the fixed days method in the context of their natural family planning activities. The training of service providers will be discussed at the level of the general assembly of Catholic nuns in February 2006.

It is probable that the training will be coordinated with the providers from the ASPF.

Goal 3: To promote the fixed days method as a method for couples, by focusing on the involvement of men

- In collaboration with the DSR, the IEC tools will be prepared and preliminarily tested to facilitate promotion of the fixed days method as a method for couples.
- NGOs and community organizations that are collaborating on the intervention were oriented regarding the need to involve men. The representatives of the CCF and the Catholic organizations will be trained in the involvement of men in the context of community awareness regarding this method.

Results

Training of service providers. A total of 165 service providers were trained. Most of the service providers (63%) were women. Most of the service providers trained were midwives (41%), followed by supervisors (15%) and community representatives (22%) (Figure 5). The service providers trained work at health centers (30%), followed by NGOs (25%), health posts (19%), and district executive teams (14%) (Figure 6). Table 8 shows distribution by type of service provider trained by region. Table 9 shows distribution by work location for persons trained by region.

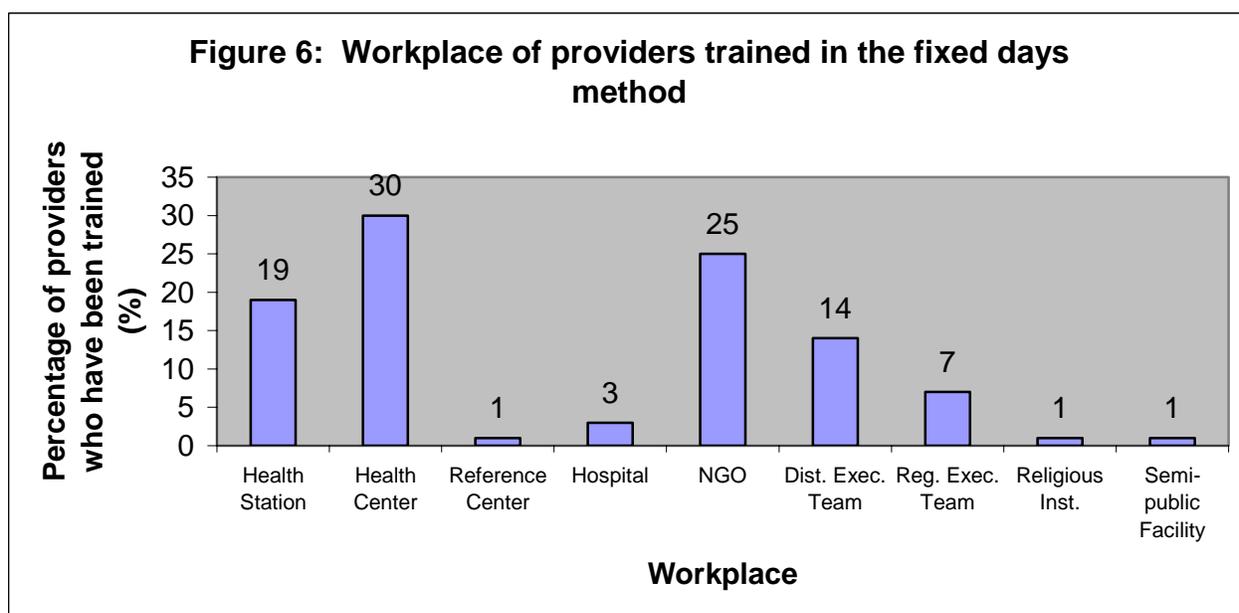
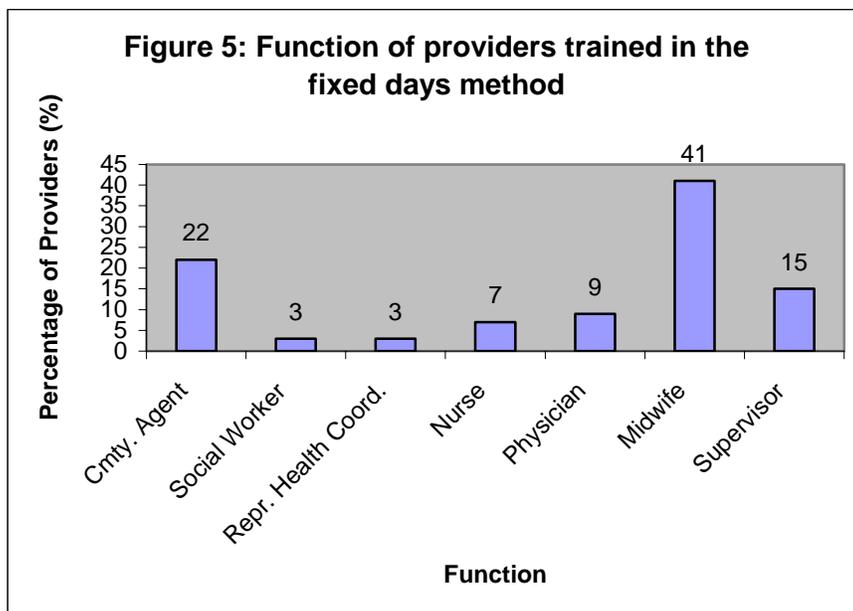


Table 8: Functions of service providers by region

	Functions of service providers by region							Total
	Physician	Midwife	Nurse	Social Worker	Supervisor	R.H. Coordinator	Cmty. Representative	
Region								
Thies	3	11	12	3	16	3	37	85
Dakar	12	56	0	1	9	2	0	80
Total	15	67	12	4	25	5	37	165

		Table 9: Origin of persons trained by region								Total	
		Health Post	Health Center	Hospital	NGO	Ref. Center	District	Region	Religious facility		Para-public facility
Region	Thies	9	7	4	41	2	11	11	0	0	85
	Dakar	22	43	0	0	0	12	1	1	1	80
	Total	31	50	4	41	2	23	12	1	1	165

Users of the fixed days method. Table 10 shows the client data in the fixed days method program for October through December 2005. In November, a total of 5 new users was observed in the Thies region. Most of the new clients (60%) were already using another family planning method. Most of the new clients (60%) decided to use a barrier method combined with the fixed days method. As of the end of December, 1 client had abandoned the use of the fixed days method.

Table 10: Clients in the fixed days method program, October–December 2005

	October 2005	November 2005	December 2005
New fixed days method clients in the program	0	2	0
Former fixed days method clients in the program	0	3	0
Clients using the fixed days method and abstinence	0	2	2
Clients using the fixed days method and a barrier method (double protection)	0	3	2
Number of pregnancies	0	0	0
Number of persons abandoning use of the method	0	0	1
Active clients	0	5	4

Coaching fixed days method providers at Joal. Five providers in the Joal district were supervised, and they showed:

- good knowledge of the cycle beads;

- difficulties in caring for specific cases, and follow-up visits.

The results appear in Figure 5.

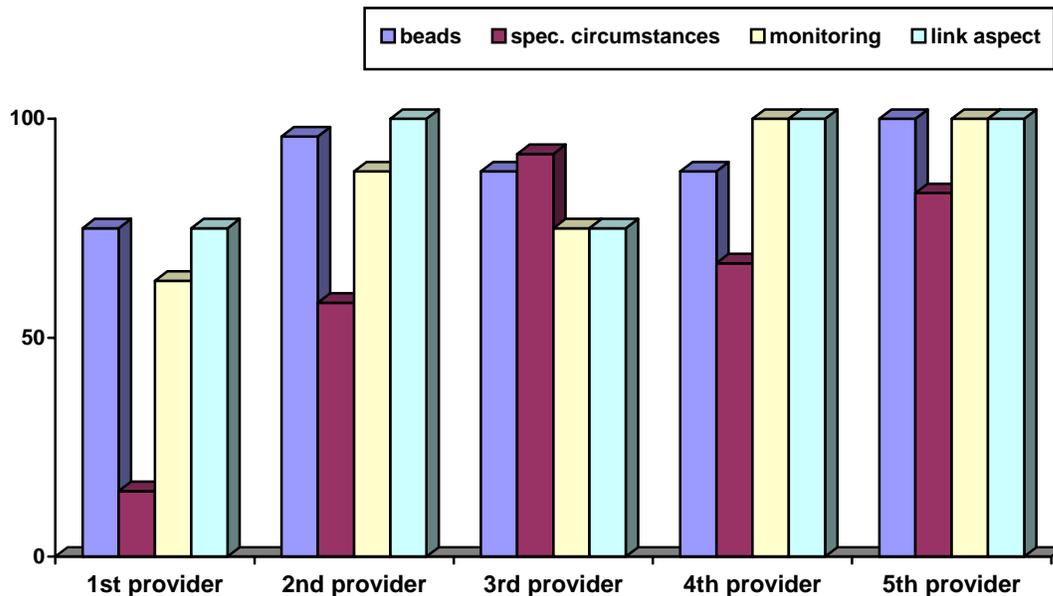


Figure 5: Skills of the fixed days method providers

Training of coordinators and health promoters from CCF

- Thirty-six coordinators/promoters and 4 supervisors from CCF were trained in community awareness regarding the fixed days method.
- A follow-up plan was prepared by the supervisors of the CCF representatives. The Joal and Popenguine representatives integrated the fixed days method into their monthly plan of action as of January 06. Those from Mbour and Thiadiaye attended the training for service providers in order to begin community awareness activities.

Development of three IEC Tools

- An aide-memoire insert used by representatives (ARPV) and the community representatives of CCF.

- A poster presenting the fixed days method as an additional method of birth spacing, to be displayed in waiting rooms of health care facilities.
- A tool for provision of services, assisting service providers to determine the eligibility of clients for the fixed days method. A desk calendar with checklists for the initial visit and the follow-up visit.

Limitations

The primary limitations of the fixed days method program are:

- The duration of the PREMOMA program. With the end of the PREMOMA program anticipated in October 2006, less than one year remains to collect the data and evaluate the impact of the new method.
- A limited sample. Eight districts in 3 USAID regions were chosen to facilitate the management of the fixed days method program in the time remaining for the PREMOMA project.

Lessons Learned

- The use of the tools developed and tested by the Institute of Reproductive Health is very important, in particular for providers who have just been trained to offer the fixed days method. During training, it was noted that providers did not use tools, such as the checklists, to determine the eligibility of a client, the calendars for calculating length of the woman's cycle, and the reminder note cards.
- The planning of trainings and in particular monitoring visits is limited by the other activities being conducted in the intervention areas.
- Community organizations and NGOs are very interested in the fixed days method and are ready to collaborate with MSH to introduce this method.
- Good feedback is necessary in order to develop and refine the IEC tools. Before the tools are finalized, the technical team had the opportunity to offer feedback and suggestions. The DSR was also involved in the development of the tools. The preliminary testing offered a public perspective on the tools, by holding a focus group.

Recommendations

- Focus on the use of service delivery tools during trainings and follow-up visits.
- Negotiate follow-up visits with the district executive teams as early as possible after trainings are held, in order to support the service providers in offering the fixed days method.
- Continue to involve the Reproductive Health Division in trainings and follow-up visits.
- Plan the training of counselors and ARPVs in the intervention areas.

Perspectives

The small number of new clients (5) in the program shows the need to improve efforts in promoting this method, not only among the public, but also among service providers. The training of counselors will also be important in promotion of the method throughout the community. The coaching visits offer an opportunity to see how to support the service providers and to ensure that they are comfortable with offering this method. It is important to work with the districts to organize visits and integrate them into their own activities.

II. Quality of Maternal Health and Family Planning Services

A. Consolidation of the process of implementing formative supervision

During this four-month period, a significant stage in the process of implementing formative supervision by the health districts was achieved. A quick evaluation of formative supervision was carried out during the previous four-month period. One of the recommendations of this evaluation was to give the health districts the initiative and an active role in the technical preparation of supervision with limited support from the central level.

As in the Ziguinchor medical region, three health districts in the Louga medical region (Louga, Kebemer and Linguere) carried out a second supervision visit at the level of

their service delivery points. A service report for the medical region with the schedule of visits invited all the MCDs to send at least two team members to participate in the visits.

At the level of each of the three districts, the district executive team agreed to carry out the entire process.

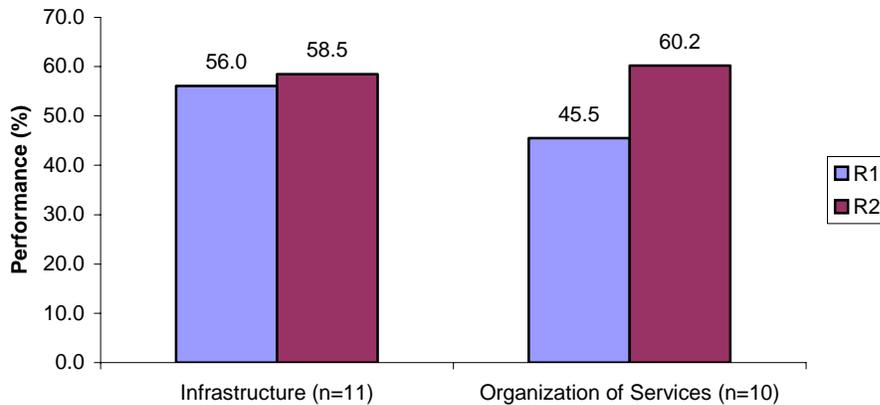
- The district executive teams thus organized a preliminary meeting with all the supervisors of the region. During this meeting:
 - the service delivery points to be visited were identified by the district executive team;
 - for each service delivery point, the goals of the supervision visit were specified, based on the results of the previous visit. The activities of the service delivery point that had low performance levels were targeted first for this visit;
 - the supervision tools and materials were shared and distributed among the various teams of supervisors, each conducted by a member of the district executive team.
- At the level of each service delivery point, the leader left the district team member in charge as the team leader to conduct the visit with the personnel from the facility, and to facilitate the meeting to prepare the action plan with the community representatives.
- Upon completion of the visits, a results meeting was held with all the supervisors to share the results and make recommendations for the health district and the medical region.

These visits allowed information to be available regarding the various activities observed and to compare changes in performance levels for the service delivery points in offering reproductive health services. Eleven service delivery points were visited in Louga, 12 in Kebemer and 7 in Linguere.

Environment, infrastructure and organization of services at the level of the service delivery points. At Louga, although it is still insufficient, the environment (condition of the

courtyard, restrooms and enclosures), infrastructure (condition of walls and floors) and the organization of services had improved throughout the 11 service delivery points visited between the first and the second supervisory visit.

Figure 6: Change in Infrastructure and Organization of Services between 2 Rounds of Supervision in Louga



Technical skills of service providers. At the level of the two health districts in Louga (Figure 7) and Kebemer (Figure 8), the performance of service providers (in prenatal visits, family planning, counseling, infection prevention and medication logistics), while still inadequate, improved between the two supervision visits, in particular in infection prevention (+30% at Louga and +33% at Kebemer). These results demonstrate the relevance of the formative approach for supervisors and allow us to expect major changes in the quality of district reproductive health services that will be truly appropriate for family health.

Figure 7: Changes in Technical Competence between Two Rounds of Supervision in Louga

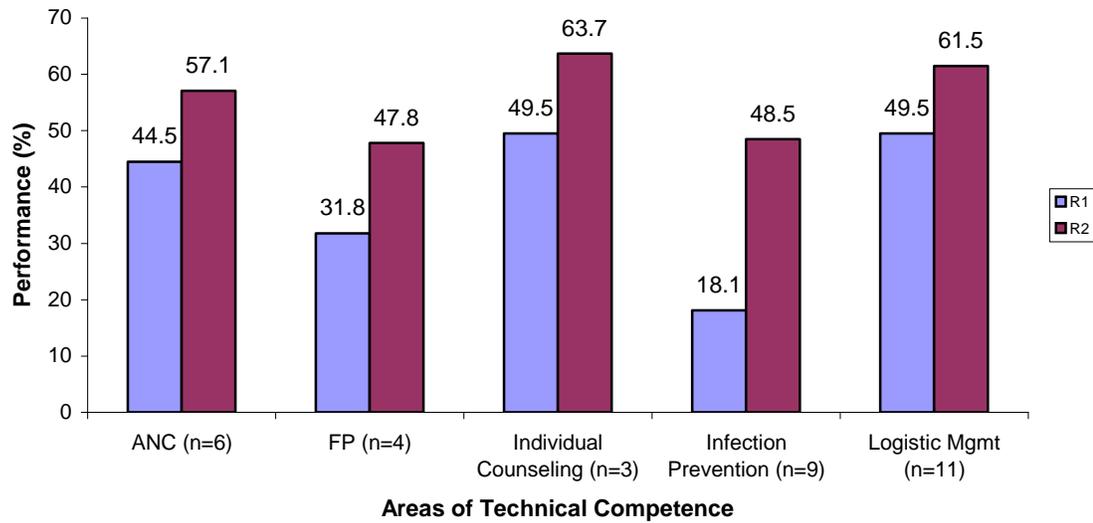
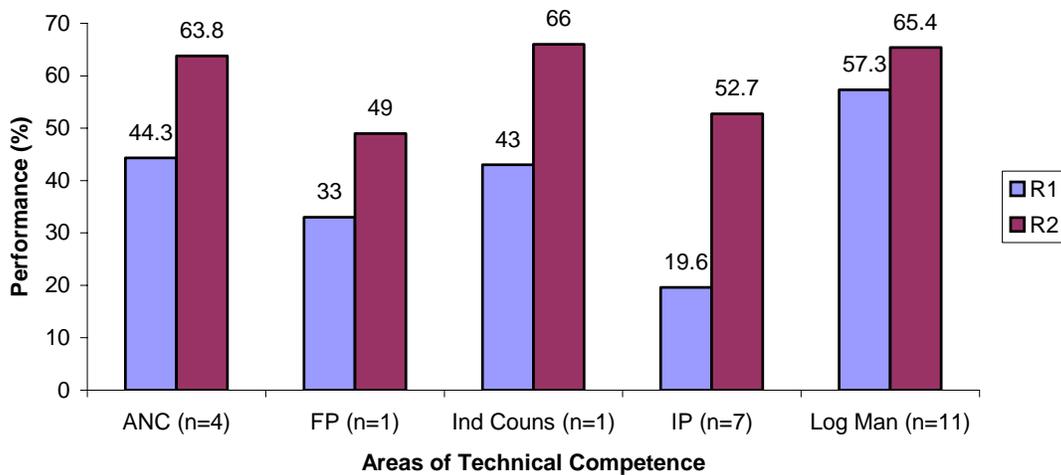


Figure 8: Changes in Technical Competence between 2 Rounds of Supervision in Kebemer



Use of management tools. The use of management tools (family planning, prenatal exams, post-natal exams, delivery records) was relatively satisfactory at the level of the service delivery points that were visited. See Figures 9 and 10.

Figure 9: Changes in Maternity Tools between 2 Rounds of Supervision in Louga

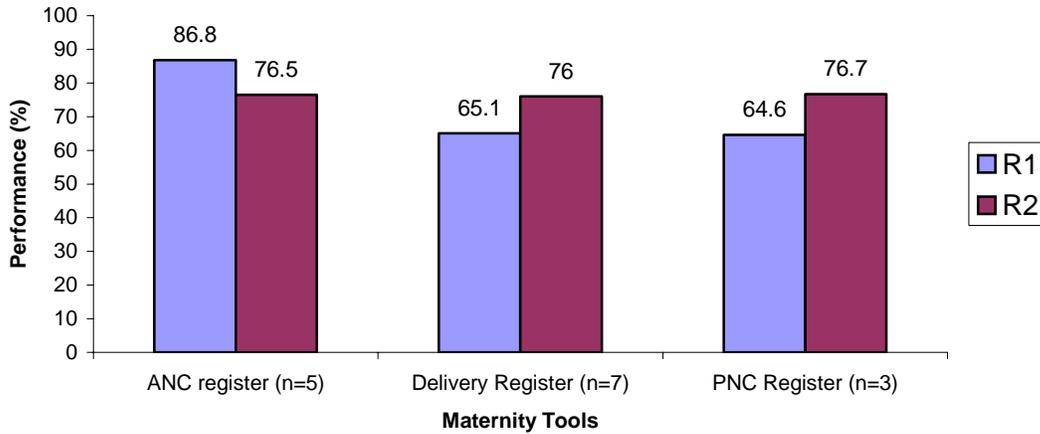
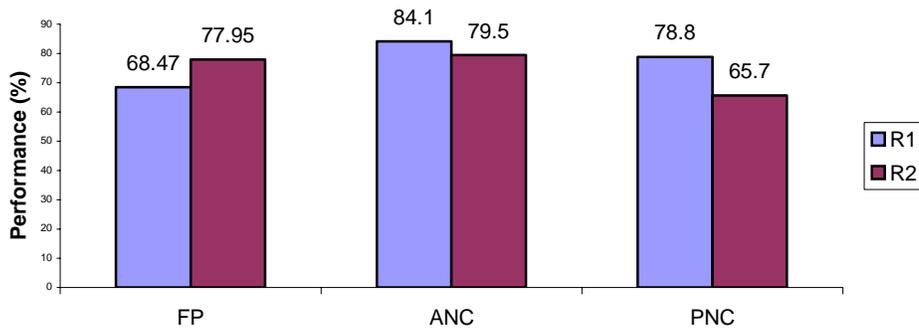


Figure 10: Changes in Management of FP, ANC and PNC Tools between 2 Rounds of Supervision in Kebemer



The commitment and motivation of members of the district executive teams, their conviction that family health can make a difference, the application by supervisors of the skills acquired in formative supervision (supervision/coaching, problem-solving assistance, etc.) and their knowledge of the personnel are certainly elements that favor the implementation of family health by at least certain health districts.

LOGISTICS COMPONENT

The purpose of this component is to increase the availability of contraceptive products available throughout the system while reducing to the greatest extent possible any stock-outs, and also to improve the management of essential medicines in general in order to facilitate their subsequent integration into a single supply system with the National Pharmacy.

Goals

- Monitor planned orders for programs, the contraceptives for which are financed by USAID during the mid-year review of Contraceptive Procurement Tables for Senegal (TACS).
- Monitor the Quarterly Inventory Reports for the Districts.
- Supply district and regional warehouses and private facilities, while maintaining appropriate inventory levels to avoid stock-outs.
- Ensure the availability of cycle beads for including the fixed days method in the method mix.
- Strengthen the skills of executive teams in using the Inventory Management Assessment Tool (IMAT), for proper supervision of logistics.
- Ensure formative supervision in logistics for depots of service delivery points, in order to foster good management of essential medicines and contraceptives.
- Evaluate the experience with integrating contraceptives into the single national pharmacy system at Kaolack.

Expected Results

- Summarize the Quarterly Inventory Reports for proper supply of regions, districts and private facilities in the country.
- Coordinate the receipt of scheduled orders for programs that use contraceptives: DSR, ADEMAs, DLSI.
- Monitor orders of cycle beads for inclusion in the contraceptive distribution system.

- Improve logistics management for essential medicines at the service delivery points, based on integrated formative supervision.
- Support the evaluation of integration of contraceptives into a single system managed by the National Pharmacy at Kaolack, in order to determine, in conjunction with the various participants (DSR, National Pharmacy) the steps to be followed to provide ongoing supply.

Strategies

- Support the Reproductive Health Division to directly supply USAID districts with a buffer inventory, at the level of medical regions.
- Implement a plan to institutionalize logistics activities of the Reproductive Health Division that will take into consideration the procurement, storage and distribution of contraceptive products throughout the country.
- Train executive teams in IMAT to ensure logistics formative supervision of the service delivery points.

Activities Carried Out

- ✚ **Mid-year review of TACS:** This activity allowed all order forecasts for the year to be adjusted by taking into account actual consumption for the first half of the year for all programs in which contraceptives are financed by USAID. It also allowed new order schedules to be prepared based on Newvern, and it facilitated the availability from all partners of information about their actual contraceptive needs to meet supply through other funders.
- ✚ **Supplying contraceptives to the regional level:** The DSR distribution system uses direct supply of districts with a buffer inventory at the level of the medical regions, which in turn supply private facilities and hospitals. At the Kaolack regional level, integration is in progress using the National Pharmacy, as is done for essential medicines. In this single system, the Reproductive Health Division supplies only the regional pharmacy storage facility at Kaolack, which is responsible for the districts. (See the supply diagram in Appendix 7.)

- ✚ **Training of executive teams in the use of IMAT:** This training is intended to strengthen the skills of the executive teams to assess management methods while making the IMAT tool available to them, in order to allow them to conduct their supervision and to monitor the indicators of their service delivery points in relation to logistics issues.

- ✚ **Integrated formative supervision:** In this activity, the management of essential medicines takes a very important place and allows corrections to be made in the structure, in relation to the executive teams, in order to facilitate implementation.

- ✚ **Implementation of a plan to ensure ongoing logistics activities within the Reproductive Health Division (DSR):** This plan is intended to monitor the transfer of logistics activities to the DSR in order to ensure their continuation.
 - In the area of contraceptive procurement, the transfer of skills is in progress, so that logisticians will maintain and coordinate the contraceptive procurement tables. Regarding securing reproductive health supplies, the Government has created a budget line item for the purchase of contraceptives, totaling 90 million, since the procurement of contraceptives has been underwritten by the partners USAID, UNFPA and JICA.
 - In terms of warehousing, management of the central warehouse was transferred to the DSR and a motorcycle was made available to them for transportation. Proposals have been made to the head of the DSR to recruit a permanent employee responsible for maintaining and managing the warehouse in coordination with the logistician.
 - The distribution of contraceptives at the level of the districts, in particular outside the USAID intervention regions, will be facilitated by the medical regions, upon proposal and distribution of a report from the Ministry inviting them to resupply every quarter through the central warehouse.

- The integration of contraceptives at Kaolack is progressing and will be evaluated using the data collected during the supervision visits. Upon completion of this evaluation and implementation by the DSR, proposals for integration schemes may be prepared, in collaboration with the partners, USAID, UNFPA, JICA, the National Pharmacy, etc.

Progress Achieved

- All districts in the USAID intervention zones were supplied with inventory levels that correspond to the established guidelines for the system. One lot of Norplant was replaced due to its expiration in November 2005. Some Neogynon was removed at Ziguinchor due to its low distribution, and it was reallocated to other districts where demand was higher. Cycle beads were distributed in the regions where one service provider had been trained (see Appendix 3).
- Upon completion of the mid-year review of TACs, the country’s contraceptive needs were adjusted and submitted to the various DSR partners (Appendix 4).
- JICA agreed to meet the demand for Lofemenal for the county for 2005 and 2006. The 2005 order is in progress.
- Couple years of protection for the country, including all programs, increased, based on the six-month figures. See Figure 11.

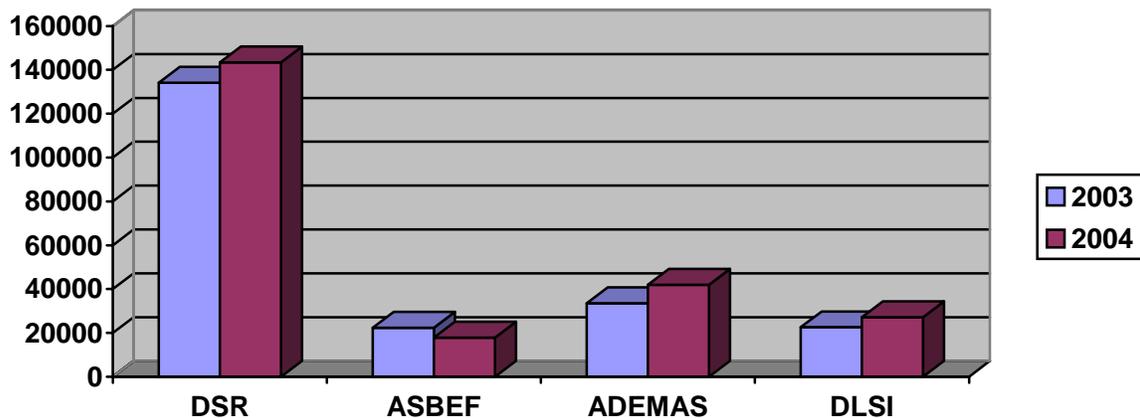


Figure 11: Evolution of the CYP by program

The CYP increased for all programs between 2003 and 2004:

- 7% for the Reproductive Health Division
- 20% for the Division to Fight AIDS and STDs
- 25% for Social Marketing Development Agency.

In contrast, the ASBEF program declined by 20% over the two years, due to the closure of its regional centers for lack of financing. **In the USAID districts, the CYP increased by at least 18% between 2003 and 2004.** See Figure 12.

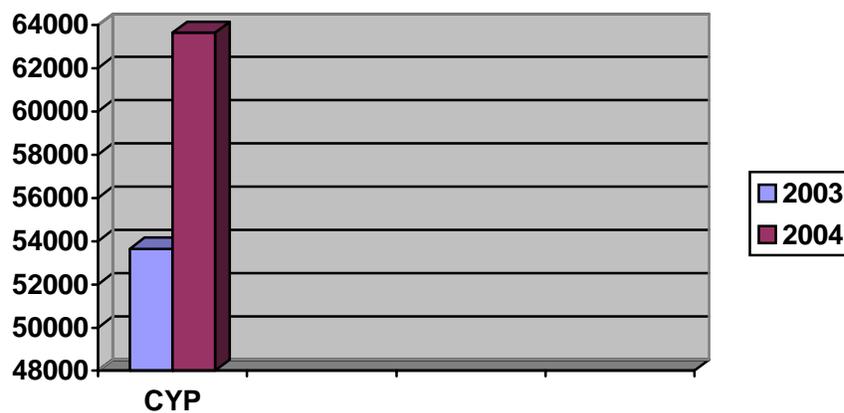


Figure 12: CYP by method in the USAID regions

Contraceptive orders. For 2005, all programs in which contraceptives are financed by USAID received their scheduled orders during the last four-month period of 2005. The order for cycle beads for the fixed days method was placed, and it should be received within the next several weeks (1,500 sets).

Formative supervision. Formative supervision has allowed the executive teams to monitor the management of essential medicines and to make corrections to the same, at the level of the service delivery points. There was a clear increase in management in comparison to the previous supervision visit for the Louga, Kebemer and Linguere districts.

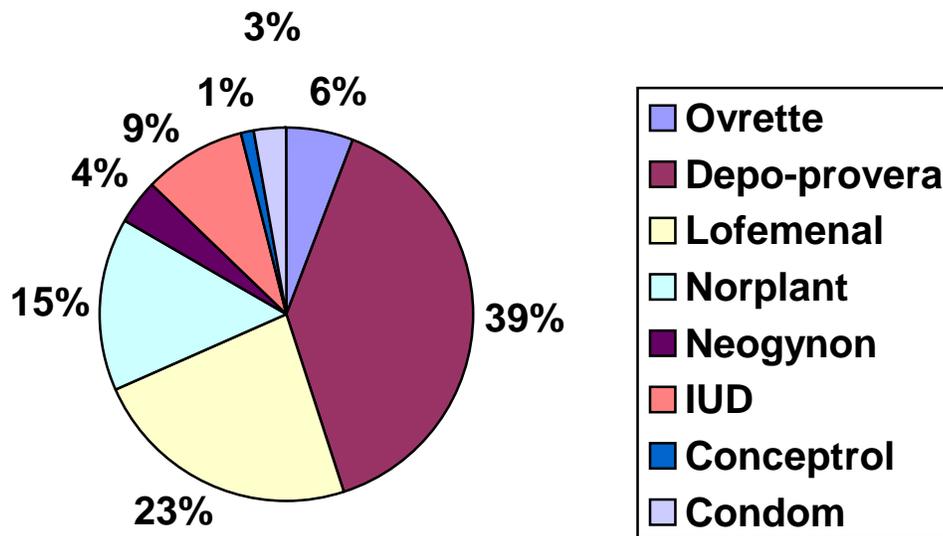


Figure 13: CYP by Method in USAID Zones

Public-private partnership for better supply of family planning. After the withdrawal of the national NGO SANFAM, the private and semi-public facilities were left on their own and could no longer manage, in particular in regards to the supply of contraceptives. Contact visits allowed a process to be started in order to supply and then supervise them in the management of contraceptives in relation to the district and regional executive teams. After the previous supervisory visit, certain private facilities and hospitals began to send their reproductive health reports to their respective districts. They involve:

- the JAMM Clinic (Dakar)
- Social Security Fund Medical Service (Dakar)
- Retirement Benefit Institute Medical Service (IPRES) - Dakar
- Water Company Medical Service (SDE) - Dakar
- SENELEC Medical Service - Dakar

- Abass Ndao Hospital - Dakar
- Dahra Mbayenne Private Health Center - Louga.

Constraints

- Delays have been observed in the forwarding of the Quarterly Inventory Reports by the district coordinators.
- The contraceptive supply for regions outside of the USAID intervention zone has been disrupted due to a lack of financing.

IEC, BEHAVIOR CHANGE COMMUNICATION, AND ADVOCACY

The activities covered by this section are intended to increase demand for services through better knowledge and increased acceptance of reproductive health services on the part of the communities.

I. Advocacy Directed at Policymakers and Local Opinion Leaders

This advocacy work contributes to "increased and lasting use of quality reproductive health services" by:

- participation in the creation of a sociocultural environment favorable to the fight against maternal mortality through advocacy activities;
- availability, for political decision-makers and health professionals, of a relevant tool to assist in effective decision-making in the context of the fight against maternal mortality.

Goals

- To extend the number of religious leaders oriented to maternal health/family planning in the intervention areas of the project, then to collect and document the results from the implementation of their commitments;
- To ensure the quality of data collection operations regarding the costs corresponding to the "mother-child package" to be included in the "Safe Motherhood Model," for its implementation in Senegal.

Strategies

For these two activities, the strategies that were developed to attain the specified goals involved:

- holding advocacy days, the highlights of which were: presentation of the REDUCE/Senegal model, translated into Arabic and Wolof, followed by discussions and the acquisition of commitments from religious leaders oriented in favor of the fight against maternal mortality;
- support for and supervision of the data collection operations in the field after the workshop to standardize understanding of the content of collection tools.

Expected Results

In conjunction with the various goals set forth above, the expected results are as follows, respectively:

- New religious leaders were oriented to maternal health/family planning, some of whom have become involved in the fight against maternal mortality;
- All data regarding costs related to the “Mother-child package” to be integrated into the Safe Motherhood Model for its implementation in Senegal were properly collected.

Activities

The following activities were scheduled for this period:

- Continue the orientation of religious leaders to maternal health and family planning using the REDUCE/Senegal Model translated into Arabic and Wolof, with a religious presentation, and monitor the implementation of the commitments they made.
- Supervise the collection of data on costs related to the “Mother-child Package” for implementation of the Safe Motherhood Model in Senegal.

Results

In relation to the religious leaders, it must be noted that participation of the project in the seminars “Pire Medical Days” organized from October 22 through 24, 2005, by the AND LIGUEEYE Pire Association was noteworthy, among other factors, due to a presentation of the REDUCE/Senegal Model translated into Arabic with a religious presentation. This presentation, co-directed by a team of two resource persons, had the participation of ten religious leaders who engaged in a passionate, yet fruitful, debate, covering the subject of family planning, in particular.

So, after the districts of Guinguineo, Konghuel and Kaffrine (visited during the period of May through August 2004), the district of Tivaouane has just had certain of its religious leaders undergo orientation on maternal health/family planning at the Pire Medical Days seminar. These orientation sessions organized with the support of members of the Islam and Population Network (RIP) and the National Association of Imams and Oulemas of Senegal (ANIOS), have allowed the number of religious leaders indicated in Table 11 to be reached, cumulatively.

Table 11: Religious leaders receiving orientation on maternal health and family planning

Districts	Orientation period	Number of leaders receiving orientation
Guinguineo	May–August 2005	9
Kongheul	May–August 2005	27
Kaffrine	May–August 2005	26
Tivaouane	September–November 2005	10
Total		72

It must be noted that 20 of these 72 religious leaders made commitments upon completion of the orientation sessions to become involved in actions to promote lower-

risk motherhood, as well as family planning. So, the monitoring of the implementation of these commitments was to follow the awareness stage. But there are time constraints which have not allowed this follow-up to take place.

Regarding the collection of data regarding costs of the “Mother-child Package” to be included in the Safe Motherhood Model for implementation in Senegal, its launch took place on December 19, 2005, with the collection operations in the target facilities and regions; these operations should continue through December 31, 2005. The collection was conducted by CEFOREP, a contracting agency through the Futures Group International, under the supervision of PREMOMA. The activities in the field were preceded by an orientation workshop for the CEFOREP team on the Safe Motherhood Model and the collection tools. This workshop was held on December 8-10, 2005, under the aegis of the Reproductive Health Division, and it was coordinated by PREMOMA, with support from the Futures Group.

Validation of the results of the integration of data collected from the Safe Motherhood Model will provide the latter with an instrument to assist in making effective decisions in the context of the fight against maternal mortality. Such an instrument will, undoubtedly, be welcomed among the many political and professional decision-makers in the health field who are involved following four years of promotion at the local, regional and national levels, using the REDUCE/Senegal Model.

II. Community Involvement in the Fight against Maternal Mortality

Alongside the two traditional activities carried out by the two types of community participants used by PREMOMA to implement IEC and BCC strategies, i.e. the community health promoters (PC) and Associations of Multifocus Agents (ARPV), a new activity related to community involvement was implemented during this four-month period: community involvement in post-abortion care.

A. Community involvement in post-abortion care

The fifth and last component of the post-abortion care model is partnership with the community in post-abortion care, and it was initiated in the three health districts of Kaffrine, Mbour and Ziguinchor. The goal of this partnership is to improve the knowledge and attitudes of the population in regards to the prevention and treatment of abortions, through communication activities directed at changing behavior. This will allow better use of post-abortion care within the three health districts. An orientation session for local officials (government and health agencies) on this approach was carried out before the activity was launched, by a team from PREMOMA and the Reproductive Health Division.

This intervention consists of three stages: Identification of difficulties and the proposal of solutions by communities, implementation and monitoring of proposed activities, and participatory evaluation. The first stage was launched during the four-month period. It is being conducted starting with three complementary activities:

- A **community-based survey** through individual interviews and focus groups that have allowed the collection and analysis of interesting data about the knowledge, perceptions and needs of various members of the community (women, men, leaders, youth) regarding women's health in general, and in particular regarding miscarriages and abortions, their prevention and treatment. The results of this survey were shared in the field with the communities (at Kaffrine: 28 members of the district executive team and service providers and 27 leaders; at Ziguinchor: 21 service providers and 37 leaders). In each of the groups (health personnel and community leaders) action plans were drawn up.
- The **"problem tree" approach** with women's groups and youth allows them to help to identify the following items for a given problem:
 - its consequences, in order to better gauge its importance
 - its causes, in order to be able to propose relevant solutions.

(Examples of problems were proposed to spur discussions: a teenage woman who dies after an illegal abortion, a woman who becomes infertile following a miscarriage with complications, etc.)

Personnel from PREMOMA and the Reproductive Health Division who have received orientation on this approach have carried out this interesting and revealing exercise with women's groups and youth groups in the Kaffrine and Ziguinchor health districts. **Ten “trees” were prepared by the 91 women in Kaffrine and Ziguinchor, broken down into groups by neighborhood and the service delivery point with which they were involved. Seven trees were prepared by the 54 youth (students and non-students) from Kaffrine and Ziguinchor.** For each tree, the group identified two causes of problems, for which effective, realistic and quantifiable solutions were developed by the community itself.

- **The theatrical works competition:** This is currently being completed in the Ziguinchor health district, which has a very well organized structure, the Departmental Music and Popular Theater Union (UDTPM).

B. Community health promoters

In the context of the fight against maternal mortality in Senegal, several strategies have been implemented in the projects and programs carried out for several decades, including the strategy involving information, education and communication (IEC) and behavior change communication (BCC). From the results, there appears to be a noteworthy gap between the acceptable rate of knowledge and the level of use of services by the population, which is still low. To correct this imbalance, an innovative approach, called the “community health promoters,” was developed and implemented.

In its conception, the community health promoter approach was intended to provide a means for members of the community to survey and monitor/encourage pregnant women to seek proper pregnancy, birth and post-partum care, and to use family planning, in the selected locations. Based on the tangible results obtained after the first implementation of this approach at 20 sites throughout the Kaolack, Guinguineo, Thiadiaye and Linguere districts, it is planned to be extended through women’s groups (GPF). This voluntary extension through a sub-contracting process is planned in the area of responsibility of the following four health posts: Ida Mouride, Gainthe Pathé

(Kongheul District), Wakoungouna, NDRAMÉ ESCALE (Nioro District), Baila, KAGNAROU (BIGNONA DISTRICT), Diegoune et Tendouck (Thionk Essyl District).

For the current period, the activities carried out consisted first of monitoring the early stages of extension of the community health promoter approach, then ensuring the quality of implementation by the agencies selected, and the proper progression of field activities of the community health promoters, with support from the targeted community leaders.

Goals

For the scheduled activities, three goals were established:

- oversee compliance with the calendar for implementation of the extension of the community health promoter approach among women's groups;
- follow-up on the various stages for the current period;
- ensure the actual launch of community health promoter activities in the field, supported by members of the community involved in the process for implementing this approach.

Expected Results

In relation to the three goals set forth above, the expected results were as follows, respectively:

- the calendar for implementation of the extension of the community health promoter approach would be respected;
- the stages for implementation would be carried out according to the guidelines established by the selected agencies;
- the community health promoters and community leaders (elected officials and religious leaders) involved in the implementation process would actually begin the field activities.

Strategies

For the activity planned, the strategies developed to attain the specified goals involved:

- holding sharing sessions with potential participants in the approach;
- orientation and/or training regarding the approach;
- monitoring and evaluation of field activities, then collection of stage result components.

Results

It must be noted that in relation to the implementation of the community health promoter approach, among women's groups, it was noteworthy, first, to monitor the various stages of the process of launching this extension. This activity was conducted in five phases, the schedule for which is presented in Table I2. The conditions for each of these phases as well as the results obtained are presented below.

Sharing reference terms from the selected agencies and the criteria for selecting community health promoters with the district executive teams, health post head nurses, officials from the women's groups, political decision-makers (local elected officials) and opinion leaders (Muslim and Christian religious leaders and public figures) in the selected intervention areas. This stage was carried out in collaboration with a member of the district executive team from each district involved, the local ANAFA representative (for the districts of Kongheul and Nioro) and the Red Cross (for the districts of Bignona and Thionk Essyl). The result of this sharing was to achieve, on the part of the various participants, a common vision of the conditions for implementation of the community health promoter approach and a good understanding of each party's responsibilities within the framework of the planned extension.

The orientation of national supervisors and supervisors from the selected agencies. The orientation has allowed the review, with the four national supervisors and the four supervisors from ANAFA and the Red Cross (two per agency, respectively), of the basic principles and the goal of the community health promoter approach, principles which are

based on the firm commitment of members of the community at various levels to implement an operational device to aid in increasing and sustaining the use of reproductive health services by pregnant women. This stage, marked by extensive discussions, was in the end approved by mutual agreement of all the participants on the principles considered to be a criterion for sustainability of the community health promoter approach.

The training of community health promoters, local elected officials and religious leaders, and the follow-up of training sessions at intervention sites. The training involved components of reproductive health and the techniques for communication in the relevant areas of intervention. Under the control of one supervisor for every two sites, training in low-risk motherhood, family planning, behavior change communication and advocacy activities were carried out per the schedule presented in Table 12. These training sessions were facilitated by the reproductive health coordinators and the health education supervisors of the districts in question. Follow-up on the training sessions was carried out in conjunction with the national supervisors from ANAFA and the Red Cross in their respective regions. This provided an opportunity to note the effectiveness of start-up of training and its proper performance throughout the eight sites in the four selected health districts. The various target groups formed during the eight sessions are indicated Table 12.

It must be noted that at the orientation meetings in the districts of Nioro and Kongheul and during the follow-up on the training sessions at the sites of Gainthe Pathé and Ida Mouride (Kongheul health district), Susana Galdos, supervisor of community activities at the MSH office in Cambridge, MA, participated (September 26-28, 2005). This travel to the field, together with the trips made previously, on September 14, 2005, in the Kaolack district (to the health center, the health posts of Koumbal and Ndiffane, and to Sikatroum) allowed Susana to collect perceptions and impressions from various participants (health care personnel, local elected officials and religious leaders and former community health promoters) regarding the community health promoter approach and its impact, before

Table 12: People trained in the eight intervention sites in the four health districts selected for extension of the community health promoter approach

Districts	Intervention Sites	CP	Political Decision-Makers (Local Elected Officials)	Opinion Leaders (Religious)	Public Figures	Total (per site)
Nioro:	Wack Ngouna	10	1	1	1	13
	Ndramé Escale	10	1	1	1	13
Kongheul	Gainthe Pathé	10	1	1	2	14
	Ida Mouride	10	1	1	1	13
Bignona	Baila	10	1	1	0	12
	Kagnarou	10	1	1	0	12
Thionk	Diegoune	10	1	1	0	12
Essyl	Tendouck	10	1	1	1	13
Total		80	8	8	6	102

becoming familiar with the various stages of implementing its extension within the context of the sub-contract. Conversations with Susana regarding the procedure and components of results already obtained have led to some strong recommendations regarding changes to the content of the community health promoter training, promotional materials and management tools made available to them; these recommendations are intended to improve the family planning services of the community health promoters.

The introduction of tools to evaluate field activities of the community health promoters was another stage in following up the implementation of the extension of the approach. To correctly evaluate the work in the field, a tool was devised to allow regular assessment of individual and collective performance of the community health promoters and the level of involvement of opinion leaders and decision-makers in this process. The six community health promoter supervisors were given orientation related to this tool (presented in the appendix) as implemented by the contracted agencies in their respective areas (two by the Red Cross and four by ANAFA). It must be noted that the

evaluation tool was presented in advance to the members of the corresponding district executive teams and health post nurses.

Upon completion of the evaluation tool orientation sessions, the six supervisors deemed it to be accessible and very practical. So, as an overture for the first bi-monthly meeting, each supervisor was requested to use this tool to assess all the evaluations carried out previously.

The introduction of the evaluation tool was furthermore an opportunity to ensure the effective launch of the field work by the community health promoters and the related community members, after completion of their training. This observation was able to be made through the communication with the health post nurses or their representatives, and home visits to the community health promoters (two on average per site). The two actions allowed some difficulties to be detected related to the community health promoters filling out the registers and referral slips. To resolve the points for improvement that were noted, the mission recommended measures to the supervisors to be implemented during the upcoming follow-up activities.

The purpose of monitoring the extension of the community health promoter approach among women's groups was marked, for the current period, by the first bimonthly progress meeting. Held according to the schedule specified in Table 13 and in conjunction with ANAFA and the Red Cross in the corresponding regions, the district executive teams and health post nurses involved, this meeting brought together at each of the eight sites all the community health promoters and members of the community (local elected officials, religious leaders and public figures) involved in this activity. These meetings were an opportunity to share the lessons learned, but also and in particular to prepare an inventory on the individual and collective level of the field activities performed by the community health promoter and members of the community in the area of responsibility of each selected health post. Tables 13-15 show the first results collected at all the intervention sites during this first stage meeting.

On average, each community health promoter recruited nearly 6 pregnant women during the first two months of activity, for an average of 3 per month. For this volunteer work, these are noteworthy performance levels for the community health promoters as well as the members of the community who support them in their field activities.

Table I3: Status of pregnant women at the sites selected for extension of the community health promoter approach

Districts	Health Posts	Deadlines	Number of pregnant women recruited	Average number of pregnant women recruited per community health promoter
Kongheul	Ida Mouride	Oct. 1-10, 2005	54	5.4
	Gainthe Pathé		71	7.1
Nioro:	Wakou	Oct. 1-10, 2005	98	9.8
	Ngouna		184	18.4
Bignona	Ndramé Escale	Oct. 1-10, 2005	39	3.9
	Baila		48	4.6
Thionk Essyl	Diégoune	Oct. 1-10, 2005	66	6.6
	Tendouck		34	3.4
Total		Oct. 1-10, 2005	594	5.94

Table 14: Status of monitoring births, post-partum care and family planning of women recruited at the eight sites selected for extension of the community health promoter approach

Districts	Health posts	Deadlines	Number delivered	Site of deliveries			Post-natal visits		Use of family planning by mothers	No. of abortions	Number monitored after abortion for use of after-care
				Home	Health point	Health posts/ centers	1	2			
Kongheul	Ida Mouride	Oct. 1 through Oct. 10, 2005	7	1	1	1	1	1	0	1	1
	Gainthe Pathé		21	8	4	9	2	0	8	1	1
Nioro:	Wakou Ngouna	Oct. 1 through Oct. 10, 2005	30	3	10	17	7	9	11	25	15
	Ndrané Escalé		56	4	37	15	37	8	5	23	3
Bignona	Kagnarou	Oct. 1 through Oct. 10, 2005	12	1	0	11	9	4	1	0	0
	Baila		8	0	2	6	7	0	1	0	0
Thionk Essyl	Diégoune	Oct. 1 through Oct. 10, 2005	20	0	0	20	10	0	0	0	0
	Tendouck		11	0	0	11	0	0	3	1	1
Total		Oct. 1 through Oct. 10, 2005	165	17	54	90	73	22	29	51	21

Table 14 shows that:

- although births at home (17/165) represent only 10.3% of total deliveries by pregnant women recruited who gave birth, these results warrant consideration that intervention by the community health promoters may have begun to diminish the sociocultural factors, especially in a rural area, that favor home births with the corresponding rather clear effect in favor of births in health facilities (health centers and posts), which represent 54.5% of the total births among the pregnant women followed. The figures appearing in the table also suggest a slight effort by women who have had an abortion to use post-abortion care;

- It follows that in spite of the disparities noted from one site to another, overall post-natal care has begun to move a little bit, and this may be due in part to the promotion work carried out in the field;
- In relation to compliance with post-delivery family planning, the data from the table show noteworthy advances of 17.5%, as well as the need for the community health promoters to redouble their efforts to achieve greater results in this field.

Table 15: Involvement of community members in the extension of the community health promoter approach

Districts	Health Posts	Deadlines	Community Members Trained	Members Trained and Involved in Field Activities	Involvement Rates of Trained Members	Activities Carried Out by Trained Community Members
Kongheul	Ida Mouride	Oct. 1 through Oct. 10, 2005	3	2	66.66%	<ul style="list-style-type: none"> - Organization of a feedback and awareness meeting by the Imam who is also the chief of the village - A report to the management of rural committee, by the community secretary representing the PCR
	Gainthe Pathé		3	1	33.33%	<ul style="list-style-type: none"> - Introduction, mobilization of community health promoters and ongoing support for the organization by the village chief during each supervision visit
Nioro:	Wakou Ngouna	Oct. 1 through Oct. 10, 2005	3	0	0%	
	Ndramé Escale		3	0	0%	
Bignona	Kagnarou	Oct. 1 through Oct. 10, 2005	3	1	33.33%	<ul style="list-style-type: none"> - Presence and support of the Imam during the 2 community health promoter informal talks
	Baila		3	3	100%	<ul style="list-style-type: none"> - 1 awareness meeting after Friday prayers - 1 meeting with women of the village to promote awareness - Support for the launch of field activities by the community health promoter

Thionk Essyl	Diégoune	Oct. 1 through Oct. 10, 2005	2	1	50%	- Promotion of low-risk motherhood included in the Eid el Fitr sermon by the Imam
	Tendouck		3	3	100%	- 1 awareness meeting after prayers by the Imam and the teacher -1 meeting with women of the village to promote awareness - Support for the launch of field activities by the community health promoter
Total		Oct. 1 through Oct. 10, 2005	23	10	41.66%	

The scheduled activities that were carried out were supplemented by other, unscheduled activities, carried out at the request of USAID or in the context of collaboration with the field partner structures. They include Pire Medical Days, organized by the AND LIGUEEYE Pire Association, and held October 22-24, 2005. Participation in these medical seminars by the project was highlighted by:

- awarding of financial support to assist in the organization of coordination meetings;
- family planning counseling meetings in conjunction with traveling consultations;
- the organization of two public presentations in two neighborhoods of the city. The presentations involved the morbidity factors related to pregnancy and the danger signs related to pregnancy, birth and the post-partum period.

The presentations were followed by radio programs coordinated by a gynecologist with the delivery of promotional materials regarding reproductive health (t-shirts and caps); and "on-site visits in the context of the preparation of the new health strategy of USAID Dakar." Team SOT3 welcomed consultant Mrs. Elisabeth Warniky from USAID, Washington, DC, when she accompanied the team on a visit to the Kaolack location, among other intervention zones. At this stage, PREMOMA made a presentation, "The Experience of Community Health Promoters" and "Improving Collaboration between Public and Private Health Structures."

The purpose of this presentation, which took place on October 20, 2005 at the Kaolack District Health Center, was to share the lessons learned from the implementation of these two approaches. After the presentation, the members of the USAID mission engaged the head physician of the district, the supervisor of private nurses and the representative of the community health promoters' coordinator, with 75% membership in the ARPV, in wide-ranging exchanges characterized by the manifestation of real interest in these two approaches. Based on the modest results presented, the two procedures were recognized as strategies that could contribute, respectively, to increased and sustainable use of reproductive health services by pregnant women and to better coordination of intervention in the field between public and private health structures.

For good coordination of the ARPV interventions, the Kaolack MCD, in October 2004, started to implement a framework for meeting and coordinating the ARPVs. This gathering, bringing together the members of the offices of the ARPVs in the district, around the district executive teams, takes place every quarter and rotates to the facilities of the local groups involved. Town mayors and rural council presidents are invited to these meetings, as well as the agencies performing USAID projects involved in the ARPV approach.

On December 3, 2005, the last cooperation framework meeting was held. Its purpose, among others, was to draw up an inventory of the action plans contracted and carried out. The project was invited to this meeting by the MCD and took part in this meeting. Participation by the project in this meeting ensured that there would be no difficulties regarding the performance of field activities related to maternal health and family planning. Furthermore, the presence of PREMOMA at this meeting was an opportunity to acknowledge, with satisfaction, the high degree of appreciation expressed by MCD and all the supervisors from the ARPVs for their partnership with MSH, and in particular in the context of the current work. In this context, the continued monitoring and supervision often sought by the district and by the coordinating group of the ARPVs constituted a strong recommendation of the project.

Constraints

Overall, the major limits identified during this period were:

- the difficulty in reactivating the partnership with the Ministry of Education (ME) to reinstate the reproductive health training and education modules already prepared for integration into the reference set of skills for Teacher Training Schools. The difficulty is due, for the most part, to the absence of activities with Teacher Training Schools during academic year 2004-2005, but also the time constraints of the structures related to essential medicines;
- the need to support other project activities at the same time as those scheduled for the period;
- the imperatives of the partnership require, at this time, responsibility for several unscheduled activities.

Lessons Learned and Recommendations

The primary lesson learned was the relevance of close monitoring of the process for implementation of the field activities, including those related to a sub-contracting process. The strong recommendation will be for priority and realistic planning of the strategic activities not carried out (in particular in relation to the expected results of the project in and with the next program).

In relation to the extension of the community health promoter approach, its implementation by the selected agencies will strengthen the follow-up of field activities and the sharing, between agencies, of the lessons learned during the progress assessment meetings.

C. Associations de Relais Polyvalents (ARPVs)

In order to increase the utilization rate of reproductive health services, PREMOMA, following the example of other SO3 agencies, called upon 123 Associations de Relais Polyvalents (ARPVs) involved with health posts and health centers in the regions of

Thies and Louga and the Kaolack and Guinguineo health districts. These agents, appointed by their communities for their community involvement, among other factors, after their initial training signed performance agreements with the supervisors of local municipalities (mayors and chairmen of rural communities) to carry out informal talks, visits to participating or targeted homes and social mobilization activities, according to a strict schedule. Therefore it has been necessary to provide them with ongoing support to increase the effectiveness of their actions. In this respect, the activities of PREMOMA in relation to information, education and communication and behavior change communication, during the period of September through December, primarily involved **monitoring** the ARPVs and the **launch of the pilot remote apprenticeship program** in addition to support to improve the quality of intervention by community activists engaged in RH IEC/BCC activities.

1. Monitoring of ARPVs

Goals

Since they have begun their activities, the ARPVs have not had technical support from the SO3 agencies and the technical departments of the Ministry of Health and Medical Prevention, which does not speak well of an improvement in their performance. To bridge this gap the SO3 agencies, in close collaboration with their counterparts from the Ministry of Health and Medical Prevention, at various levels of the health system, conducted the first follow-up activities, from October to July of 2005,, to provide a maximum degree of information about:

- the level of knowledge regarding reproductive health, decentralization and proper governance of multifocus agents;
- the technical and administrative capabilities of the ARPVs;
- the associative dynamic of ARPVs;
- the perceptions and opinions of leaders, providers, men, women and youth regarding ARPVs and their activities.

Results

The summary of the monitoring results (Tables 16 and 17) reveals that:

- the agents interviewed had good knowledge of the benefits related to pre- and post-natal visits, assisted birth, family planning, contraceptive methods and the procedures for their use;
- in contrast, their knowledge was insufficient in relation to morbidity factors and danger signs during pregnancy, birth and the post-partum period, as well as the benefits, inconveniences and side effects of contraceptive methods.

Table 16: Knowledge of maternal health

Subjects	Level of Knowledge	Percentage	Comments
Knowledge of reasons for consultations by a pregnant woman	insufficient	35.0%	Many of the agents interviewed (39 out of 60) knew the reasons that should cause a woman to go to the service delivery point
	acceptable	50.0%	
	good	10.0%	
	excellent	5.0%	
Knowledge of the intervals for prenatal care	yes	61.7%	62% knew when prenatal care should take place. But although the percentage is high for CPN 1 (100%) and CPN 2 (96%), it drops to 85% for CPN 3 and drops a notch for CPN 4 (66.7%).
	no	38.3%	
Benefits of assisted birth	insufficient	41.7%	Rather good knowledge on the part of agents of the benefits of assisted birth
	acceptable	53.3%	
	excellent	5.0%	

Table 17: Knowledge of family planning

Subjects	Level of Knowledge	Percentage	Comments
Knowledge of contraceptive methods	insufficient	30.0%	
	acceptable	48.3%	
	good	11.7%	
	excellent	10.0%	
Benefits for the mother of spacing out births	insufficient	36.7%	Rather good knowledge on the part of the agents of the benefits of birth spacing, i.e., 8 excellent answers and 30 acceptable.
	acceptable	50.0%	
	excellent	13.3%	

Recommendations

- Strengthen the skills of the agents on subjects related to the danger signs during pregnancy and the post-partum period, and the benefits, inconveniences and side effects of contraceptive methods;
- Further strengthen promotional materials and communications tools provided to the agents.

From this perspective, during the next six-month period, formative supervision should be emphasized, to allow us to tailor interventions to the needs and expectations of each ARPV. Given the results of the monitoring, actions should be prioritized that aim to consolidate the knowledge of the agents about subjects they are less familiar with, i.e., danger signs in pregnancy and the post-partum period, and the benefits, disadvantages and side effects of contraceptive methods.

2. The Pilot Remote Training Program

Another method for supporting the ARPVs consists of strengthening the technical and relational skills of the agents, through a remote training program focused on maternal health, infant survival, family planning, adolescent health, STDs/HIV and behavior change communication. This experimental program, which currently only involves five ARPVs in the Guinguineo health district, using the ARPVs of the Linguere District as pilot sites, is structured around four broadcasts. Dissemination of these broadcasts, which started during the last week of November of this year, is the culmination of the implementation of a series of sequenced activities involving health professionals (clinical service providers and agents involved in IEC and BCC), scriptwriters, radio technicians, dramatic artists specializing in radio theatre and the ARPVs.

An initial evaluation was carried out to determine the level of knowledge of the agents in relation to the first presentation. This evaluation was carried out as follows:

- Determine the number of times the agents listened to all the broadcasts.

- Identify any constraints related to listening to the broadcasts.
- Determine effective means for listening to the broadcasts that would allow exchanges between the agents.
- Determine the levels of knowledge of agents in relation to the broadcasts.
- Make corrections to the various levels of knowledge.

The following results were recorded:

Listening to broadcasts.

- The 5 ARPVs in the district listen to the broadcasts, i.e.: 27 in the rural community of N'gathie Naode, 26 in the town of Guinguineo, 20 in the rural community of M'Badakhone, 24 in the rural community of Gagnick, and 28 in the rural community of N'Diago.
- The broadcast schedules are convenient.
- The agents responsible for monitoring the program in terms of compliance with schedules and the quality of sound, in particular, correctly fill out the forms prepared for that purpose.
- The exercises to examine knowledge and application in the field were carried out.
- Group listening sessions facilitate discussions of the content of broadcasts and the resolution of questions.
- Delays were observed between the schedules and the broadcast times of the programs, due to a change in the radio program schedule.

Evaluation of knowledge.

- **Safe motherhood.** The knowledge of the agents in relation to attitudes of pregnant women to ensure proper monitoring of pregnancy were significantly improved. After listening to the initial broadcasts, they increased from 28% to 57%. See Figure 14.

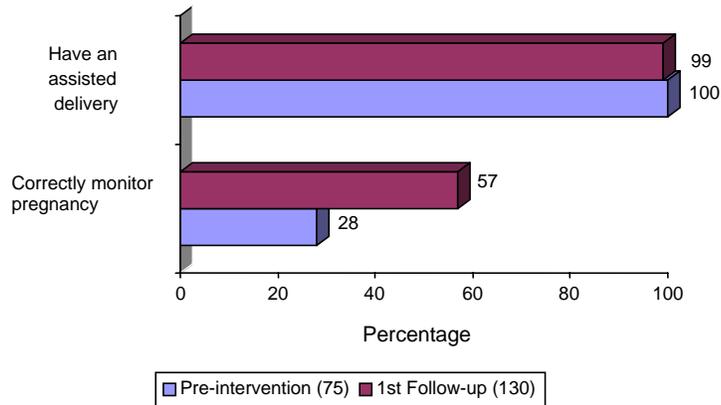


Figure 14. Percentage of ARPVs who know what must be done for a safe pregnancy

- Malaria in children.** Although all the signs of malaria are not fully grasped by the agents, it is nonetheless true that their knowledge regarding means of prevention and home care have clearly increased, as Figure 15 illustrates.

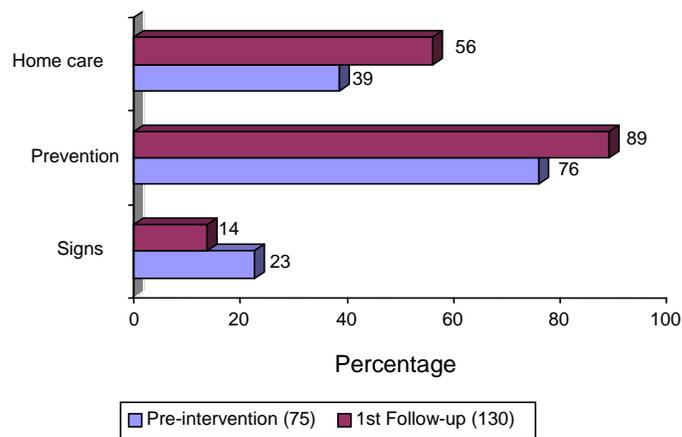


Figure 15. Percentage of representatives who know about the signs, prevention and home care of malaria

- **Behavior change communication.** After the broadcasts regarding techniques for BCC, an improvement in the knowledge of the agents of from 17.3% to 21.5% was achieved.

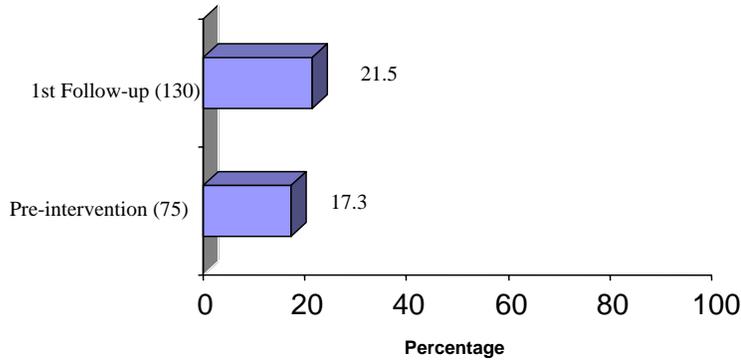


Figure 16. Percentage of agents who know the proper attitudes for effective behavioral change

3. Interventions

Application of an individual interview questionnaire with the ARPV agents regarding the knowledge contained in the programs that were broadcast.

- Organization with each ARPV of a plenary meeting to provide feedback regarding programs that were broadcast and to strengthen the knowledge and skills of the agents.
- Joint resolution of the difficulties that arose while the ARPVs were conducting field activities.

**SECTION B: DETAILED INVENTORY OF PROGRESS ON THE ACTION
PLAN, SEPTEMBER-DECEMBER 2005**

Strategies	No. of Activities	Activities	Status	Dates	Level & Location	Problems/comments	
Lobbying of elected officials and decision makers for increased and sustainable use of Reproductive Health services		Orient and ensure the monitoring of implementation of commitments by religious leaders related to Maternal Health/Family Planning	Completed	Oct. 23, 2005	Health Post - Pire	Monitoring of commitments was not able to be carried out due to schedule constraints	
		Monitoring of data collection regarding mother-child package costs for Implementation of the Safe Motherhood Model in Senegal	Completed	Dec. 19–31, 2005	Nationwide	RAS	
		Organize the return of results from the integration of Reproductive Health into the reference documentation for EFI skills	Not completed		Nationwide	Absence of activities with EFIs in 2004/2005 and schedule constraints of the Ministry of Education	
Strengthening of the public-private partnership		Survey Primary Care Facilities in Dakar	Not completed		District	Failure to carry out the activity is related to schedule constraints	
Community involvement in the fight against maternal mortality		Follow-up on the various stages of the process to launch the extension of the community health promoter approach in women's groups and actually start up field activities	Share the reference terms of the acting agencies and the criteria for selecting community health promoters	Completed	Sept. 12–21, 2005	District of Nioro, Kongheul, Thionk Essyl, Bignona	Sharing with ECDs, Health Post Nurses, women's group supervisors and community representatives (local elected officials and religious leaders) completed.
			Direct selected acting agencies and follow the entire process of launching field activities	Completed	26/09 03/10 27-31/09 04-08/10	Idem	
			Introduce tools for evaluation of community health promoters and ensure effective start-up of field activities	Completed	13-18/11	Idem	
			Organize the first bi-monthly meeting of the stage inventory	Completed	12-17/12	Idem	

Strategies	Activities	Status	Dates	Level and & Location	Problems/comments
Community involvement in the fight against maternal mortality	Involvement of communities to better use post-abortion care <ul style="list-style-type: none"> ✚ return of the community survey ✚ preparation of action plans 	In progress		District of Mbour, Kaffrine, Ziguinchor	
Improvement of maternal health services	Direct service providers in Niore regarding prenatal care during formative supervision	Not completed		District	Family health not yet scheduled for Niore
	Supplement training of providers of maternity care at health centers regarding post-abortion care/manual intra-uterine vacuum aspiration	Not completed		Regional	Schedule constraints
	Training of 119 health post nurses in post-abortion care	In progress		Regional	Under contract with CEFORP 61% trained (71/117)
	Training of counselors in post-abortion counseling in the 22 districts in question <ul style="list-style-type: none"> ✚ Training of trainers ✚ Training of counselors 	In progress Not completed		Regional District	3 sessions out of 4 scheduled It will begin after completion of the curriculum, after training of the trainers
	Organize orientation sessions regarding active management of the third phase of labor	In progress		District	10 health districts out of 24
	Support the implementation of formative supervision: <ul style="list-style-type: none"> ✚ Louga – 2nd visit ✚ Ziguinchor – 2nd visit 	In progress		District	
	Conduct follow-up visits of the action plans for formative supervision at Thies, Louga and Kaolack	Not completed		District	Constraints related to the cholera epidemic
	Supervision of post-abortion services and supply of manual intra-uterine vacuum aspiration syringe kits	Not completed		District	

Increases in the choice of contraceptive methods	Return results of studies regarding IUDs		In progress		Regional District	10 health districts out of 24
	Support the refresher training program for government midwives regarding IUDs		In progress		Central, regional and district	73 government midwives trained out of 200 planned (36.5%)
	Support the introduction of the fixed days method in the range of family planning methods available	Decentralized training	In progress		District	
		Monitoring/coaching of providers	In progress		District	
		Integrate the fixed days method into the supervision grid	Completed		Central	
		Integrate the fixed days method into PNP documents	Not completed		Central	
	Integrate the fixed days method into the system for supplying contraceptive products	Not completed		Central		
Ensure the availability of contraceptives	Mid-year review of TACS		Completed	Sept. 20–23, 2005	Central MSH	
	Supply contraceptives to warehouses serving public and private institutions		Completed		Regions and districts	
	Training in IMAT, the Dakar Regional Executive Team and Reproductive Health Division		Completed	Dec. 27–29, 2005	Central	
Ensure the availability of contraceptives	Support execution of the plan prepared to secure reproductive health products		In progress		Central	Plan made available to the head of the Reproductive Health Division
	Support for evaluation of the integration model for contraceptive logistics into the National Pharmacy in progress in the Kaolack region		In progress		Central	Proposal submitted and preparation of data in progress
	Participation in the integrated formative supervision of service delivery points		Completed		Regions Districts	

SECTION C: PROGRESS MADE IN CARRYING OUT THE ACTION PLAN, SEPTEMBER-DECEMBER 2005

The rate of completion of activities broken down by component shows that the largest portion of activities is dedicated to family planning (43%), monitoring prenatal preventive activities (32%) and assisted deliveries (25%).

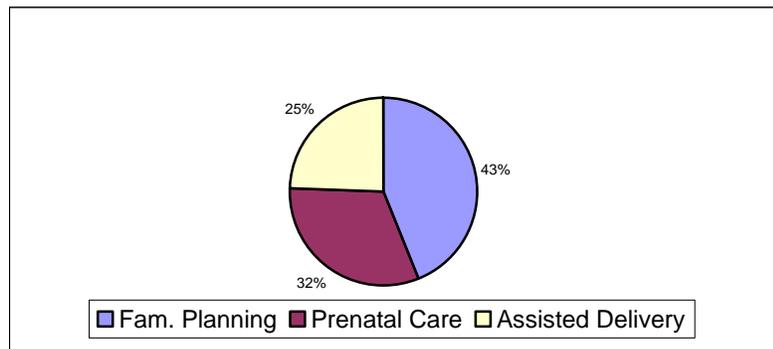


Figure 17. Rate of completion of activities by component

As for the level of completion, 96% of the activities take place at the community level, i.e., at the health district level.

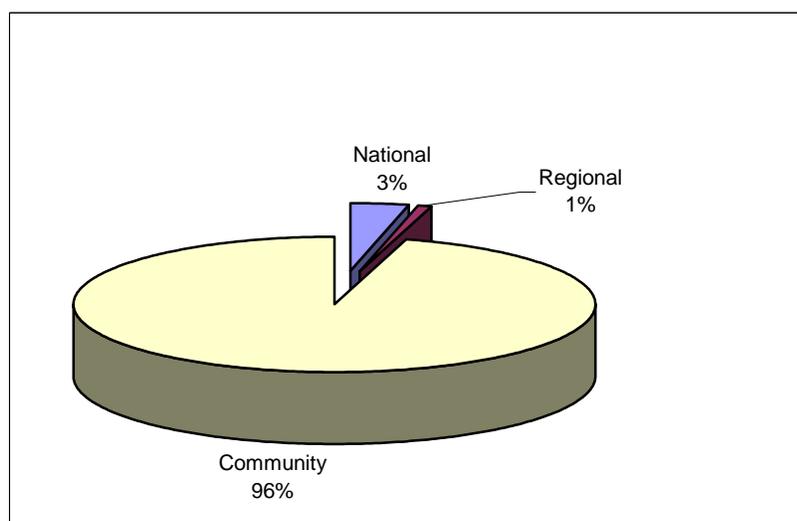


Figure 18. Distribution of expenses incurred by level of intervention

Appendix 1: External Missions

Susana Galdos, Principal Program Associate at MSH Boston, conducted two missions to Senegal, from September 8 to 24 and then from November 6 to 19, to support clinical activities (community post-abortion care) and activities related to IEC/BCC/advocacy (design of the pictograph and the aides-memoires for low-risk maternity, remote learning for ARPVs, extension of community health promoters).

Philippe Moreira, PREMOMA Team Leader, made an administrative and financial procedures orientation trip from MSH Boston from September 18 to October 7, 2005.

Fatim Tall Thiam, PREMOMA Clinical Counselor, conducted a mission to the United States from December 6 to 20, 2005: Presentation at the meeting of the PAC Consortium Group, of the American Public Health Association 133rd Annual Meeting (December 10–14, 2005 in Philadelphia), visit to MSH Boston, December 15 – 20, 2005.

Sarah Alkenbrack, Senior Research Associate at The Futures Group International, conducted a technical assistance mission to Senegal from December 7 to 10, 2005, and introduced the Safe Motherhood Model and trained the PREMOMA and CEFOREP staff in the collection, entry and analysis of data related to the model.

Appendix 2: Internal Organization of the Project over Its Life

The following changes in responsibilities occurred in the project staff:

- Dr. Philippe Moreira, Assistant Team Leader, became Team Leader, replacing Dr. Ousmane Faye, who became Team Leader of the MSH Project in Rwanda;
- Alioune Wade, Accounting Manager, became Director of Operations;
- Dr. Fatim Tall Thiam, previously a Program Assistant, became a Clinical Counselor.

Internal informational meetings were held in the form of brown bag sessions. The first meeting took place on December 8, 2005, covering the plan to reactivate IPT among pregnant women.

Appendix 3: Logistical Management of Cycle Beads for the Fixed Days Method

Status of distribution of cycle beads for implementation of the fixed days method

Structure/Individual	Cycle beads distributed to structures/districts	Cycle beads distributed during training	Total
MSH Thies	50	50	100
Joal	100	15	115
Thies Medical Region	75	22	97
Guediawaye	85	39	124
Mbao	50	15	65
Rufisque	50	26	76
Mbour Christian Children's Fund	0	43	43
Total	410	210	620

Status of inventories of cycle beads for the fixed days method

	Starting Inventory	Items added	Items distributed	Items lost	Ending Inventory
Cycles	1,000	0	620	0	380

Appendix 4: Contraceptive Needs in Senegal

**Reproductive Health Division, Social Marketing Development
Agency, Division to Fight AIDS and STDs
Upon completion of the mid-year review**

Product	2005	2006	2007
Depo-Provera	131,000	356,000	416,000
Conceptrol	0	0	355,200
Lofemenal	265,200	824,400	919,200
Ovrette	0	157,200	156,000
No-Logo Condoms	2,220,000	10 094 000	7,674,000
Norplant	3,650	6,350	6,250
Cooper-T (IUD)	2,600	5,600	8,800
Blue-Gold Condom	0	5,526,000	7,287,000
Duofem	50,400	90,000	92,400
Femidon	0	0	50,000

Appendix 5: Status of Inventories

Reproductive Health Division (DSR)

PRODUCT	INVENTORY AS OF SEPT. 30, 2005	ITEMS ADDED	ITEMS DISPENSED	ITEMS LOST	INVENTORY AS OF DEC. 1, 2005
Condoms	58,168	2,830,168	33,000	0	2,855,336
DEPO PROVERA	25,525	234,725	76,458	0	183,792
LOFEMENAL	94,300	359,500	97,436	0	356,364
IUD	0	5,415	1,785	0	3,630
CONCEPTROL	296,200	0	104,000	19,500	172,700
NORPLANT	3,072	0	1,208	1,056	808
OVRETTE	47,100	159,900	40,149		166,851
Social Marketing and Development Agency (ADEMAS)					
DUOFEM	0	96,000	96,000	0	0
Condoms	0	4,881,000	4,509,000	0	372,000
STDs/AIDS					
FEMIDON	333,000	393,000	17,000	0	709,000
Condoms	510,000	0	438,000	0	72,000

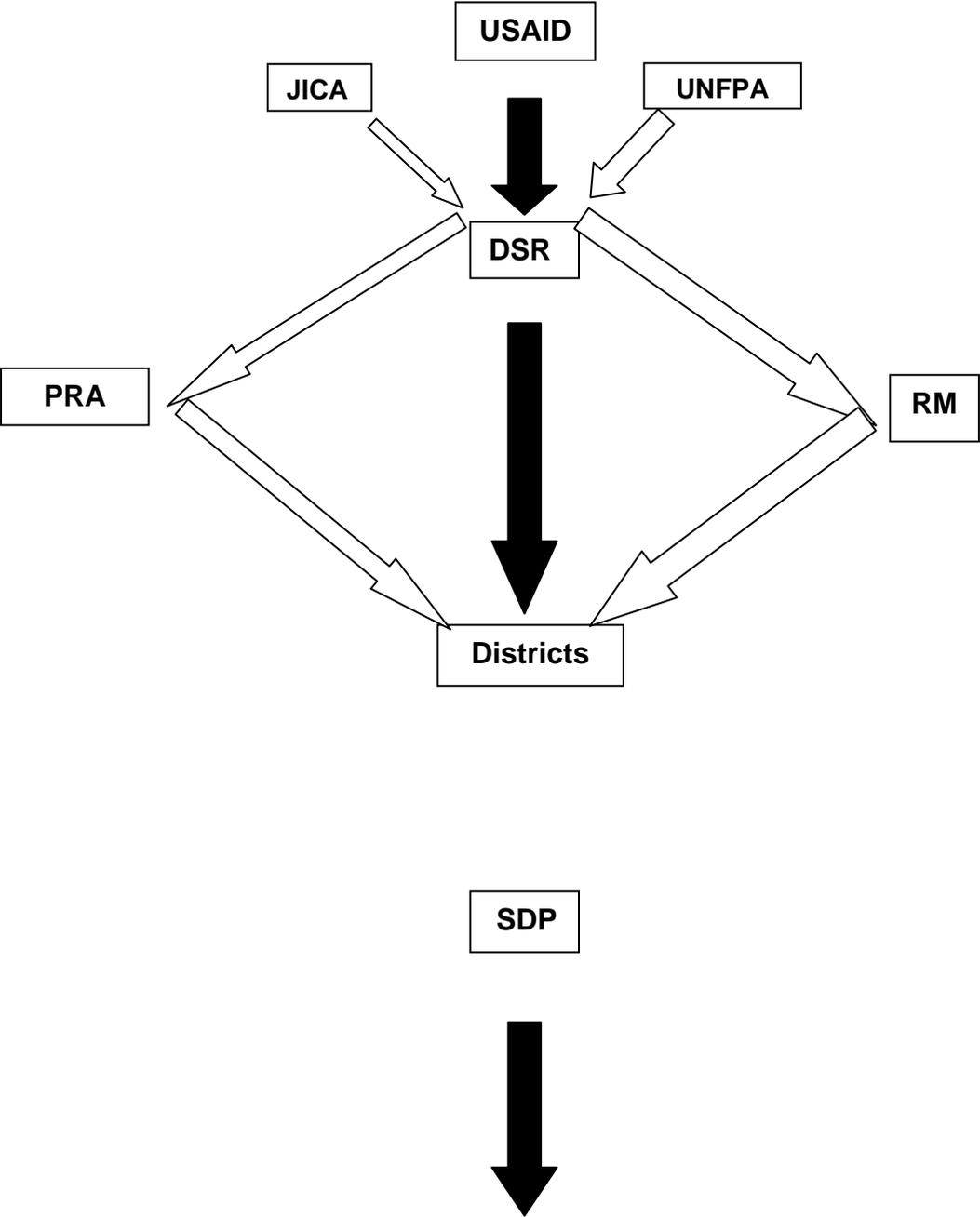
Appendix 6: Supply of Health Districts and Regions, Sept. 1–Dec. 31, 2005

RECIPIENTS	LOFEMENAL	OVRETTE	IUD	CONCEPTROL	DEPOPRO	NORPLANT	CONDOMS	FEMALE CONDOM	NEOGYN ON	DATES
Thies Medical Region	19000	6000								10/09/2005
MSH Thies	4800	2400								10/09/2005
Dakar Medical Region	20000	20000								12/09/2005
Reproductive Health Division (DSR)							9000			12/09/2005
Reproductive Health Division/MSPM	6000	3600		4800	3000					15/09/2005
ZIGUINCHOR Medical Region	12000	2400			3000	50				15/09/2005
Dakar Medical Region			100							21/09/2005
APPR Rg TAMBA/KOLDA	13200	2400		8200	5400	150	24000			01/10/2005
MSH Thies	4800		100	4800	1000	50				11/10/2005
ST LOUIS	12000	3600			7000	25	27000			11/10/2005
MSPM							9000			11/10/2005
Repr. Health Office/CEFOREP/FORM IUD			50							13/10/2005
Kaolack Medical Region	2600				3000					18/10/2005
KAOLACK Reg. Supply Pharmacy	7200		400	9600	8000	100	6000			18/10/2005
Mekhe Dist.	2200	200			800	10				24/10/2005
Tivaouane Dist.	3200		25		2000	15				24/10/2005
Dakar Medical Region		12000	200		10000	800				24/10/2005
Mbour Dist.	3400	1000				50	3900			25/10/2005
Popenguine Dist.	1200	3400		500		12				25/10/2005
Khombole Dist.	1800			400	1200					26/10/2005
Thies Dist.	5400	5500		4000	6000	24	1800			26/10/2005
Dakar Medical Region			200							26/10/2005
Thadiaye Dist.	1100	200		200	800					27/10/2005
Joal Dist.	2800	1000		800	1200					27/10/2005
Thies Medical Region	4600	2400	200		400	139	15000			28/10/2005
National Pharmacy	4800	4800								31/10/2005
Ziguinchor District			48			50				07/11/2005
Linguere	943	428		38	1103		100			07/11/2005
Dahra	570			600						07/11/2005
Dahra Mbayenne	100	100		100						07/11/2005
MSH Louga	1200	1200	75	2000	2400	50	6000			07/11/2005
TOTAL	132,100	70,900	1,398	33,300	52,800	1,525	95,700			

SUPPLY OF HEALTH DISTRICTS AND REGIONS from Sept. 1 through Dec. 31, 2005 (continued)

RECIPIENTS	LOFEMENAL	OVRETTE	IUD	CONCEPTROL	DEPOPRO	NORPLANT	CONDOMS	FEMALE CONDO M	NEOGYNON	DATES
Kebemer District	2400									08/11/2005
Kebemer District	3123	520	25	932	150					08/11/2005
Louga Medical Region			75							08/11/2005
Oussouye Dist.					50					08/11/2005
Regional Depot			100		6000	348	6000			08/11/2005
Repr. Health Office/CEFOREP/FORM IUD			200							22/11/2005
Reproductive Health Division (DSR)	1200						300			22/11/2005
Health Department	2400									24/11/2005
Diourbel Medical Region	7200	7200	200	6000	1800	100	15000			01/12/2005
Dakar Medical Region	21600	4800	200	4800	2000		21000			07/12/2005
Bakel District	300	200	50	500			3000			09/12/2005
Kidira District	300	100	25	100	200	14	300			09/12/2005
Goudiry District	1800	1800	50	500	600	200				09/12/2005
Regional Depot			50	500	200					09/12/2005
Tamba District	1200		50		1600	13	6000			09/12/2005
Kedougou District	1200	300	25		400		3000			10/12/2005
Velingara District					200					11/12/2005
Kolda District	2400		50	600			3000			12/12/2005
Kolda Medical Region	7200	1800		4800			12000			12/12/2005
Sedhiou District	2400	2200	100	2600	400		18000			12/12/2005
IPRES	500	100					500			15/12/2005
Primary Hospital	300	300	50	300			600			23/12/2005
TOTAL	50,000	18,800	1,150	21,200	13,400	675	88,700			

Appendix 7: Distribution Diagram for Contraceptives in Senegal



Appendix 8: PREMOMA M&E Plan

Indicators	Follow-up 1		Follow-up 2		Cum. %	Goal	Comments
	No. of districts	Performance level	No. of districts	Performance level			
AVAILABILITY OF CONTRACEPTIVES							
Percentage of service delivery point warehouse management trained in inventory management	25	70%	13	100%	100%	100%	
Percentage of service delivery point warehouse management that respects inventory standards	25	35%		58.20%	38%	100%	
Percentage of service delivery point warehouse management or PICS available 90% of days in the past six-month period (PICS = pills, injections, condoms, spermicide)	25	85%	5	100%	87%	100%	
Percentage of district warehouse product managers trained and updated on management tools	11	65%	18	75%	70%	100%	Average, not cumulative
Percentage of district warehouses with no contraceptive inventory shortages during the past six-month period	11	51%	16	67%	59%	100%	Idem
Percentage of mothers who have had at least one post-natal visit in the six weeks following delivery in the district	25	28%	2	25%	25.76%	50%	
ACCESS TO AND QUALITY OF SERVICES							
Percentage of service delivery points offering family planning services	25	96%	5	100%	96%	100%	
Percentage of service providers that respect national protocols and standards for management of family planning	24	46%	5	54.32%	47%	100%	
Percentage of family planning service providers that respect the standards and protocols for family planning counseling services	25	46%	5	62.38%	49%	100%	
Percentage of service delivery points that respect the standards and procedures for management of prenatal care	25	48%	5	51.76%	50%	100%	
Percentage of pregnant women who have had at least one prenatal visit	25	38%	2	32.50%	34.09%	90%	
Percentage of pregnant women having attended all 3 prenatal visits	25	35%	2	51.00%	36%	60%	
Percentage of women who came to all 3 prenatal visits who are receiving IPT (or a chemical prophylaxis prescription)	25	92%	2	66.00%	92%	100%	

Percentage of service delivery points that respect the standards and procedures for prevention of infections	25	27%	5	51%	32.53%	100%	
Percentage of service delivery points where COPE was introduced	25	100%				100%	COPE was introduced on the first follow-up visit
Percentage of service delivery points that implemented COPE to improve the quality of services			5	100%	100%	100%	
Percentage of service delivery points where at least one service provider received training in prenatal care from the project	25	94.44%	15	100%	100%	100%	
Percentage of service delivery points that correctly filled out the family planning register	25	58.82%	5	77%	62.06%	80%	
Percentage of service delivery points that correctly filled out the prenatal care register	25	83.83%	5	75.28%	81.68%	80%	
Percentage of service delivery points that correctly filled out the delivery register	25	69%	5	75.28%	70.00%	80%	
Percentage of service delivery points that correctly filled out the post-natal care register	24	61.50%	5	74.40%	60.35%	80%	
Percentage of service delivery points with at least one service provider trained to offer Norplant	25	87.50%	5	100%	91.67%	100%	
Percentage of service delivery points offering emergency OB care	25	59.92%	5	78.86%	64.91%	100%	
Percentage of service delivery points offering informal talks	25	64.21%	5	86.20%	67.25%	100%	
Percentage of service delivery points with at least one counselor or service provider to offer counseling services	25	90.63%	5	96.40%	92.50%	100%	
DEMAND FOR REPRODUCTIVE HEALTH SERVICES							
Percentage of men in favor of family planning	Thiès (20) Louga (10)	18.25%					
Percentage of women who know the benefits of and schedule for prenatal care	Thiès (254) Louga (423)	96.45%					
Percentage of women who know the schedule for 3 prenatal visits	Thiès (535) Louga (313)	45.85%					
Number of decision makers (lawmakers and local elected officials) and leaders (religious officials and women's and youth movement leaders) made aware and given orientation as community health promoters	Linguere Thiadiaye Kaolack Guinguineo	206	Nioro Kongheul Bignona Thionk Essyl	16	222	150	Follow-up 2 involves the extension of community health promoter activity in 4 districts

Percentage of decision makers and leaders given awareness training and orientation as community health promoters, who conduct activities to promote low-risk motherhood and family planning within their communities	Linguere (44) Thiadiaye (33) Kaolack (102) Guinguineo (27) Total (206)	100%		41.66%		75%	Idem
Percentage of decision makers, leaders and community health promoters who know at least 2 benefits of family planning	Linguere (20) Thiadiaye (13) Kaolack (26) Guinguineo (10) Total (206)	98%				75%	
Percentage of decision makers, leaders, community health promoters who know the schedule for prenatal care	Linguere (20) Thiadiaye (13) Kaolack (26) Guinguineo (10) Total (206)	62%				75%	
Percentage of decision makers, leaders and community health promoters who know at least 2 benefits of family planning	Linguere (20) Thiadiaye (13) Kaolack (26) Guinguineo (10) Total (206)	94%				75%	
Percentage of pregnant women surveyed by community health promoters who have had at least one prenatal visit	Linguere (222) Thiadiaye (570) Kaolack (1982) Guinguineo (331) Total (206)	90%				80%	

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