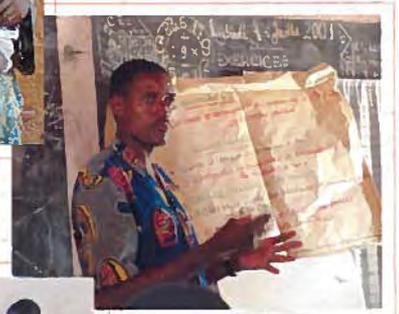


The Benin Integrated
Family Health Program

January 11, 1999–January 10, 2004

PROSAF Final Report



U.S. Agency for International Development
Promotion Intégrée de Santé Familiale dans le Borgou et l'Alibori
Benin Ministry of Health

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Table of Contents

LIST OF FIGURES AND TABLES	iv
ACRONYM LIST	v
EXECUTIVE SUMMARY	vii
INTRODUCTION	1
PROSAF VISION	5
MAJOR RESULTS AND APPROACHES	8
Achievements Summary Data	8
Implementation Approaches	8
ACHIEVEMENTS	17
Departmental Level	17
Health Zone Level	31
Health Center Level	44
Community And Family Level	56
CHALLENGES AND OPPORTUNITIES	72
ANNEX	74
Appendix 1: PROSAF Performance Monitoring Plan Indicators	74
Appendix 2: List of Documents and Tools Developed during PROSAF	79
Appendix 3: Summary of Training Participation	81





List of Figures and Tables

Figures

Figure 1. A Comprehensive View of Quality Improvement	6
Figure 2. Systems View of Health Service Improvement	9
Figure 3. Quality Assurance Triangle	11
Figure 4. Improving Performance through Capacity Building: A Continuous Process	13
Figure 5. The Management Cycle	14
Figure 6. Child Health Booklet.	25
Figure 7. Vaccination Hand	26
Figure 8. Performance in Family Health Product Order Management	30
Figure 9. Performance of Health Zone Management Teams in Implementation of Planned Activities.	33
Figure 10. Availability of Family Health Commodities in Health Centers.	35
Figure 11. Performance of Health Zone Management Teams in Health Center Supervision	37
Figure 12. Progress in the Offer of the Minimum Package of Family Health Services.	49
Figure 13. Performance of Service Providers in Key Family Health Components	51
Figure 14. Availability of Minimum Package of Family Health Services.	55
Figure 15. COGEC Performance Index in Concentration Zones	59
Figure 16. Village Health Committee Performance Index	60
Figure 17. Community-Based Service Coverage in Concentration Zones.	62
Figure 18. Trend in Adequate Coverage of Pre-natal Consultation in Bembèrèkè/Sinéde Health Zone	66
Figure 19. Knowledge of Family Health among Families and Communities in the Borgou/Alibori	68

Tables

Table 1.	Principal Family Health Results	8
Table 2.	Health Services Components and Management Support Subsystems	10
Table 3.	HZMT Performance Index	41

Acronym List

ABPF	Benin Association for the Promotion of the Family (<i>Association Béninoise pour la Promotion de la Famille</i>)
AIDS	Acquired Immunodeficiency Syndrome
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior change communication
CBSA	Community-based service agent
COGEC	Commune management committee
COGES	Sub-prefecture management committee
CLUSA	Cooperative League of the USA
CPR	Contraceptive Prevalence Rate
CRS	Catholic Relief Services
DDSP	Departmental Directorate of Public Health
DHS	Demographics and Health Survey
DPP	Directorate of Planning and Programming
DSF	Directorate of Family Health
EONC	Emergency Obstetric and Neonatal Care
EQGSS	Evaluation of Quality Management of the Health System
ERPA	Rapid Evaluation of Health Worker Performance
HIV	Human immunodeficiency virus
HZMT	Health zone management team
IEC	Information, education, and communication
IGA	Income generating activities
IMCI	Integrated management of childhood illness





IPC	Interpersonal communication
KAP	Knowledge, attitudes, and practices
MOH	Ministry of Health
MOU	Memorandum of understanding
NGO	Non-governmental organization
PATH	Program for Appropriate Technology in Health
PBA	Benin-German Primary Health Care Project
PNC	Pre-natal care
PoNC	Post-natal care
PSS	Swiss Health Project
PROSAF	Benin Integrated Family Health Program (<i>Promotion Intégrée de Santé Familiale dans le Borgou et l'Alibori</i>)
QA	Quality assurance
QI	Quality improvement
ROBS	Benin Network of Health NGOs
SNIGS	Routine Health Information System
STI	Sexually transmitted infections
TBA	Traditional birth attendant
URC	University Research Co., LLC
USAID	United States Agency for International Development
VHC	Village health committee
WHO	World Health Organization
ZOPP	Planning by Objectives

EXECUTIVE SUMMARY

THIS final report on the Benin Integrated Family Health Program, or PROSAF (*Promotion Intégrée de Santé Familiale dans le Borgou et l'Alibori*), highlights the main accomplishments achieved under the five year contract funded by the United States Agency for International Development (USAID). From 1999 to 2004, PROSAF worked in close collaboration with Benin's Ministry of Health (MOH), implementing programs at all levels of the health system—from the community and family level to the central level—in two health departments in Benin, Borgou and Alibori. PROSAF's primary objective was to increase the use of family health services and prevention measures within a supportive policy environment in these two health departments.

To achieve this objective, PROSAF's activities focused on improving planning and coordination; increasing access to health services and products; strengthening the capacity of health workers to provide quality services; disseminating information about healthy behaviors; and encouraging communities to participate in decision-making about the health services available to them. Working closely with the Departmental Directorate of Public Health (DDSP), PROSAF provided training, supervision, and coaching to health zone management teams (HZMTs), focusing on their role in planning, monitoring, managing financial resources, and improving clinical care in the facilities for which they are responsible. Due in part to PROSAF's efforts to build capacity, improve organization of services, and rehabilitate several health facilities, over 50% of the population in Borgou/Alibori now has access to a minimum package of family health services. PROSAF's support of the organization and construction of the departmental warehouse, along with training of facility staff in logistics management, has increased the availability of family health products. Through the creation and deployment of a regional training team and the use of on-the-job coaching, health worker performance has improved





significantly, particularly in pre-natal care, family planning, and integrated management of childhood illness (IMCI). Demand for family health services and products has increased as a result of PROSAF's work with traditional media groups and local radio stations to change local health beliefs and behaviors, which led to a nearly three-fold increase in the contraceptive prevalence rate (CPR) and a 37% increase in the number of children fully vaccinated before their first birthday.

The implementation of these varied activities was grounded in several key concepts that provided a consistent approach throughout the project. First, PROSAF employed a systems approach, which focuses on improving the processes used to provide health care services rather than improving primarily the quality of inputs (e.g. training of health workers, improving infrastructure) to accomplish a change or improvement in health system outputs. Key processes include improving the organization of clinical and preventive care, and improving support services such as supervision, planning and monitoring, and logistics. Second, PROSAF emphasized establishing a culture of quality throughout the health system, from service delivery to management. This was achieved by introducing quality management and focusing on continuous improvement using routine monitoring data. Third, PROSAF's comprehensive capacity building approach included coaching within the work environment and follow-up supervision which reinforced new skills and motivated trainees to implement what they had learned. Finally, a participatory approach was woven throughout project activities to encourage community members to participate in the management of primary health care services, and to provide input and take responsibility for improvements both within health centers and within their communities. PROSAF



succeeded in establishing close working relationships with counterparts at all levels, and fostered donor collaboration.

This report summarizes the results achieved over the five-year implementation period. The report is organized around the main levels of the health system, starting with the department level and followed by health zones, health centers and the community level. As the following pages illustrate, PROSAF's continued commitment to its objectives and dedication to building a collaborative spirit, have resulted in numerous and wide reaching achievements. Although not without its challenges and obstacles, PROSAF's efforts on behalf of Benin's MOH and USAID have laid the groundwork for future change in the health system of the Borgou/Alibori. From 2004 to 2006, PROSAF *Transition Phase*, a two-year USAID contract, will continue to reinforce PROSAF accomplishments by expanding the reach of its activities and working hand in hand with the DDSP to ensure that the achievements of PROSAF are sustainable achievements; and that they are used as building blocks for continued change and progress toward improved health.



INTRODUCTION

Under a five-year contract from USAID/Benin, the Benin Integrated Family Health Program, or PROSAF (*Promotion Intégrée de Santé Familiale dans le Borgou et l'Alibori*), actively supported the Ministry of Health (MOH) to increase the use of family health services and prevention measures within a supportive policy environment in two health departments, Borgou and Alibori, from 1999 to 2004.

Borgou and Alibori (Borgou/Alibori) are in northern Benin, cover almost half of the country's landmass, and are home to approximately 20% of its population. They were chosen because of the severity of their health problems in comparison with the rest of the country.



Throughout the life of the project, PROSAF has worked closely with the departmental, or regional, health directorate by developing activities that directly support the MOH priorities of improving family health services, preventing and managing priority diseases, and managing health services through capacity building and health zone development. Another important government priority that became a PROSAF cornerstone was strengthening the involvement of commu-

nities in health care. PROSAF also supported the work of non-governmental organizations (NGOs).

A consortium of four organizations joined together to implement PROSAF. University Research Co., LLC (URC), the prime





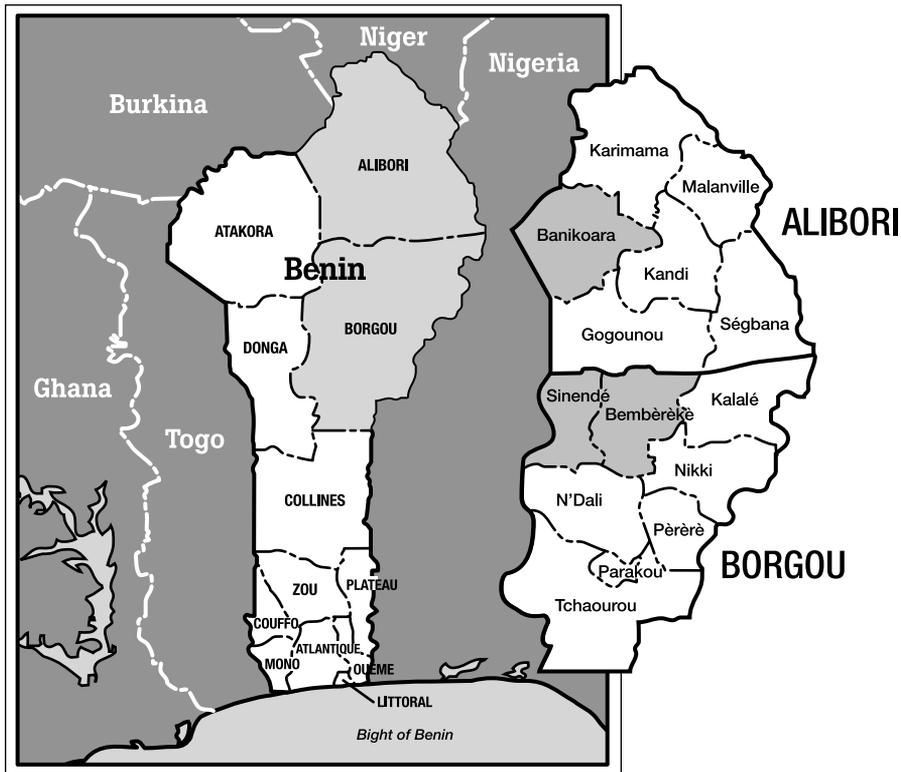
contractor, was responsible for overall technical and administrative direction and for managing a team of three subcontractors. The *Association Béninoise pour la Promotion de la Famille* (ABPF) worked to increase access to family health services and products in the program area, building on its experience in family planning and sexually transmitted infection/human immunodeficiency virus (STI/HIV) services throughout Benin. The Cooperative League of the USA (CLUSA) provided expertise in innovative training and empowerment of community-level organizations to participate in local health service management. The Program for Appropriate Technology in Health (PATH) supported activities aimed at changing the behavior of providers and communities to achieve better health.

Drawing on the strengths of each consortium partner, PROSAF addressed the following five distinct, yet complementary, sets of activities, or results packages, to improve family health services.

Improved health planning and coordination: Planning and coordination are key management functions that must be performed in a systematic and strategic manner to positively and significantly impact a health system. To that end, PROSAF focused on assisting the departments and the health zones to improve their planning processes and strengthen coordination of activities among all programs and health centers.



Increased access to family health services, including family planning, maternal and child health, and STI/HIV: Communities and families need access to family health services and to open communication with health workers, preferably in their own language. PROSAF introduced the minimum package of family



health services and worked with providers to improve interpersonal communication and local language skills.

Increased capacity of health workers to provide quality services: All health workers need to be well trained and able to deliver the integrated package of health services according to nationally established clinical guidelines. They also need to be able to monitor their own work and make ongoing improvements when necessary. PROSAF provided training, coaching, and supervision for health workers with a comprehensive quality assurance (QA) focus.

Increased knowledge and behaviors supporting the use of family health services, products, and prevention measures:





Both communities and providers need to have the knowledge, information, and materials to make informed choices for care, and communities need to take responsibility for health behaviors of their members. PROSAF worked to disseminate culturally appropriate messages on key health issues through diverse communication channels.

Increased public involvement in the planning and delivery of communitylevel health services and prevention measures in selected target areas: Health centers need to be actively supported by the families and community organizations they serve. PROSAF worked to strengthen the ability of communities to take an active role in the delivery and management of health care services in their region.

PROSAF implemented its activities throughout all seven zones of the Borgou/Alibori with more intensive community mobilization and QA efforts in two zones, Banikoara and Sinendé/Bembèrèkè (see map), referred to as *concentration zones*.

The following report summarizes the approaches, activities, and results of PROSAF's work in the Borgou/Alibori. It begins with a brief description of PROSAF's vision regarding the expected contributions of each level of the health system and then describes the key approaches that have led to the projects' primary achievements. Next, it highlights major achievements at each of the health system levels. Finally, it presents some challenges faced during the project, suggests solutions to these obstacles, and concludes with opportunities for continued work in the region.



PROSAF VISION

The PROSAF vision for quality, integrated services focuses on four distinct levels: family, community, and community-based organizations; health care providers and health centers; Health Zone Management Teams (HZMTs), and the Departmental Directorate of Public Health (DDSP). Technical assistance was tailored to each level. At the family and community level, PROSAF assistance focused on promoting healthy behaviors and community-based services. With community organizations, the emphasis was on mobilization and health education activities. Health worker and health center support focused on training, supply, and supervision. At the HZMT and DDSP levels, work addressed improvements in planning and monitoring.

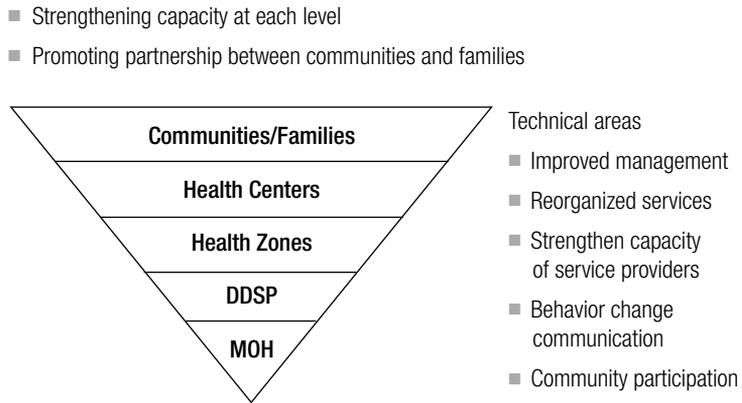
The vision for success at the family and community level includes ensuring access to services, increasing awareness and responsibility for good health practices, and providing adequate financial resources. Access refers to the availability to all individuals of quality health services offered in a comfortable environment. Responsibilities, at this level, refer to the responsibility of individuals, families, and communities to utilize health services when appropriate, actively seek information about health issues, and communicate their health expectations. Financial resources often are scarce, so services should be affordable. Finally, sufficient financial resources should be at the disposal of the community to make necessary improvements to the health system.

The vision at the health center level involves a commitment to the provision of quality services, improvement of competencies, collaboration, and motivation. Central to this vision is the expectation that health center staff offer services that respect the needs expressed by clients, collect and utilize data to improve services, and offer services in an efficient manner to all who seek them. In turn, health workers can expect to receive training, supervision, and support to equip them to achieve this vision. PROSAF's vision





Figure 1. A Comprehensive View of Quality Improvement



for health workers also involves collaboration in the form of sharing information with a team of individuals and working alongside community members and community organizations to achieve mutual goals.

At the health zone level, the vision for PROSAF’s work centers on Health Zone Management Teams. Each team is responsible for defining a clear mission and for developing norms and standards for the integration of family health services, as well as for ensuring implementation and follow-up on the integration of services. Additionally, the HZMTs are responsible for developing a vision for work at the zone level and for sharing that vision with all partners; developing and executing a zone-level budget; and actively contributing to the DDSP’s planning and implementation processes. With regard to human capacity development, HZMTs are responsible for developing training curricula based on established norms and standards and for the thorough training of health workers in their respective zones. Once workers are trained, HZMTs must provide appropriate supervision and follow-up to ensure that the minimum package of family health services is being offered and provided in accordance with established norms and standards. HZMTs also are expected to be knowledgeable about QA approaches and to be able

to transfer this knowledge to health workers through training and coaching. On a management level, HZMTs have primary responsibility for efficiently managing human, financial, and material resources and ensuring that they are equally distributed throughout their respective zones. HZMTs have the opportunity to benefit from working with a team and are expected to foster collaboration among counterparts and motivate health workers to succeed.

PROSAF's vision for the DDSP level begins with establishing a clear mission and a policy, including norms and standards, for implementing the integration of family health services. Like the HZMTs, the DDSP is responsible for sharing its vision with all levels of the health system. The DDSP's primary responsibility is to ensure that the HZMTs have the resources, skills, and information necessary to carry out their responsibilities by providing resources, training, supervision, and coaching. The DDSP must contribute to the planning processes and implementation at the central, or MOH, level. In addition, the DDSP should strive to manage departmental resources efficiently and ensure that they are distributed equally throughout the department. Primary responsibility also lies with the DDSP to foster a spirit of teamwork and collaboration among all those working to improve the health system in the Borgou/Alibori.



MAJOR RESULTS AND APPROACHES

Achievements Summary Data

Table 1. Principal Family Health Results

Indicators	Baseline (DHS 1996)	KAP 2000	KAP 2002
Contraceptive prevalence	3%	7%	11%
Exclusive breastfeeding	19%	52%	61%
Fully immunized children	41%	37%	56%
Oral rehydration therapy	29%	15%	61%
Seek services (child fever)	45%	49%	55%

Note: DHS is Demographics and Health Survey; KAP is Knowledge, attitudes, and practices.

Results for all twenty-seven indicators tracked by PROSAF through the Performance Monitoring Plan can be found in Appendix 1.

Implementation Approaches

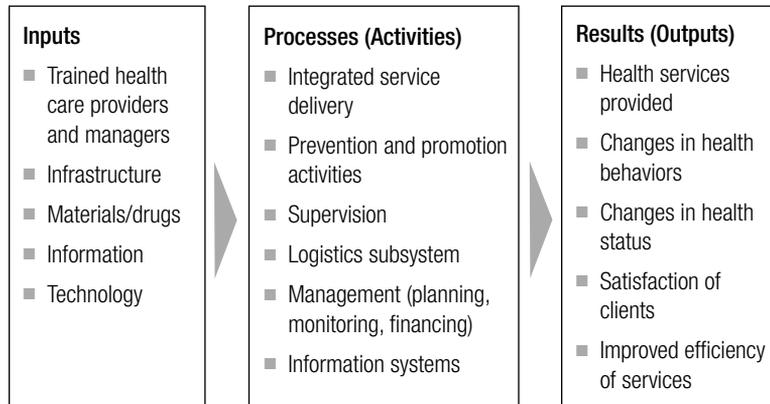
PROSAF used several approaches to guide the implementation of activities. These approaches, summarized below, include a systems approach to improving health care performance, quality assurance methods, capacity building using ongoing monitoring and coaching, management strengthening, and collaboration and partnerships. These approaches have been used throughout the program and applied to different components during the implementation process.

Systems Approach

The basis for the design and implementation of PROSAF activities is the systems approach. This approach emphasizes the importance of understanding and improving the processes that link resources to results. It is essential to view the performance of the system as a whole—from resources needed (i.e., inputs) to activities carried

out (i.e., processes). Inputs and processes that each meet commonly defined standards together ensure or improve the quality of care (output/outcome).

Figure 2. Systems View of Health Service Improvement



The systems model also facilitates the defining of optimal standards of care, based upon available resources. Instead of focusing on inadequate levels of resources—be it lack of training, materials, or resources—health care staff and managers in Benin have worked to define optimum use of available resources and to ensure that all activities and processes are aligned to make optimal use of those resources. Table 2 presents the main health services and management support subsystems that together comprise the health system in the Borgou/Alibori.

PROSAF has supported the improvement of the minimum package of family health services, which has nine different components (see Table 2). To ensure that all these components are being offered in an efficient manner to all clients, an integrated service model has been developed that ensures that every client is proactively offered all services and that no opportunities are missed.

In addition to the clinical subsystems, there are eleven management subsystems, which together constitute the core of the support





Table 2. Health Services Components and Management Support Subsystems

Health Services Components	Management Support Subsystems
Prenatal care	Planning
Birthing	Coordination
Post-natal care	Information
Well-child care	Logistics/supply
Vaccinations	Clinical/service organization
Nutrition	Training
Curative care	Supervision
Family planning	BCC/IEC
Nutrition	Human resources
	Financial
	Community participation

systems of the departmental health organization. Improved performance of each of these subsystems was an important program goal.

Quality Assurance

Quality assurance has been a cornerstone of PROSAF's implementation strategy. The QA approach is not a separate program or a set of separate actions working independently. Rather, it creates a culture of quality in the health system and among communities, and establishes common definitions and approaches for improvement. All PROSAF activities have been based upon four main QA principles: 1) the importance of client perspectives and needs, 2) an understanding of health care as processes and systems, 3) the use of data to test changes, and 4) teamwork and the use of data to make decisions.

To improve health service performance, QA encompasses three core groups of activities: defining quality, measuring quality, and

Figure 3. The Quality Assurance Triangle



improving quality. Figure 3 illustrates the mutually supportive nature of these sets of QA activities; all three groups of activities are important and mutually reinforce one another. There is no one specific way to start QA. Through the use of the QA methodology significant results have been achieved. These results can be grouped under each of the three core groups of activities, as shown below.

QA Activity Examples of Activities Undertaken

Defining Quality	Participated in the development of standards for obstetrical care Participated in the adaptation of IMCI protocol to local conditions Developed guidelines for logistics management Developed guidelines for management of DDSP team Defined roles and responsibilities of community-based health workers
Measuring Quality	Developed integrated supervision checklist Assisted with the development of health score card Trained communities to collect and analyze health data Worked with health centers to use data to identify problems and to measure improvement Assisted with improvement of SNIGS
Improving Quality	Formed and supported problem solving teams of communities and health centers Trained in new standards, using integrated training curriculum Trained health workers in local languages to improve communication with clients Developed user-friendly client and provider job aids in local languages





To be able to measure quality of performance, each component, or subsystem, must have well-defined norms and standards. PROSAF provided assistance to the MOH to develop or update standards, a function of “defining quality” as used in Figure 2. This assistance ranged from establishing standards for IMCI, emergency obstetrical care, and logistics systems to developing standards for financial management and community-based services. Particular emphasis was placed on building capacity to measure quality. In addition to strengthening the Routine Health Information System (SNIGS), PROSAF introduced several important tools to allow health care managers and providers assess their own performance (see box, PROSAF’s Tools for Measuring Quality). These tools included an assessment of the management and quality of care as well as the rapid assessment of clinical performance, which have become institutionalized as important periodic monitoring tools. Additionally, each health zone now has a scoreboard allowing the management team to review on a monthly basis the performance of main indicators and plan activities accordingly. Finally, the revitalization of the supervision system, using a focus on problem solving and teamwork, provides ongoing support for health workers to improve quality, the third angle of the QA triangle.

PROSAF’s Tools for Measuring Quality

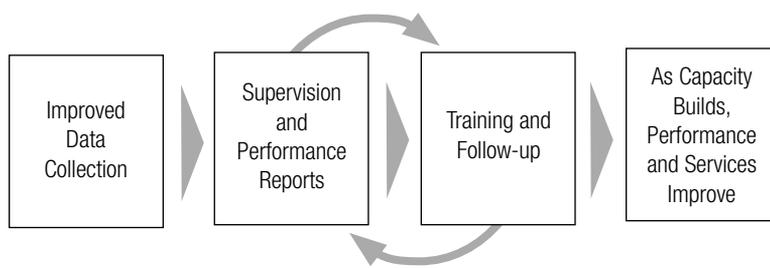
- Evaluation of Quality Management of the Health System (EQGSS)
 - Knowledge, Attitudes, and Practices (KAP) Surveys
 - Scoreboard for use at the departmental and zone levels
 - Rapid Evaluation of Health Worker Performance (ERPA)
 - Introduction of formative supervision and reinforcement of the supervision system
-

All improvement efforts in Benin have been based on data collected either routinely or through targeted assessments. Communities and health centers have begun to jointly analyze and solve priority health challenges, and health zones have developed improvement plans using scoreboard and rapid assessment data.

Capacity Building

PROSAF's capacity-building approach includes not only training, but ongoing support and monitoring of performance. This approach starts with the identification of gaps between actual and desired performance, the identification of causes of performance problems, and the selection of the most appropriate solution(s) to those problems: all parts of an improved data collection system. Only when the initial analysis indicates a lack of provider knowledge is training the appropriate intervention to improve skills. Where training would not close the gap, PROSAF emphasized post-training follow-up, supervision, and coaching as equally important and interrelated components of capacity building. The process establishes a feedback loop between training/follow-up and supervision/performance (see Figure 4). As long as the feedback loop continues, capacity is strengthened with the result of improved service quality. The ability to improve performance and to maintain acceptable levels of performance among personnel relies on the effective application of these interrelated components.

Figure 4. Improving Performance through Capacity Building:
A Continuous Process



Management Strengthening

PROSAF believes that by demonstrating the effect of modern management principles to stakeholders, such principles will be incorporated into the stakeholders' management practices,

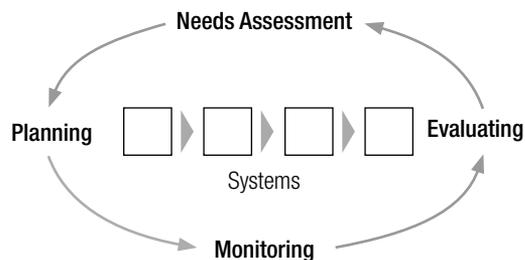




enhancing the effectiveness of organizations and, ultimately, improving health care quality in the Borgou/Alibori. The following five steps in management strengthening were used for all subsystems (see Table 2):

- 1) **Improving resource utilization:** Managers typically control four types of resources: human, physical, systems and financial. PROSAF confronted inadequacies in all four areas. Within the context of the program's available resources, assistance has been targeted to improve each type of resource. Additionally, considerable effort was directed at improving coordination among the donors working in the two departments to enhance efficient use of resources and reduce duplication of investments.
- 2) **Mastering the management cycle:** The management cycle has four key phases: assessing **needs**, **planning** to meet those needs, **monitoring** planned activities, and **evaluating** performance (Figure 5). The counter-clockwise direction of the arrows emphasizes the importance of knowing the desired result before assessing needs. The internal squares represent the inputs, processes, outputs, and results that comprise every system. PROSAF has provided technical assistance and capacity building to increase the ability of managers to understand and employ all phases of the management cycle.

Figure 5. The Management Cycle



- 3) **Applying quality management principles:** PROSAF has embraced the principles of quality management for all its work. This is evidenced by the participatory processes used to build consensus for the desired improvements, be they in management, community participation, or clinical services.

There are four guiding principles of quality management:

- Client focus;
- Understanding work as processes and systems;
- Testing changes and emphasizing the use of data; and
- Teamwork.

- 4) **Applying a coaching model of capacity development:** The coaching model for management capacity development uses the following steps:

- Teamwork;
- Compliance with management principles;
- Development of periodic monitoring mechanisms;
- Acceptance of responsibility for results;
- The use of QA techniques to teach problem analysis and solution development skills; and
- Modeling of coaching behavior (e.g., PROSAF staff and consultants act as coaches for the DDSP team and train them to become coaches of HZMT teams).

- 5) **Introducing ascendant planning:** To improve planning at all levels of the health system and increase coordination between levels, PROSAF implemented an ascendant planning process in the concentration zones of Banikoara and Bembèrèkè/Sinendé. This process started at the commune level where, beginning in 2000, COGEC developed annual health facility work plans for health problem-solving and management. This





annual planning process began with a workshop involving representatives from the village health committees (VHCs), health workers, commune management committee (COGEC) members, and other commune leaders. Once the health facility work plan was complete, it was presented for validation to a wider group of individuals including locally elected individuals; mayors and other administrative services representatives; and members of associations. It then was submitted for inclusion in the zonal level strategic plans. HZMTs then facilitated workshops during which they would adopt the annual work plans developed by the COGEC.

Partnerships and Collaboration

Partnership and collaboration is another key approach PROSAF applied to achieve results and improve the health system in Benin. PROSAF actively sought the development of a partnership and collaborative relationship with its counterparts at the MOH, and in particular, the DDSP. PROSAF also established partnerships and fostered collaboration with other stakeholders in Borgou/Alibori, including local NGOs, other USAID-funded organizations [e.g., Basic Support for Institutionalizing Child Survival (BASICS), PRIME and DELIVER], and donor agencies [Benin-German Primary Health Care Project (PBA), United Nations Children's Fund, World Bank, and Swiss Health Project (PSS)]. PROSAF strongly believes in drawing on the expertise and resources of all players in the Borgou/Alibori to achieve sustainable results.



ACHIEVEMENTS

The main achievements realized during PROSAF are summarized in this section by health system level—departmental, health zone, health center, and family and community. This presentation allows for an assessment of the progress made from the perspective of those who work in the health system and its beneficiaries.

Departmental Level

Summary of Departmental Level Results

Strengthened management capacity

- Tools for performance assessment: Management Assessment, ERPA, KAP
- Management improvement plan for the DDSP level
- Training curricula on minimum package of family health services including QA, logistics, formative supervision, integrated offer of services, community-based services, interpersonal communication
- Departmental in-service training process defined and implemented
- Design, follow-up and evaluation of strategic plans
- Strengthened capacity in formative supervision
- Design and production of IEC materials in support of family health services

Improved competencies

- Introduction of QA concepts and approaches for MOH, DDSP, health zones and hospital staff
- Creation of departmental training team
- Constitution of two IMCI training teams

Improved logistics and creation of a departmental warehouse

- Creation of warehouse
- Applying quality improvement techniques to logistics management
- Ongoing assessment of departmental warehouse performance
- Provision of telephone system to DDSP
- Equipment for DDSP conference room
- Set up of a computer lab at the DDSP





Strengthening Management Capacity

Tools for performance monitoring: Improvement of health services is predicated on the availability of accurate and complete data on the performance of the system and its processes. PROSAF worked to develop the capacity of the DDSP to evaluate the health management system, health worker performance, and outcomes of health care services on a routine basis. For this purpose, three important tools were introduced, namely the Management Assessment, the Rapid Evaluation of Health Worker Performance (ERPA) and the Knowledge, Attitudes and Practices (KAP) survey. The Management Assessment is a comprehensive set of tools designed to evaluate the quality of performance of the main processes of the health system, including clinical care and the essential support system and the level of integration of care and services provided to patients. This very comprehensive assessment was carried out twice during the five-year contract and covered all seven zones of the Borgou/Alibori.

The following subsystems constitute the core of the assessment:

1. Clinical service delivery
2. Planning and health management information systems
3. Ongoing training and supervision
4. Human resource management
5. Logistics and commodities provision
6. Information, education and behavior change communications
7. Community participation and partnerships

The following ten tools were developed to assess these subsystems:

1. Checklists for management components
2. Tool for assessing supervision provision
3. Tool for assessing health management information systems

4. Tool evaluating health worker needs and level of information on health system management
5. Tool for assessing health centers' organizational capacity and the availability of services and commodities
6. Guide for conducting observation to assess service provider compliance with norms on the minimum package of family health services
7. Guide for exit interviews with clients to assess access, utilization and satisfaction with services provided
8. Interview guide for service providers related to training, supervision, motivation and opinions on the minimum package of family health services
9. Tool for evaluating the management committees in terms of organization, level of involvement in health center management, committee operations, results and issues faced
10. Focus group discussion guide on the expectations and opinions of community members on health care delivery

Data from the **Management Assessments** formed the primary input for the development of the three-year strategic plans, as well as for the development of technical assistance and identification of training needs.



The **Rapid Evaluation of Health Worker Performance (ERPA)** was conducted twice during the life span of PROSAF. Through observation of client/provider interactions, ERPA assessed provider compliance with clinical norms. Data for ERPA were collected from a sample of health centers in each of the seven health zones. Four data





collection tools were designed to assess provider performance in IMCI, pre-natal care (PNC), delivery, post-natal care (PoNC), and family planning.

The **Knowledge, Attitudes and Practices (KAP)** survey was conducted in 2001 and again in 2003 in collaboration with the DDSP and Catholic Relief Services (CRS). The purpose of the KAP is to determine whether or not information, education, communication/behavior change communications (IEC/BCC) interventions in the following key health areas have changed behaviors of families and communities in the Borgou/Alibori:

- Family planning
- Malaria prevention and care
- Vaccination
- HIV and STI prevention/treatment
- Diarrhea prevention

The KAP surveys were conducted with women and men using individual questionnaires and respondents were chosen by a random sampling procedure using the DHS sampling frame. Different questionnaires were used for men, women, and households. Indicators from both CRS and PROSAF were represented in the questionnaires and questions were based on the 1996 Demographics and Health Survey and the 1999 CRS Knowledge, Practice and Coverage (KPC) Survey.

These three performance monitoring tools introduced by PROSAF were carried out in close collaboration with and in most instances by the health workers and managers themselves, especially the Management Assessment and the ERPA. A key feature of the Management Assessment is that the observations are done by health workers, each observing colleagues in another district. Data from the assessments were rapidly presented to the staff that was observed, providing immediate feedback on performance and

the quick initiation of the improvement process. An important benefit of involving health workers in the assessment is increased awareness of the importance of norms and standards and the need for compliance with both clinical and support service norms.

Plan for DDSP management improvement: In 2001, PROSAF worked with the DDSP to develop a management capacity development plan. This plan used the systems perspective and identified the core processes which make up the management system of the two departments, each with its concomitant inputs and internal processes. The concepts of a culture of quality and coaching for improvement were established as cornerstones for the improvement plan. Data from the Management Assessment



formed important input to develop detailed plans for each of the management subsystems. The implementation of the management capacity development plan was closely coordinated with the development of the decentralization strategy fostered by the MOH and by the gradual strengthening of the health zones, which were formed during 2000.

Training plan: In 2000, the DDSP and PROSAF developed a three-year departmental training plan. Training needs were determined by the first 1999 Management Assessment and by inputs from supervision reports.

The training plan detailed five objectives:

1. **Improving coordination of training activities** in the department by establishing a departmental training team, training standards and tools, a training activity information system, and annual training plans





2. **Improving the quality of training provided** by developing and implementing basic and advanced training of trainers curricula and providing follow-up and supervision
3. **Strengthening the departmental and zonal level capacity to plan and deliver health services** by using results from the Management Assessment to identify areas for improvement, developing or improving management tools, developing a management training curricula, and providing training in the management cycle
4. **Strengthening the capacity of health workers to provide quality health services** by using results from the Management Assessment to identify areas for improvement, providing follow-up and supervision, developing and disseminating norms and standards for clinical care, and developing and pilot-testing a family health services training curricula, and expanding the reach of project training activities
5. **Improving the quality of personnel supervision** by using results from the Management Assessment to identify areas for improvement, developing supervision tools, and developing a training curriculum on supervision, training the department and zone supervisors on supervision, emphasizing coaching and use of supervision tools

Subsequent to the development of the training plan, annual training plans were prepared to specify the types of training activities that would take place each year.

Training curriculum development: PROSAF worked with the departmental training team to develop an integrated training curriculum on family health protocols, health services, IMCI, Emergency Obstetric and Neonatal Care (EONC), QA, interpersonal communication (IPC), and the minimum package of family health services for the various levels of staff in the health system. PROSAF

also collaborated with DELIVER to develop a training manual and job aids for logistics management of family health products. These curricula were then used to train heads of the DDSP departments and health zone coordinators as trainers in logistics management of family health commodities. The DDSP now has qualified staff and technical resources to supervise and coach HZMTs.



In order to ensure that training for all types of health workers was carried out within the same overall framework and with the same focus towards establishing a culture of quality, PROSAF assisted the DDSP

with the formulation of an integrated curriculum. This curriculum included:

- Principles of integration
- Quality assurance
- Interpersonal communication
- Organization of services and team work
- Integrated offer of essential services
- Management of material, financial, and human resources
- Supervision and monitoring
- Logistics and supplies
- Problem solving using data and operations research

Twenty-four of the health workers trained participated in additional training on the proactive offer of family health services, an approach that emphasizes the importance of actively asking the client about and checking for health conditions in addition to the one for which the client currently is seeking care, and proposing appro-





priate service. These 24 trainers and coaches not only would apply their new skills in their own health centers, but also would go on to train and coach other providers in their respective zones.

Strategic planning: PROSAF contributed in several ways to the DDSP-level strategic planning efforts. At the beginning of the project, PROSAF staff helped the DDSP evaluate its 1997-1999 strategic plan. The two organizations then used that evaluation as a basis for departmental planning. For the 2000-2002 strategic plan, PROSAF assisted in the development of the vision and mission statement, which were based on community input and strategic directions identified in the Management Assessment. In 2002, PROSAF supported the development of the 2002 and 2003 action plans, as well as the 2003-2005 strategic plan.

The development of this three-year strategic plan and annual action plans benefited the DDSP in several ways. They helped the DDSP to justify activities and their related budgets and to prevent duplication in activity funding in the health zones. To encourage a culture of using data for decision-making, PROSAF conducted a mid-term review of the 2003-2005 strategic plan. The review highlighted the strengths of the plan, such as the existence of coordinated financial and technical support in the Borgou/Alibori for implementing the various MOH programs. Weaknesses identified included a lack of supervision of HZMTs by the DDSP; overly ambitious, unrealistic action plans that did not account for time and resource constraints; and delays in sending funding to the zones.

Supervision: PROSAF has strengthened the departmental supervision system and improved both DDSP and HZMT capacity to organize formative supervision in the Borgou/Alibori. The program has focused on training health workers, HZMTs, and DDSP staff, providing appropriate tools for supervision, and coaching in the use of the tools. (See a detailed description of formative supervision training in the Health Zone Level section.)

Design and production of IEC materials: The strategy for the development of IEC materials was based on a literature survey, a national inventory of IEC materials, the 1999 Management Assessment results, and subsequent focus groups. Digital photography and computer-based graphics permitted rapid development and field-testing of culturally appropriate images for print materials. The development of the IEC materials followed a structured process of message development, pre-testing, and restitution of test results with the partners and the MOH.



In collaboration with the MOH, NGOs, and international partners, PROSAF developed and produced thousands of IEC materials and distributed them to health care providers and their clients, schools, social centers, and community-level NGOs. Original materials were developed for malaria, including 170,000 folders, 400 sets of counseling cards containing 16 images, and 400 posters. Partners also have used these materials and images.

Figure 6. Child Health Booklet



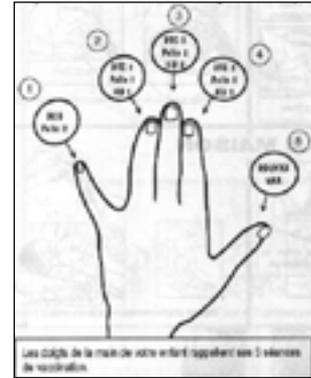
After an initial printing of 30,000 copies of a Child Health Booklet (Figure 6), developed by PROSAF, the national IMCI program adopted the booklet, which illustrates messages for the five main IMCI themes. The *Vaccination Hand*, (Figure 7), a participatory IEC support that uses a rhyme to link the five fingers of one hand to the five childhood vaccination sessions, has been successfully piloted in two communes. For family planning, 50,000 multi-method flyers on contraceptives and 4,200 posters were adapted from





existing Population Services International (PSI) and ABPF materials. In addition to these materials, the community based service agents (CBSA) have received 400 folders with samples of contraceptives and 400 cloth poster sets depicting male and female reproductive organs. Also, the family planning play continues to be shown via 100 videocassettes that were produced and distributed.

Figure 7. Vaccination Hand



Improved Competencies

Introduction of QA management: The main focus at the level of the DDSP with regard to quality management was on the enhanced understanding of the health system as a series of systems, where each must determine norms and standards and must monitor performance using routine data. These two concepts became the cornerstones for subsequent “just-in-time” training around key concepts of improvement. Emphasis was on the importance of supervision of the health zones and the integration of support coming from the departmental level.

Departmental training team: To ensure capacity of the departments to continuously update the skills of health care workers and ensure competence according to the latest clinical guidelines, PROSAF worked to establish a cadre of trained trainers at both the departmental and zonal levels. In 2000, a departmental training team was formed to develop curricula and deliver training courses throughout the Borgou/Alibori. Team members were selected by the DDSP in consultation with PROSAF based on stability and an interest and aptitude for training. A desire for representation from both the public and private sectors also played an important role in the selection process. Once established, the departmental training

team, comprised of DDSP staff, HZMT members, and others, were trained in pedagogical skills. To become certified trainers, departmental training team members were required to successfully apply their newly acquired training skills during at least two training sessions. All of the current departmental training team members have achieved certification by delivering training courses for health workers on topics such as contraceptive technology, infection prevention, and mentoring. The transfer of training and supervision capacity to the departmental training team was evident by the fact that all training activities during the final year of the project were conducted by the departmental training team. (See Appendix 3 for a summary of training participation during PROSAF).



An important focus for training became the newly adopted strategy for the Integrated Management of Childhood Illness (IMCI). PROSAF supported the MOH to develop its own IMCI training manual, based upon the approaches fostered by WHO. In 2002, 19 doctors participated in a training of trainers course in Porto-Novo. During the course, participants had the opportunity to practice supervision skills by supervising one another. Nine of those who participated in the initial training were selected to be trained in facilitation techniques for teaching IMCI modules. With their new set of skills, this team of trainers would then proceed to train 97 health workers in the three IMCI pilot zones. To add to the number of trainers, eight more doctors were trained, bringing the number of trained IMCI trainers to 17. These 17 trainers then formed two IMCI training teams, one for the Borgou and one for the Alibori. Through PROSAF funding, the DDSP was able to augment its capacity in IMCI by employing a course director, an assistant course director, two clinical instructors, and the 17 course facilitators.





Improved Logistics and Creation of Departmental Warehouse

To strengthen the national logistics system and improve distribution of health product supplies in the Borgou/Alibori. PROSAF has focused on increasing the proximity of drugs and commodity supply to health centers and on enhancing the capacity of HZMTs and care providers 1) to correctly estimate the amount of products they need based on their monthly mean consumption, 2) to correctly complete the order forms, and 3) to submit their orders before stock-out occurs.

PROSAF supported a review of the logistics system during a consensual departmental workshop. The underlying factors that contribute to poor supply and distribution of drugs in the Borgou/Alibori and leading to frequent stock-outs were identified and analyzed. These factors were the non-availability of drugs and commodities at the CAME supply warehouse in Cotonou, the remoteness of Borgou/Alibori from the CAME warehouse, the poor control system, and the lack of clearly defined norms in the management and distribution of drugs. PROSAF has supported the DDSP to tackle the latter two factors, over which the program has more control.

Departmental Warehouse

PROSAF, the DDSP, and the CAME management board identified the development of a departmental warehouse as key to strengthening the logistics system and reducing stock-outs. A financial and technical feasibility study of a warehouse was conducted with the technical and financial support of PROSAF. The DDSP identified the site where the warehouse would be built and held negotiations with administrative and municipal authorities. At the central level, the MOH, the CAME representatives, and the donors met, with PROSAF support, to commit to funding the warehouse. PROSAF contributed furniture to the warehouse and support for the adaptation and computerization of the management system.

Improving HZMT competencies in applying quality improvement techniques to the process of family health product management and to supervise health centers: With PROSAF support, the DDSP has trained almost 200 HZMT members, health care providers, and drug managers in the seven health zones to use family health product management tools. Today, at least 80% of the health personnel at the zone and health center levels are capable of managing logistics according to norms and procedures. PROSAF has trained and supported the seven HZMTs to provide formative supervision of product management in the health centers and to apply quality improvement techniques to the process of family health product management. In addition, PROSAF has strengthened the monitoring of orders, which is now automated in all zone offices.

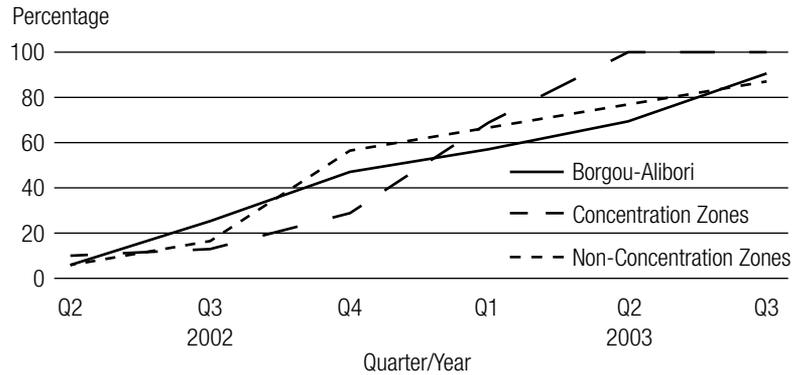
Assessing the departmental warehouse performance and providing guidance to the manager: PROSAF met with the manager of the departmental warehouse each quarter, and discussed issues related to supply, distribution, and the reinforcement of the health zone management capacity. During these meetings, PROSAF provided guidance and technical assistance when needed. PROSAF also conducted a performance assessment of the departmental warehouse after six months of operation. Performance was measured through use of the warehouse automated database and interviews with the warehouse and health zone managers. The results are as follows:

- Availability of the 40 products with the highest consumer demand in the Borgou/Alibori increased from 75% in January 2003 to 90% at the end of June 2003.
- The warehouse response to health zone orders rose from 70% of orders filled in January 2003 to 95% of orders filled at the end of June 2003.
- Users express satisfaction with the warehouse in terms of ease of accessibility, decrease in parallel orders, decrease in delivery time, and reduction in travel costs.





Figure 8. Performance in Family Health Product Order Management



The Performance Index in Family Health Product Order Management measured this achievement. This indicator comprises three criteria: 1) family health product stock forms are up-to-date; 2) estimated quantity of family health products to order is accurate; 3) purchase orders are sent on time. This index was measured each quarter from the second quarter of 2002 to the third quarter of 2003. The results presented in Figure 8 reflect the proportion of health facilities respecting all three criteria. The data shows significant progress has been made in family health product order management.

Between the fourth quarter of 2002 and the third quarter of 2003, a mean of 66% of public service delivery points in the Borgou/Alibori submitted correct and timely orders for family health products, including contraceptives and selected essential drugs. However, the performance achieved in the two concentration zones, where problem solving teams and coaching practices had been established earlier, is higher than performance in the other zones. As shown in Figure 8, the concentration zones reached 100% performance in the second and third quarters of 2003.

Health Zone Level

When PROSAF began, health zones had not yet been officially established in the Borgou/Alibori. Health zones were created as part of the process of decentralizing health services management, which followed the model of district management for primary care supported by WHO. A large part of institutional strengthening support provided by PROSAF has been directed to help clarify the roles and responsibilities of health zones, to design new management processes and to strengthen the skills of the health zone management teams.

There are seven zones in Borgou/Alibori, each led by a Health Zone Management Team (HZMT). HZMTs serve as the primary management and decision-making body for all health services in their zone. Each HZMT is led by the health zone coordinator, most often a medical doctor, and is made up of five to ten health personnel, including the zone hospital director, a senior nurse, a midwife, an accountant, the principal physician from each commune, the maintenance officer and, in some cases, the social welfare officer. The health zone coordinators are selected and assigned by the central level of the MOH and report to the departmental health director.

Support provided by PROSAF to the health zones included building management capacity, developing indicators and using them to monitor performance, improving training capacity, and updating equipment, materials and facilities. Through PROSAF's efforts HZMTs in Borgou/Alibori have demonstrated the success of strong management and teamwork.





Strengthened Management Capacity

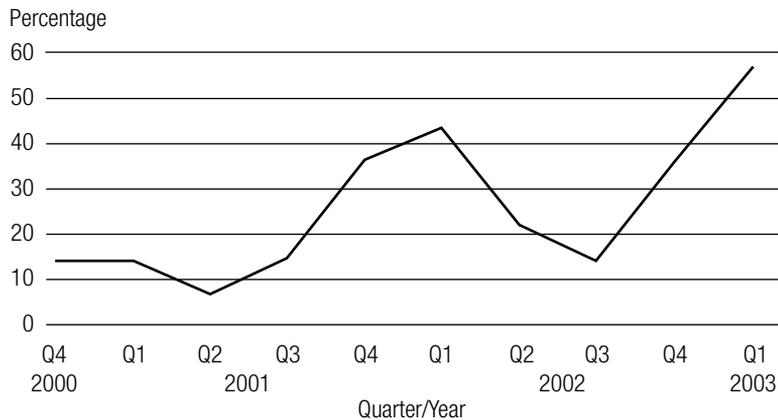
To improve the overall management capacity of HZMTs, PROSAF provided training in a variety of areas, including quality assurance (QA), planning, financial and logistics management, and formative supervision.

Planning: In 2002, the MOH introduced a bottom-up annual planning process that enabled the incorporation of lower-level priorities into regional and national health plans. This process of “ascendant planning” begins at the sub-prefecture health center level, with each level’s priority setting and budgeting work feeding into the next level’s plans until regional plans are consolidated at the central level of the MOH. PROSAF provided financial and technical support to the Directorate of Planning and Programming (DPP) and the Ministry of Finance to carry out a workshop to introduce the process, the planning templates, the reference documents and practical exercises. A second workshop on planning skills aimed at improving participants’ knowledge of planning by objectives, or

Summary of Health Zone Level Results

- Strengthened management capacity
 - Training of HZMT in planning, financial and logistics management, formative supervision, and quality assurance
 - Ascendant planning implemented in concentration zones
 - Improved program monitoring
 - Introduction of collaborative improvements for key primary health indicators
 - Scoreboard indicators developed and used quarterly by HZMTs each quarter
 - Team of trained trainers and coaches in each zone
 - Training materials provided
 - Improving equipment, materials, and facilities
 - Supervision vehicle
 - Computers and printers
-

Figure 9. Performance of Health Zone Management Teams in Implementation of Planned Activities



ZOPP, with a goal to finalize HZMT strategic plans for 2003-2005. ZOPP's three main steps include situational analysis, definition of objectives (e.g., determining the overall goal, target group, and zone objectives), and development of a summary table.

By the end of the workshop, participants had defined results to be achieved based on their objectives, defined activities necessary to achieve the results, developed indicators to verify the achievement of results, identified sources for verifying the indicators, and estimated the input and costs for defined activities. The result of this training was that 2003-2005 strategic plans and 2004 annual plans were developed on time and with clear indicators, incorporating priorities identified and proposed from lower levels in the health system.

Financial management: The first necessary step toward strengthening skills in financial management at the health zone level was to reach consensus on the financial management model to be used. Following a field visit to health districts and health district training sites in Burkina Faso, a training curriculum for financial management was developed. Health zone coordinators, managers





from the seven health zones, the deputy director in charge of decentralization, and the head of financial services at the MOH were trained. Topics covered in this training included:

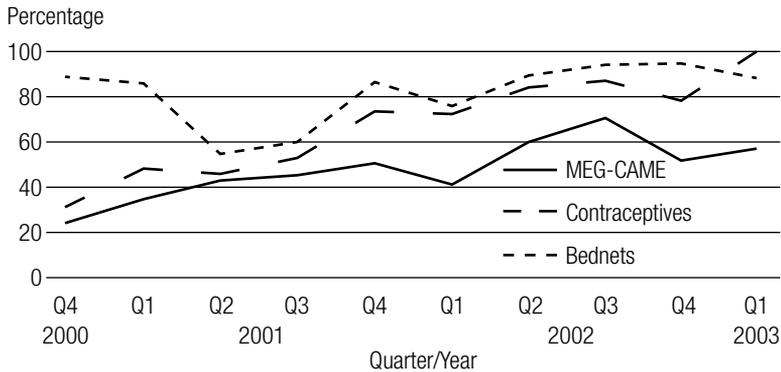
- The importance of health care financing as it relates to health care policy, particularly in the health zones
- Classification of different costs and payment shares
- Clarification of roles and responsibilities in financial management at the zone level
- Explanation of utilization of different financial management tools
- Presentation of the principles and rules governing budget development and management



Two months after the training, a follow-up visit confirmed that all health zones had implemented appropriate record-keeping procedures. Additionally, all HZMTs had integrated financial management into their supervision system.

Logistics management: Today, 80% of health workers at the zone and health center levels have the ability to manage logistics according to norms and standards developed by the MOH. This is due to the fact that 200 HZMT members, health care providers, and pharmaceutical managers have become cognizant of the importance of good logistics management for successful service provision. They all have been trained to use family health product management tools that were designed by the DDSP with support from PROSAF.

Figure 10. Availability of Family Health Commodities in Health Centers



HZMTs also were trained to provide formative supervision of product management at the health centers, and to apply quality improvement techniques to the process of family health product management. Lastly, PROSAF provided technical support for the automation of product ordering through computerization of the logistics management system.

The standardized bottom-up process of quality improvement in the management and ordering of drugs includes the following: at the end of each month, the health center team meets to report health statistics, including the analysis of data on stock movements, orders, and product stock-outs. The probable causes of weaknesses are identified and solutions that can be applied immediately are implemented. Corrective actions are verified and reinforced during formative supervision visits by the HZMTs. During quarterly monitoring, each health center presents its performance improvement trends in family health product management and explains to the other health centers what local solutions helped it make progress and what problems it encountered.

Formative supervision: The Borgou/Alibori supervision management system was evaluated during the 1999 Management Assessment. The assessment showed that only 6 % of health workers





had received four or more supervision visits during the previous year (see Figure 11). Regular formative supervision is essential for improving performance and quality of care.

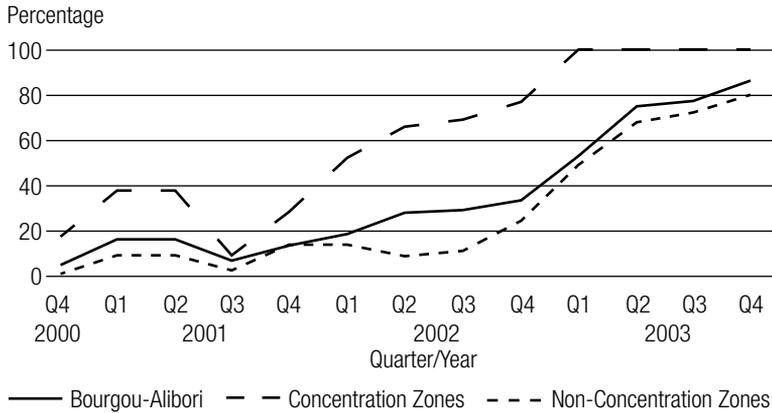
Consensus was reached on the content of formative supervision through a consultative process during which supervision methods and practices were identified and the profile and characteristics of a good supervisor defined. These definitions were incorporated into a comprehensive supervision plan, including supervision instruments, supervision planning and programming guidelines according to level, and a description of the supervision feedback and reporting process. The supervision plan specified that seven HZMT

members and DDSP staff would be trained in formative supervision and use a coaching approach to support newly trained supervisors to monitor health worker performance. PROSAF's first step toward facilitating implementation of the supervision training plan was to support the DDSP in the development of a supervision training manual and checklist. The checklist is composed of specific care delivery and management norms and standards to be performed by the HZMT and health workers. Second, the manual and checklist were piloted during a training session with half of the members of HZMTs (59 people). Third, the manual and checklist were revised based on feedback from the participants. Once the manual and checklist were finalized, formative supervision training was scaled up to include the remaining untrained members of the HZMTs and health workers. PROSAF provided intensive post-training coaching to reinforce the proper use of the newly introduced formative supervision method and tools. At the completion of PROSAF, all the DDSP staff members and 75% of personnel at the zone and health

Formative supervision is defined as:

1. Follow-up on the last visit
 2. Case management observation (at least 3 client-provider encounters on PNC, and/or family planning and/or IMCI)
 3. Document analysis
 4. Feedback with health agents (observations and document analysis)
 5. Problem-solving dialogue with health agents
-

Figure 11. Performance of Health Zone Management Teams in Health Center Supervision



center levels had been trained to manage formative supervision according to standard norms and procedures.

As early as 2002, HZMTs were beginning to take ownership for the formative supervision process. For example, following the 2002 Management Assessment, all seven HZMTs adapted their supervision checklists on their own accord to reflect many of the service delivery norms evaluated in the Management Assessment. This sense of ownership over the formative supervision process is an important step toward the sustainability of the process within the Beninese health system.

PROSAF has provided intensive post-training coaching to each HZMT to ensure that the new formative supervision method and tools are being applied and used as described in the manual and tools. First, PROSAF encouraged the HZMTs to strictly respect their supervision planning to achieve the norm of providing at least one supervision visit to each health center each quarter, regardless of heavy workloads and other interfering factors. Secondly, data were used to identify the poor performance areas in each health center that required formative supervision, and the most qualified HZMT





members were selected to undertake the supervision. Thirdly, PROSAF provided technical guidance to the zone supervisors to fulfill the most difficult criteria of formative supervision, such as follow-up and implementation of recommendations from the previous visit and observation of at least three client/provider interactions in IMCI, family planning, and/or PNC. This coaching has increased the HZMTs capacity to innovate in managing formative supervision.

To monitor the results of the improved supervision system, the Performance Index of the Supervision System was developed. The index was measured on a quarterly basis from the first to the fourth quarter of 2003. A health center supervision visit is considered to be formative when the following five criteria are met:

1. Follow-up and implementation of recommendations from the last visit
2. Observation of at least three client-provider interactions in IMCI, family planning, or PNC
3. Analysis of documents
4. Feedback to the health workers on document analysis and observation of interactions
5. Dialogue for solving problems with the health workers

The results in Figure 11 reflect the mean of the proportion of health facilities that have received four formative supervision visits in a year. The data show that significant progress has been made to improve the performance of the supervision system.

Between the first and the fourth quarter of 2003, the percentage of public health centers in the Borgou/Alibori receiving a formative supervision visit during the quarter rose from 54% to 85%. The

success of formative supervision visits is evidenced by the fact that throughout this time period the two concentration zones, where problem-solving teams and coaching had been established earlier, maintained a performance level of 100%.

Quality assurance: To reinforce QA management at the zone level, PROSAF held three training sessions on QA for HZMTs. The three sessions were: an orientation session (attended by 20 individuals from the two concentration zones); a five-day session on QA approaches, tools, and principles (attended by five members of two HZMTs); and a five-day session on QA approaches, tools, and principles with an emphasis on coaching techniques (attended by 27 individuals). The third session focused on transferring training capacity to HZMTs and preparing them, with technical assistance from PROSAF community facilitators, to conduct a series of three training sessions for 47 health workers and 210 COGEC and VHC members.



To introduce a collaborative approach for improving the performance of service providers and the health system in the Borgou/Alibori, a workshop was conducted to develop collaborative model reference documents. The goal of the workshop was to establish primary health care models for each zone and begin the process of monitoring the key improvement indicator for each model. The priority models selected were prenatal consultations, deliveries, postnatal consultations, IMCI and family planning. This workshop was offered to coordinating physicians, division heads from the DDSP, midwives, and head nurses with experience in the provision of clinical and preventive services. This workshop resulted in the production of the following draft documents:





- A description of the proposed organizational structure for managing the collaborative model according to health system level in the Borgou/Alibori
- A proposed list of collaborative goals for performance improvement, according to themes selected by the health zones
- A proposed service model according to selected theme
- A proposed package of changes according to family health services components
- A proposed list of performance indicators according to component.

Improved monitoring of activities: PROSAF supported all seven HZMTs to develop detailed plans to monitor health provider performance.

The HZMTs of Banikoara, Bembèrèkè/Sinendé, Malanville/Karimama, Nikki/Kalalé/Pèrèrè and Parakou/N'Dali developed detailed plans to monitor health provider performance, and health care providers in these zones were trained to use a tool to facilitate the use of routine health data to calculate performance indicators. Health care providers in these five zones also designed standardized steps for the delivery of prenatal, childbirth, postnatal, and family planning care that are consistent with existing protocols. The providers had begun providing care according to the standardized steps and systematically collected health data on the performance indicators in their monitoring plans.

At the health zone level, data from health centers were aggregated by the statistician and used as inputs by the HZMTs in preparation for the quarterly monitoring meeting. Representatives from health centers in Banikoara, Bembèrèkè/Sinendé, and Parakou/N'Dali who attended these meetings enthusiastically searched for solutions to their performance issues during presentations by and discussions with their peers.

Table 3. HZMT Performance Index

	Bembèrèkè Sinendé	Banikoara	Malanville Karimama	Parakou N'Dali	Nikki Kalalé Pèrèrè	Kandi Gogounou Ségbana	Tchaourou	Total
At least one HZMT meeting held during the previous quarter 7/7	✓	✓	✓	✓	✓	✓	✓	7/7
At least 75% of activities planned in the previous quarter carried out	✓	✓	✓	✓		✓		5/7
Routine health information data from the previous quarter compiled for each zone	✓	✓	✓	✓	✓	✓	✓	7/7
HZMT performance rating (all criteria met)	100%	100%	100%	100%	0%	100%	0%	5/7 71%

Scoreboard Indicators Developed and Used by HZMTs

In response to a specific need identified during post-training follow-up and coaching visits with health workers, PROSAF supported the DDSP's efforts to draft a "how to" manual on the management of data for performance monitoring. All zone statisticians and health workers were trained to better collect and analyze data for rapid and appropriate decision-making. Subsequent quarterly review meetings in the concentration zones revealed significant improvement in the ability to collect and manage data and use it in the decision-making process. The success of the training prompted the DDSP to hold a workshop at the departmental level to build consensus around the mechanisms needed to improve the collection, analysis, and use of the National Routine Health Information System, or SNIGS, data. SNIGS contains data on health care service delivery, health services management, epidemic surveillance, as well as data collection forms. Workshop participants identified strengths and





weaknesses of the data management procedures and proposed solutions. A concrete result of this workshop was the development of a *tableau de bord*, or “scoreboard”, to monitor key family health indicators by care level.

Following the workshop, a finalized version of the family health scoreboard was distributed to the DDSP, health zones, and private clinics, and the HZMTs began using the scoreboard to monitor and improve performance. Health workers systematically collected health data on performance indicators and recorded it on their scoreboards. They compiled data on a monthly basis, held a one-day monitoring session at the end of each month, and reported data to the health zone statistician. The health zone statistician, in turn, aggregated the health center level data and provided it as an important input for HZMT quarterly monitoring meetings. During supervision visits, health zone supervisors verified the quality of data collected and coached health workers in the calculation of the indicators. Supervisors then demonstrated how to use the data that had been collected to track performance. Health workers now can assess their own performance, share results with the team, and identify appropriate solutions to improve performance.

The scoreboard has become a key feature of the performance improvement process in the Borgou/Alibori and has greatly increased the efficiency of collection, management, and use of data.

Strengthening Zone-Level Training Capacity

With an eye toward sustainability, PROSAF worked with the DDSP and HZMTs to build training capacity and to develop a systematic training approach to train health workers and mentors. This included the creation of zone-level training teams and the provision of training materials. Among these materials, ZOPP boards were provided to the seven zone offices and the 14 commune health centers in the Borgou/Alibori. In addition, PROSAF supplied the

zone offices and commune health centers with training materials, including anatomical models and curricula for contraceptive technology, infection prevention, the use of family health protocols, mentoring, supervision techniques, EONC, and IMCI.

Improving Equipment, Materials, and Facilities

While PROSAF's overall strategy at the health zone level was to support the decentralization process by reinforcing HZMT capacity to provide managerial and technical support to health centers, PROSAF also provided some equipment to facilitate HZMT success in these areas.

For example, in 2001 and 2002, the Parakou/N'Dali health zone reported the lowest level of supervision performance, achieving only one criterion out of the five required. At the request of



Supervision vehicle for Parakou/N'Dali

the DDSP, PROSAF provided the health zone with a vehicle to help the HZMT carry out supervision visits and to motivate the team to improve data collection. The provision of the vehicle resulted in improved performance in supervision in the zone. Indeed, during 2003, the Parakou/N'Dali zone was among the three top performing zones in formative supervision, as well as in collaborative improvement and integrated offer of the minimum package of family health services.

Additionally, PROSAF provided computers and accessories to all health zone offices, the seven zone hospitals, and the 14 commune health centers in the Borgou/Alibori to reinforce their capacity in data management, processing, and analysis for decision-making. Once the new computers were installed, all HZMTs were able to send reliable monthly reports on time to the statistics unit of the DDSP. The computers helped them compile their data more





quickly and save time controlling for completeness and checking for inconsistencies. They also were able to organize quarterly reviews of activities and data, which are critical for performance monitoring and improvement.

PROSAF also provided the local radio stations with computers and accessories to help them produce radio spots and messages on health.

Health Center Level

The Management Assessment conducted in 1999 provided baseline data related to the capacity of health workers at the health center level in the Borgou/Alibori. Based on these data, PROSAF developed a plan to strengthen service provision at this level by:

- increasing health worker capacity in several key clinical areas
- fostering an integrated service delivery model
- strengthening interpersonal communication and focusing on satisfying client needs
- expanding community based services
- improving facilities

Strengthening Service Provider Competencies

The main clinical areas that required substantive training and coaching were IMCI, emergency obstetrical and neonatal care, contraceptive technology, including Norplant provision, and infection prevention.

IMCI training: Once the MOH approved the roll-out of IMCI in 2001 and 2002, PROSAF collaborated closely with the MOH, as well as with the PROLIPO/Ouémé project to design the IMCI implementation strategy. IMCI was officially launched by the MOH in June 2002. PROSAF provided significant technical assistance in the

development of seven training modules, a set of five wall posters, a booklet of tables, and an instructor's manual. PROSAF trained 19 physicians (nine of whom were from the departmental training team), in the IMCI training methodology. Of this pool the most qualified nine received follow-on training in facilitation.

Summary of Health Center Level Results

- Strengthening service provider competencies
 - Training in IMCI, EONC, contraceptive technology, infection prevention, Norplant, interpersonal communication
 - Integrating services
 - Availability 5 days/7 days
 - Proactive offer of services
 - Improving performance through coaching (*Tutorat*)
 - Family health protocol curriculum development
 - Strengthening community-based services
 - Improving equipment, materials, and facilities
 - Provision of medical equipment
 - Rehabilitation of health facilities
-



Three zones were selected for the initial IMCI roll-out: Tchaourou, N'Dali/Parakou, and Kandi/Gogounou/Ségbana. PROSAF completed five training sessions in IMCI for 120 health workers. During these trainings, participants engaged in

group and individual exercises, obtained feedback on their work, participated in discussions, conducted role plays, and attended hands-on training sessions in the clinical setting.

A monitoring visit seven weeks following the IMCI roll-out demonstrated the success of the training. All mothers interviewed were satisfied with the care provided by health workers trained in IMCI, 94% of health workers visited systematically used the IMCI guidelines to identify danger signs, and 80% correctly evaluated the





vaccination status. Health workers knew how to use the IMCI strategy to recognize emergencies and refer them immediately.

Emergency obstetrical and neonatal care (EONC): In

cooperation with INTRAH/PRIME, PROSAF implemented the following steps toward improving EONC:



- Updated clinical standards for EONC
- Trained a departmental EONC committee to provide coaching on compliance with prenatal care, family planning, service integration, and EONC standards
- Planned EONC interventions
- Familiarized health workers with the minimum package of family health services emphasizing EONC
- Trained seven trainers at the central level to use the EONC curriculum developed by the PRIME and PROSAF teams
- Planned EONC courses for midwives and nurses responsible for maternity centers

A total of 79 midwives and nurses were trained in EONC in Banikoara, Bembèrèkè/Sinendé, Malanville/Karimama, and Tchaourou.

Contraceptive technology and infection prevention: To improve the quality of reproductive health service delivery, PROSAF assisted the departmental training team in the training of 100 health workers and mentors in contraceptive technology and infection prevention. Almost 100% of trained health workers observed following the training were in compliance with infection prevention standards, such as washing hands before and after each procedure, wearing a lab coat, and preparing decontamination solution. Two courses on contraceptive technology were held for 30 health workers in Tchaourou and Nikki/Kalalè/Perèrè health zones. Courses were led by departmental trainers, and HZMT trainers.

Norplant: Thirteen midwives from three of the seven zone hospitals, the Departmental Hospital Center, and seven commune health centers were trained and equipped to offer Norplant. The training was based on 15 training modules developed by ABPF and was carried out with their technical assistance. The Directorate of Family Health at the MOH provided the Norplant devices. Each trained midwife received at least one post-training supervision visit from the ABPF training team.

Interpersonal communication: Good interpersonal communication is a cornerstone of quality care. It also is key to establishing a working environment geared towards quality, in which various actors in the health system view each other as internal clients whose needs must be met. In order to strengthen awareness for and capacity in interpersonal communication, a new curriculum was developed and introduced to the 14 members of the Departmental Training Team and the manager of the HIV/STI unit of the DDSP. All of the health workers in the Banikoara and Tchaourou health zones have been trained in interpersonal communication. Additionally, three health workers from each of the following zones participated in interpersonal communication training: N'Dali/Parakou, Nikki/Kalalè/Pèrèrè and Bembèrèkè/Sinendé.





Integrating Services

Promoting the integrated offer of the minimum package of family health services has been part of PROSAF's strategy to improve access to health services throughout the life of the project. This approach goes beyond the geographical definition of access and emphasizes the daily availability of a range of services to respond to demand. Specifically, the definition of integrated service delivery includes two main components: all nine services of the minimum package must be offered proactively in the health center; and all these services must be offered 5 days per week.

The integration of services necessitated a comprehensive set of activities to respond to changes in the organization of services, skills to be able to counsel or offer all services, coaching to help see the changes through, and a thorough system of supervision and monitoring of indicators, which became part of the routine analysis and feedback at the level of the health zones.

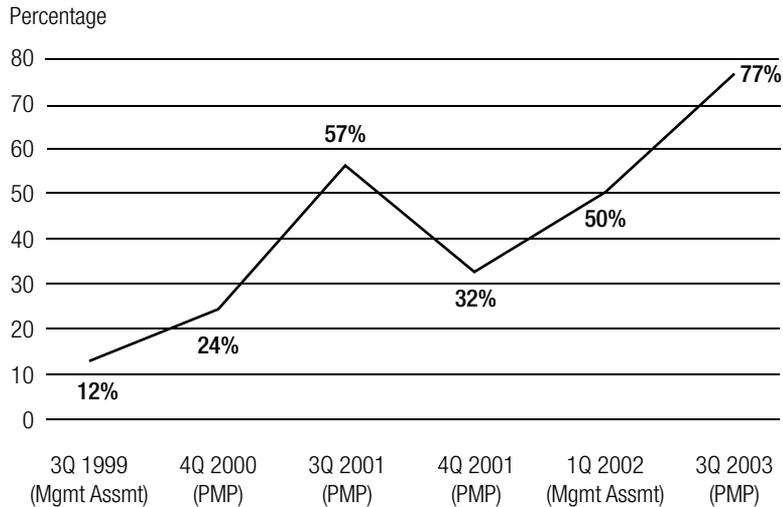
Data show that the integrated offer of the minimum package of family health services increased from 12% in 1999 to 77% in 2003 (see Figure 12).

Coaching

Coaching has proven to be a particularly effective performance improvement approach and has received very positive feedback from counterparts. Coaching takes place after a formal training session and in the workplace. Coaches provide guidance and support while health workers apply skills learned during the training. The coach is integrated into the health center team to provide mentoring and support to staff to improve their competencies while they work. Coaches also assist with the planning and implementation of corrective actions.

Training curriculum on family health protocols: Using the coaching format, PROSAF and PRIME II, together with the Directorate of Family Health (DSF), JHPIEGO, and the National Coordination

Figure 12. Progress in the Offer of the Minimum Package of Family Health Services



Unit for *Tutorat*, prepared a training curriculum on family health protocols that included follow-up and evaluation tools for health care providers. This curriculum met needs that had been identified in the health zones and brought together several components into a single integrated curriculum: training methodology (“learning for improved performance”), using a combination of classroom training, *Tutorat*, and self-learning; components of the minimum package of integrated family health services; and protocols for

family health services. A manual for tutors and a guide for self-learning were developed at the same time.



The integrated curriculum was first tested by 15 trained and experienced trainers/coaches. They and other departmental





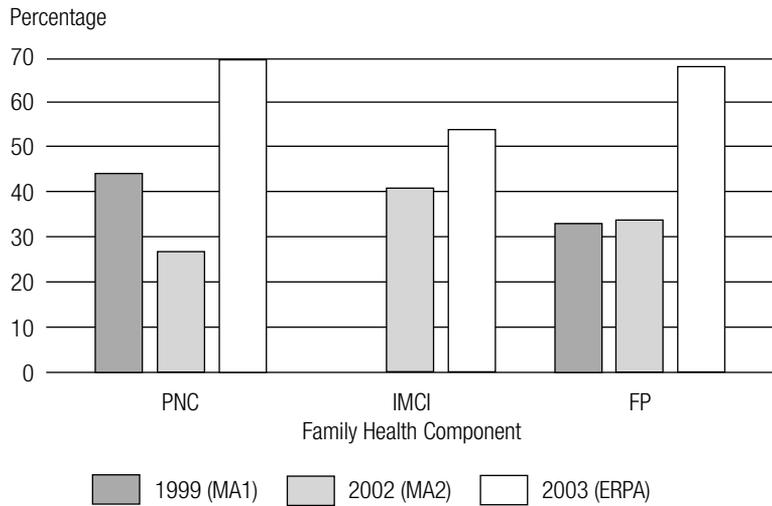
trainers used the curriculum in 2001 for two training sessions of 42 health care workers: 11 from Banikoara, 21 from Bembèrèkè/Sinendé and 10 from Malanville/Karimama. Based on their feedback, the curriculum was revised and improved.

A formative evaluation of both tutors and health care workers trained in the integrated curriculum was carried out, coupled with two post-training field visits. The evaluation assessed the effectiveness of the curriculum content and of the three different training methods used: classroom training, *Tutorat*, and self-learning. The results were very convincing. Of 39 tutors and health care workers evaluated, 94% could identify the appropriate protocol and knew how to use it as demonstrated through a case study. All agents interviewed stated that the use of protocols helped them make a correct diagnosis and good decisions on treatment and follow-up. Furthermore, they valued the contribution of the *Tutorat*, most notably the support to integration of services in the health center, infection prevention, and improved care—all resulting in higher utilization of the health centers.

After the evaluation of the success of the use of the integrated services curriculum in the concentration zones, its expansion took place in two phases:

In the first phase, 12 providers were selected and trained to be coaches or tutors and later received training in training methodology and the principles and applications of *Tutorat*. The providers were from Tchaourou, Parakou/N'Dali, Nikki/Kalalé/Pèrèrè and Kandi/Gogounou/Ségbana (all non-concentration zones). These 12 professionals thus formed the second group of tutors for the Borgou/Alibori. Next, they were trained in the content of the integrated services curriculum and the use of the family health protocols, ensuring they would be well prepared to subsequently train and coach health care providers. The responsibility of the tutors was to introduce the family health protocols in their respective

Figure 13. Performance of Service Providers in Key Family Health Components



health zones and to support their application and the improvement of provider performance through tutoring and guidance on self-learning.

In the second phase, the trained tutors trained 42 health care providers: 20 from Nikki/Kalalé /Pèrèrè and 22 from Tchaourou. These trainings took place in March and June of 2003.

All of these training and coaching activities have led to an increase in health worker performance regarding family health service delivery, as illustrated by the Figure 13. Data from the Management Assessments and the Rapid Evaluation of Health Worker Performance (ERPA) show that performance of health workers with regard to prenatal care and family planning has increased dramatically from 1999 to 2003. The results for IMCI are less impressive due to the fact that training of health workers in clinical IMCI began in late 2002.





Strengthening Community-Based Services

Defining the community-based service (CBS) model: PROSAF has contributed to the expansion of family health service delivery by placing these services closer to the population via community-based service agents (CBSAs). PROSAF refined a CBS model by incorporating lessons learned from the experience of Africare’s child survival project in Benin and from CLUSA’s experience in community development. Building on these experiences led to new ideas that addressed issues such as the content and financing of the initial CBSA kit, training and motivation mechanisms for the CBSAs, supervision and monitoring, regular and continuous supply of family health products, and involvement of COGECs in the drug ordering process.

A CBSA training curriculum also was developed based on existing curricula and adopted by representatives from the central, departmental, and health zone levels of the health system, including the national community IMCI working group. The main themes covered by the curriculum are the definition of community-based services, STI/HIV/AIDS, malaria, diarrhea, family planning, and nutrition. The CBS model has facilitated the implementation of community-based services in the two Borgou/Alibori concentration zones.



The introduction of quality assurance at the level of the health center was linked closely to the strengthening of community involvement in health management and prevention activities (see Community and Family Level section for a more detailed description of this approach from the community perspective.) The QA approach in this context was based on forging strong partnerships between

health centers and communities and identifying and improving jointly chosen health problems. This approach was implemented in 21 communities in Bembèrèkè/Sinendé and Banikoara. The teams were made up of health workers, COGEC members, and community resource persons. These community health center teams would come together to work on the following:

- Share ideas about strengths and weaknesses of the existing services
- Establish consensus on how to address the main problems
- Identify complementary actions that both health centers and communities could take to solve the problems identified
- More clearly define roles and responsibilities of health centers and communities with regard to priority health interventions
- Document the strategies adopted

Training was provided in rapid team-based problem-solving techniques, and a collaborative approach was adopted for the first cycle of problem-solving so that each team could benefit from the experience of others working on the same problem. The teams in the Bembèrèkè/Sinendé health zone worked on the low rate of proper prenatal consultation coverage, and those in Banikoara worked on the low rate of child immunization coverage. PROSAF provided supervision and mentoring to help the teams solve the various problems they encountered, including calculating indicators, irregular meetings, and documenting the problem-solving process.

The use of the rapid problem-solving method allowed the quality improvement teams to be active participants in the collection and analysis of the data and the identification of solutions. It demonstrated that through collaboration and sharing of ideas, the teams can find solutions that are within their own power to implement,





they develop common visions for problems and how to address them, and have strengthened partnerships between communities and health centers.

In Bembèrèkè/Sinendé, prenatal care coverage went up from 2% to 15%.

An analysis of the impact of the use of this QA strategy has shown positive changes, not only in the functioning of partnerships, but also in the attitudes and motivation of health workers. Specifically, health workers had increased appreciation for the potential of positive contribution by communities to improve quality of health services; and recognized that communities can indeed identify important health problems. Health workers also improved their own ability to work with communities, sought language classes to better communicate in local languages, and were more open to constructive feedback from communities (Case Study: Community-Health Agent Partnerships in Quality Assurance, J. Aubel). Specific changes that were made with greater ease and less resistance by health workers were integrated service delivery, improved interpersonal communication and increased outreach. In many communities, this work has led to self-started additional improvement initiatives.

Medical Equipment, Materials, and Facility Improvement

The 1999 Management Assessment of the Borgou/Alibori health system had indicated that health centers needed updated medical equipment and facility refurbishment to enable successful implementation of the strategies described above.

To improve the ability of health centers to provide the minimum package of family health services, PROSAF provided 94 health centers and zone hospitals in the seven health zones, as well as the OSV-Jordan Clinic and the Departmental Hospital Center, with

medical equipment and furniture, birthing kits, scissors for minor surgery, sterilization kits, and clinical examination tables.

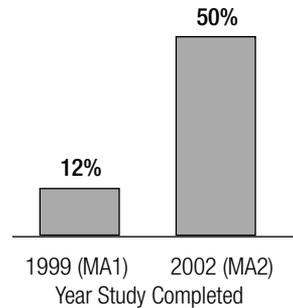
PROSAF also purchased medical equipment and furniture for the 15 sites selected to offer Norplant. This purchase included enough Norplant kits for training sessions and an initial supply for selected health centers. The MOH Family Health Directorate (DSF) and ABPF participated in this process by supplying the DDSP with some of the Norplant medical equipment and enough Norplant products for the first training session.

To improve clinical working conditions, PROSAF refurbished three health centers in the concentration zones where the quality improvement strategy was first introduced. The objective was to ready the selected health centers for provision of quality integrated family health services. In the Goumori Health Center in Banikoara, for example, PROSAF facilitated the completion of the construction of the incinerator to be used for proper disposal of its biomedical waste. Before rehabilitation, the maternity unit in The Gamia Health Center in Bembèrèkè was two kilometers from the dispensary unit. A renovation brought the two units of the health center together at the same site and facilitated the provision of quality integrated family health services and access to communities.



Newly constructed incinerator

Figure 14. Availability of Minimum Package of Family Health Services





Five other health centers—one in Banikoara and the remaining four in non-concentration zones—were selected by the DDSP to be refurbished with PROSAF support. The photo shows the refurbished maternity clinic of Goumori in Banikoara.



Goumori Maternity Clinic

Community and Family Level

When PROSAF began in 1999, the MOH already had articulated a decentralized structure in which the principle of community participation and the representation of village-level concerns at all levels of the department health system was firmly established. Members of the VHC, COGES, and COGEC had been selected in many communities. PROSAF's role was to develop and implement strategies to ensure that communities, particularly at the health center level, would truly participate as integral members in the management of the health system.

PROSAF built the capacity of the VHC, COGES, and COGEC members through a combination of training and coaching. The assistance of PROSAF to strengthen community participation and foster social mobilization focused on the two concentration zones. While most efforts were directed toward the 21 COGEC in these zones, support also was provided to the remaining zones for introduction of CBSA.

To improve access to services, PROSAF supported the implementation of a network of community-based volunteers, who were trained and given a list of basic medical supplies, IEC materials, condoms, and bednets.

Summary of Community and Family Level Results

- Community action plans designed and implemented
 - Community-health services partnership strengthened
 - Community-based health activities
 - 219 community based service agents performing (CBSA)
 - Community-EONC (piloted in Malanville)
 - Community-IMCI (piloted in three zones)
 - Joint community and health center quality improvement teams set up
 - Literacy training conducted
 - Communication and behavior change strategy:
 - Messages on family health 5 days/7 on 4 rural radio stations
 - Strengthen capacity and use
 - Popular and traditional media developed
 - IEC/BCC materials for CBSA
 - Child health booklet
 - Flyers on family planning, malaria and prenatal care
 - Training of 10 NGO members in BCC/counseling
 - Income Generating Activities (IGA) piloted
-

Community involvement—through the village health committees, the COGECs and the COGES—has been an integral part of PROSAF’s approach. PROSAF has worked to build the capacity of these community groups to mobilize community members to participate in improving their health systems; to develop community based service systems through training, coaching and supervision of community based service agents; to apply a quality improvement approach; and to conduct behavior change communications campaigns. To further solidify the participation of the community in health-related activities, PROSAF also has provided local language literacy training, developed community-based initiatives in IMCI and EONC and piloted income generating activities.





Community Mobilization

The process of community mobilization focused on strengthening the capacity of COGEC members in management, including planning and financial oversight in community-based health activities. Communities also started working together with health center staff to solve commonly identified problems, such as low attendance of pregnant women for prenatal consultation.

To measure changes in levels of community participation, criteria were established to determine the success of VHCs, COGES, and COGEC. Different criteria were identified for each of these community level groups. For example, the following six criteria were used to measure COGES and COGEC performance:



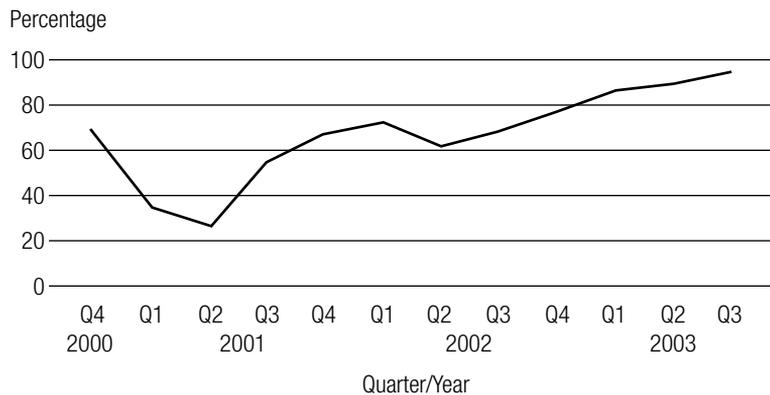
1. Existing annual workplan
2. Monthly implementation of workplan activities, including awareness sessions, training, financial and drug management, promotional activities and meetings
3. Weekly deposit of health facility revenues
4. Quarterly implementation by COGEC of at least two awareness sessions on health topics
5. Active participation of the COGEC in drug management, including inventory of health facility drugs, storage of keys, signature on the inventory purchase order and vouchers

6. At least three COGEC meetings held during the quarter with the required quorum of two thirds of the nine official COGEC members

These six criteria measured the capacity of planning, financial and drug store management, and implementation of planned activities.

Figure 15 illustrates COGEC performance in the concentration zones according to the six criteria listed above from year 1999 to 2003.

Figure 15. COGEC Performance Index in Concentration Zones (%)



To assess VHC performance, three criteria were measured on a quarterly basis:

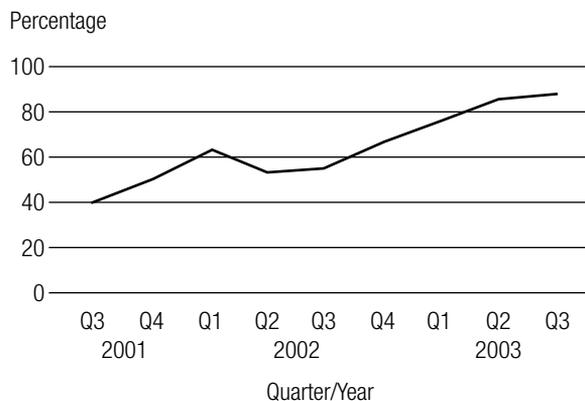
1. Planned activities are implemented (e.g., financial management, support to CBSAs to determine solutions to problems, motivation, conflict management, supervision of CBSA, re-supply of drugs)
2. At least two meetings held



3. Application of solutions proposed by the CBSA during the previous quarter

Figure 16 shows VHC performance in the two concentration zones from 2000 to 2003.

Figure 16. Village Health Committee Performance Index



The performance indicators were used as proxy indicators for community participation. As show in Figure 15, COGEC performance increased from 70% at the start of the project to 95% during the final quarter of 2003. Figure 16 illustrates a similar trend among VHCs. At the beginning of PROSAF, 40% of VHCs were meeting the three criteria. This percentage increased to 89% by the end of the project.

Ascendant Planning

Implementation of the ascendant planning process began at the community level in the concentration zones of Banikoara and Bembèrèkè/Sinendé in 2000. To date, 630 community leaders in these zones have participated in the ascendant planning process.

During the second quarter of 2003, PROSAF provided technical assistance to COGEC in the concentration zones to conduct a mid-

term evaluation of the annual planning process. The evaluation showed that 237 COGEC members, health workers, and locally elected individuals attended the annual planning workshop and that, for the first time, the workshop was fully financed by each health facility. The mid-term evaluation also showed that 90% of planned COGEC activities were implemented in Banikoara. In Bembèrèkè/Sinendé, that number was 80%. Activities were implemented on a monthly basis by the COGEC and health workers. These activities included problem solving activities using a quality assurance approach; financial and drug management; clinical service delivery; promotional activities, such as awareness sessions at the community level; fundraising; community-based services management; technical supervision of CBSAs; general assemblies and monthly meetings.

Community-Based Health Activities

Community-based service agents (CBSAs) became an important and integral part of PROSAF's efforts to bring health services and products to the community level. The Borgou/Alibori covers a vast geographic area of 25,856 square kilometers, stretching 200 kilometers wide and 440 kilometers long. While each commune has at least one health center, some villages may be as many as 45-60 kilometers from the nearest health center. Distance presents



a major obstacle to many individuals seeking health care services, products, or advice. Thus, each CBSA living among the people s/he serves is an accessible source of health information and products. CBSAs are trained to provide basic

health information on various key health topics, including family planning awareness, malaria prevention and treatment, HIV and STI prevention, diarrhea prevention and treatment, and nutrition.

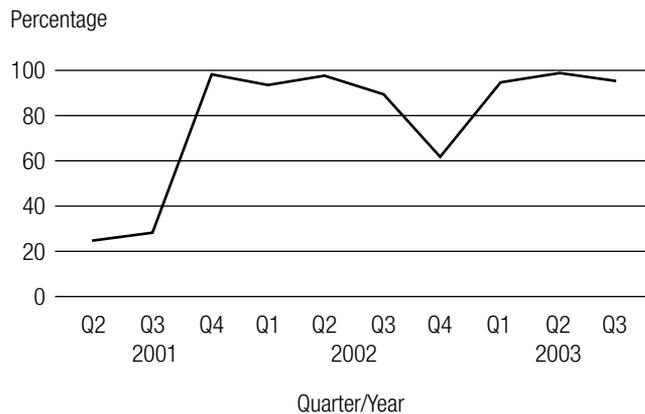




Each CBSA also offers a minimum package of products and services, including essential drugs (i.e., chloroquine, paracetamol, and aspirin), contraceptive methods (pills, condoms and spermicides) and educational meetings on family planning awareness, malaria prevention and treatment, HIV and STI prevention, diarrhea prevention and treatment, and nutrition.

There are 219 trained CBSAs in the concentration zones and 183 in the non-concentration zones. Establishing the CBSA network began with defining community-based services. Next, with assistance from PROSAF, a community partnership was negotiated between communities and health facilities to improve quality and use of health services. Subsequently, a community self-assessment was conducted by PROSAF Community Facilitators using a participatory process. Agents were chosen democratically by the communities to become VHC members and CBSAs during open village meetings. Selected agents were provided initial and refresher training, equipment, and supervision to effectively offer community-based services. Figure 17 illustrates the level of community-based service coverage achieved in the concentration zones.

Figure 17. Community-Based Service Coverage in Concentration Zones



Community-based integrated management of childhood illness (IMCI): Kandi/Gogounou/Ségbana became the site for a pilot community IMCI initiative in 2002. PROSAF collaborated with Catholic Relief Services (CRS) to provide technical and financial assistance for the initiative. Teams of local NGO representatives, social workers, and health and agricultural workers were formed at the commune level. These teams then were trained and coached by a zonal level technical team made up of HZMT members and local NGO staff. The training curriculum covered the community-IMCI technical content, the concept of CBS, the community mobilization process, adult education principles and communication and facilitation skills. Three health centers established partnerships with 17 villages. Following the completion of PROSAF, the commune-level teams continued their work and began to facilitate a community self-assessment to identify problems and plan solutions. Once the self-assessment is completed, the teams will train and equip community volunteers, implement the activities specified in their workplans (e.g., IMCI key practice promotion, awareness meetings, and drug and financial management), and monitor and evaluate the implementation of community IMCI.

Community emergency obstetric and neonatal care (EONC): Starting in 2001, PROSAF piloted a community EONC initiative in the Malanville/Karimama health zone, in collaboration with Intra-Health International/PRIME (INTRAH/PRIME). Once a health center serving 11 villages had been selected for the pilot, PROSAF coached the HZMT to select and train five community facilitators. The trained facilitators worked with the 11 villages to establish solidarity funds, which are funds made available by each community to support the cost of transportation and care for village women who must be referred to a health facility for emergency obstetric and neonatal care. Each village decided how the funds were to be collected and determined a mode of emergency transport to Guéné health center. Memoranda of understanding (MOUs) were developed between communities, taxi owners, and health facilities. These MOUs described the way in which each of the parties





would respond during an obstetrical emergency. The MOUs established written agreement between the health center, the communities and the taxi drivers and specified a set of rules for emergency transportation of pregnant women facing delivery problems. The COGEC at the health facility was responsible for informing all the taxi drivers of the content of the MOU and ensuring that the transportation fees accepted by both parties would be respected. Additionally, procedures for solidarity fund management were put in place by each COGEC with the technical assistance of PROSAF through Community Facilitators; and 110 community volunteers (e.g., CBSAs, VHC members, traditional birth attendants) were trained by health workers or midwives to recognize danger signs during labor and delivery.



Quality Improvement Teams

One of the important achievements under PROSAF has been the use of quality improvement approaches by communities. This approach built upon the strengthened confidence of communities to take responsibility for their own health. The QI approach emphasized the importance of the use of data to identify health priorities and further strengthened shared responsibility for improvement.

In 2001, PROSAF assisted the COGEC from the two concentration zones to establish 21 QI teams to prioritize health issues and determine solutions to address them. Each QI team, comprised of consumers, community leaders, community members and health workers, were assigned coaching teams to support them. Each coaching team was made up of a HZMT member and a PROSAF Community Facilitator and was supported by the PROSAF QA team and outside consultants. The first task of the QI teams was

to identify three priority health problems using a combination of health statistics, community opinion, observation, and prioritizing techniques coupled with a consensus-building process. Community members, health workers, and HZMTs were involved in the consensus-building process. One priority issue was chosen from among the three that surfaced. In 2001, QI teams in Banikoara identified childhood vaccination coverage as the priority health issue. In Bembèrèkè/Sinendé, the issue was pre-natal care (PNC).

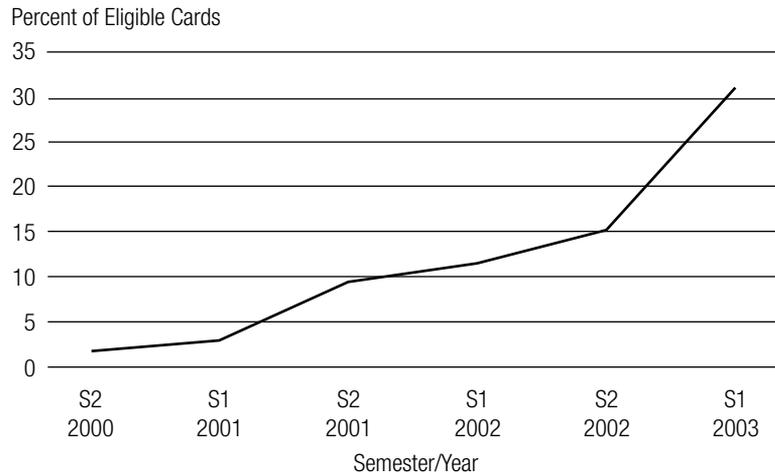
Following the identification of the priority health issue to be addressed in each zone, QI teams were trained in problem-solving techniques on a “just-in-time” basis. In other words, training was provided according to the level of the process at which the teams were working (e.g., training was provided in planning when teams reached the planning stage, and budgeting when teams reached the budgeting stage, etc.). First, they identified the root causes of the problem based on the experience of the community. Second, they chose solutions based on the potential for sustainability and involvement of community members. Examples of selected solutions include organization of a village meeting to explain the advantages of seeking prenatal care; organization of a training for traditional birth attendants (TBAs) on completing pre-natal visit cards; or setting up a team of volunteers to look for children in village who did not complete their vaccinations. Finally, the QI teams monitored the results. Progress and results were shared at monthly commune-level meetings and at the quarterly zone-level meetings. Figure 18 illustrates the successful expansion of PNC coverage in Bembèrèkè/Sinendé.

The efforts of the QI teams were reinforced by media messages delivered at the market, over the radio, in health centers, and in homes. These messages emphasized the benefits and availability of health care services at the community level. Health workers provided health education messages to QI teams to bolster their efforts to increase vaccination and the use of PNC services.





Figure 18. Trend in Adequate Coverage of Pre-Natal Consultation in Bembèrèkè/Sinendé Health Zone



Community Partnership Strengthened through Literacy Training

Benin has many and varied cultures and languages. Within its borders, 66 ethnic groups are represented, each with its own language. In the Borgou/Alibori alone, there are 17 ethnic groups and 17 main languages. Many health workers assigned to the northern Borgou/Alibori department are from the south and do not speak the same languages as the clients they serve. Increased literacy among CBSAs, VHCs, COGES, and COGEC improves their ability to communicate with all actors in the health system and provide more effective health services. Thus, to improve health worker-client communications and to increase effective communication, PROSAF financed and monitored a literacy program in the concentration and non-concentration zones. PROSAF provided direct financial support to 18 health workers who attended the 6-day literacy class conducted by the local NGO, DERANA. The high demand for such training is illustrated by the fact that 1,406 individuals audited the class on their own accord simply because they wished to learn to read and write. Also, following the initial

training, 70 more health workers sought financial support from PROSAF to participate in literacy training.

During subsequent quality assurance (QA) and CBSA training activities, PROSAF staff remarked on the noticeable improvements in participants' abilities to read and write. There also was evidence of more positive relationships between health workers and clients as health workers who benefited from literacy courses were able to communicate with clients in their local language without needing a translator.



Behavior Change Promotion through Multi-Media Campaigns

To inform, motivate, build skills, increase demand for health services, and reassure community members of social approval for the new behaviors, two major multi-media campaigns on reproductive health and child health were conducted during PROSAF. Simultaneously, health workers and CBSAs prepared to respond to increased demand by assuring the availability of quality health services and products. Both campaigns combined mass media through radio spots, community media through theatrical performances and griots, or traditional praise singers, and interpersonal communication through CBSAs. Additionally, these campaigns informed community members that they could benefit from the offer of the minimum package of family health services every day and immunization services every working day. Implementers of these communication campaigns worked to gain feedback from audiences and to incorporate the feedback into the next performance with the same audience. This approach demonstrated the power and effectiveness of improving quality through direct and





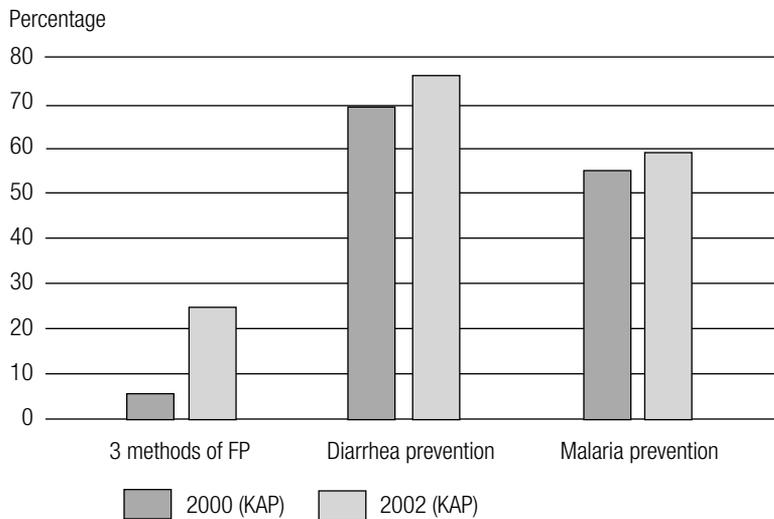
continual feedback from the target population into the communication process.

Additionally, rural radio animators (see photo) were trained to develop radio spots and to share the requisite health information with audiences. Collaboration with the northern branch of the national broadcasting system has produced a model medical advisor program in conversational format targeting rural populations.



Rural radio animator

Figure 19. Knowledge of Family Health among Families and Communities in the Borgou/Alibori



Training of NGOs in BCC counseling: To expand community-level BCC coverage, PROSAF trained 36 supervisors and outreach workers from the Benin Network of Health NGOs (ROBS) and 22 field staff from ten local NGOs. Two NGO personnel were further trained as community-level BCC trainers. NGO personnel were trained in a community-based BCC approach using counseling cards and skits to encourage group reflection and decision-making leading to small, feasible behavior changes. Training was also provided in the use of available IEC materials, interactive awareness-raising games, and rapid participatory follow-up assessments. PROSAF provided IEC materials and follow-up support for more than 480 health education sessions on family planning and malaria during the NGO communication campaigns. As a result of the training and material provided, the NGOs now include family health messages in their routine activities, an important contribution to the sustainability of PROSAF activities.

Income-generating activities: With the goal of developing sustainable sources of financing for health center-level health promotion activities, PROSAF launched a pilot income-generating activity (IGA) program in the two concentration zones. In order to implement this pilot, the following steps were used by HZMT with PROSAF financial and technical support:

1. Development of the protocol for the pilot describing objectives, target groups and methodology.
2. Identification of the beneficiary COGECs by HZMT using a range of criteria, including the 2002 performance index of each COGEC, the quarterly income of each COGEC, and performance in financial management.
3. Identification of the project based on brainstorming done by COGEC members and using a classification system to identify the more profitable activities.





4. Completion of a feasibility study on economic profitability, the capacity of the COGEC to run the project if funded, and the availability of funding for the activity. Based on these criteria, the COGEC developed proposals with PROSAF technical assistance.
5. Submission of proposals to a review committee made up of HZMT members and local agriculture and social welfare representatives who reviewed COGEC project proposals at the zone level and decided which projects to grant based on criteria used during the feasibility study.
6. Training of members of each COGEC who received a grant in financial management to monitor the funded project.
7. Organization of a launching ceremony by each COGEC to announce the start up of its activity and publicize its project.
8. Monitoring and evaluation of the granted projects by the review committee of each health zone to ensure the proper management of funds made available for the project.

In 2003, all 21 COGECs in the two concentration zones went through the process outlined above. Seven COGECs were granted funding to begin their proposed pilot IGAs. These COGECs are Ina, Gamia, Sékèrè, Fo Bouré, Ounet, Founougo and Kokey. Each of the granted COGEC implemented one activity. Activities include a merchandise store, a village gas station, a restaurant and a taxi service. While PROSAF provided the majority of funds required, communities contributed 20% of the funds needed to start the IGAs. These funds were raised by the COGEC from the cotton producer groups. The fundraising and the financing of a feasibility study by the communities provide indication that health workers and COGECs had enthusiastically embraced the IGA development implementation process.

At this writing, all seven IGAs continued to function. The next steps involve documenting the process and replicating the program in the other health zones.



CHALLENGES AND OPPORTUNITIES

PROSAF has achieved many important results to assist the government of Benin to continue to strengthen family health services. The following challenges, potential solutions and opportunities have been identified.

Challenge	Solution
Availability of qualified staff	Training of assistant nurses in family health protocols Systematic briefing of new health agents in family health protocols
High staff turnover	Decentralization of human resource management Use of software for human resource management at health zone level
Leadership and teamwork at all levels	Institutionalize ascendant planning and quarterly review meetings at health center, zone and DDSP levels
Culture of performance and excellence	Institutionalize QA and extend quality improvement to the entire health system
Decentralized management	Timely distribution of funds to health zones for planned activities Assign trained financial managers to all the health zones
Permanent availability of family health commodities at all levels	Integrate supply of all health commodities at national level Mobilize and secure financial resources needed for commodities at all levels of the health system Make CAME-Parakou the commodities provider for all the health zones Develop zone-level warehouses and computerize the commodities management Intensify supervision on management commodities

Challenge	Solution
Financial support to community initiatives	Incorporate community initiatives activities into work plans and allocate funds for implementation Develop and support Income Generating Activities as alternative sources of income for community initiatives
Ownership of community partnership of health personnel	Include community partnership in health workers' pre- and in-service training Reinforce the need for accountability of health workers regarding community partnership

Opportunities

- Increased commitment of health sector stakeholders
- Greater community leader self-confidence
- Improved quality management at all levels
- Favorable experience with planning at all levels
- 80% of the populations of Borgou/Alibori reached by radios
- IEC/BCC materials developed and distributed
- Community-based services, popular and traditional media, and radio messages are appreciated
- Qualified training teams in place at the zone and departmental levels
- Decentralized management towards health zones
- Improved capacity of HZMTs to monitor and evaluate performance
- Functioning departmental warehouses for family health commodities
- Over 50% of health agents of Borgou/Alibori trained in the minimum package of family health services



ANNEX

Appendix 1. PROSAF Performance Monitoring Plan Indicators

#	Indicator	Indicator Definition	Survey Area	Baseline	2000	2001	2002	2003	Data Source
1	Contraceptive Prevalence	Proportion of women of reproductive age (15-49 years) married or in union who are using a modern contraceptive method at the time of the survey.	Borgou/Alibori	3% (DHS)	7.2%		11.2%		KAP Survey
			Concentration Zones			16%		Mini-KAP Survey	
2	Couple-Year of Protection	Estimate of the number of couples (of reproductive age) protected against pregnancy by family planning methods during a period of one year based upon the volume of all contraceptives sold or distributed to clients free of charge during that year.	Borgou/Alibori	6,257	15,089	17,237			SNIGS. The 2000 calculation includes data sources and contraceptive methods that were not included in the 1999 calculation. Data sources for years 2000 and 2001 include PSI, ABPF, SNIGS, and OSV-JORDAN. Contraceptive methods for the years 2000 and 2001 include condoms, vaginal tablets, foams, pills, injectables, IUD, sterilization and implant.
3	Exclusive Breast-Feeding	Proportion of all infants 0-3 months of age who are being exclusively breastfed.	Borgou/Alibori	19% (DHS)	52%		60.9%		KAP Survey. The 2000 KAP survey did not provide a sample size of children 0-3 months large enough to provide statistically significant results for this indicator. A separate survey was carried out in January 2001 to measure this indicator.
4	Fully Vaccinated Rate	Proportion of children 12-23 months of age who were fully vaccinated before their birthday.	Borgou/Alibori	41% (DHS)	37%	55.5%			KAP Survey
			Concentration Zones			60%		Mini-KAP Survey	
5	Oral Rehydration Therapy (ORT) Use Rate	Proportion of all children under three years of age who have had diarrhea in the past two weeks and were treated with Oral Rehydration Therapy (ORT).	Borgou/Alibori	29% (DHS)	15.4%		60.7%		KAP Survey
			Concentration Zones			50%		Mini-KAP Survey	

#	Indicator	Indicator Definition	Survey Area	Baseline	2000	2001	2002	2003	Data Source
6	Home Treatment/Care Seeking for Fever (Malaria)	Proportion of children under five years of age who had a fever episode.	Borgou/Alibori	45% (DHS)	48.5%	63%	54.5%		KAP Survey
			Concentration Zones						Mini-KAP Survey
7	Performance Index for COGEC	Composite index to measure planning and management functions of the COGEC.	Borgou/Alibori	29%	70%	65%	78%	95%	The baseline is taken from the Management Assessment (1999) and was calculated based on 3 of the 5 criteria related to the management function of the COGEC (PROSAF. Résultats globaux de l'EQGSS, Décembre 1999, p.79).
			Concentration Zones						Activity Reports and COGEC. Data for 2000 and 2001 use the six criteria tool that was developed during the PMP finalization process.
8	Performance Index for Health Zone Team	Composite index to measure planning and management functions of HZMT.	Borgou/Alibori	0%	26%	36%	14%	71%	Activity Reports; SNIGS. This indicator was revised in 2002 to better reflect the situation in the field.
9	Performance Index for VHC	Composite index to measure planning, management and representation of the VHCs.	Borgou/Alibori	0%	0%	51%	67%	89%	VHC Reports. Results for 2001 are based on the criteria contained in the previous version of the PROSAF Performance Monitoring Plan (March 2001).
10	Family Health Product Order Management Index	Proportion of public service delivery points submitting correct and timely orders for key family health products over previous 3 months.	Borgou/Alibori				45%	90%	Health Center Stock Forms and DDSP Records.
			Concentration				29%	100%	
11	Availability of Minimum Package of Family Health Services	Proportion of public and private health centers offering the minimum package of family health services.	Concentration	11.9%	24%	57%	50%		Management Assessment. Baseline information was collected during 1999 Management Assessment from 44 health centers (42 public and 2 private clinics). Data for 2000 and 2001 are based on the results of quarterly monitoring of health centers.

#	Indicator	Indicator Definition	Survey Area	Baseline	2000	2001	2002	2003	Data Source
12	Integrated Offer of Minimum Package of Family Health Services	Proportion of public and private health centers offering the minimum package of family health services in an integrated manner.	Borgou/Alibori	12%	24%	32%	50%	77%	ERPA
13	Community Based Distribution (CBD)	Proportion of villages in target zones served by community-based agents offering a minimum package of family health products and services.	Borgou/Alibori		0%	30%	99%		Activity Reports and COGEC. Data for 2000 and 2001 use the six criteria tool that was developed during the PMP finalization process.
14	CBS Agent Home Visit	Proportion of households that report having received at least one CBS agent home visit during the last two weeks.	Borgou/Alibori Concentration Zones		11%	15%	7.9%		KAP Survey Mini-KAP Survey
15	Supervision System Performance Index	Proportion of health centers where staff received formative supervision at least once in the previous quarter.	Borgou/Alibori Concentration Zones	6.7%	9%	46%	20%	85%	Management Assessment and Supervision Reports Management Assessment and Supervision Reports
16	Health Worker Performance Index	Proportion of observed client-provider encounters in which health workers:							
		1. complied with essential prenatal care norms (PNC)	Borgou/Alibori	44.4%			27%	69.6%	Management Assessment
		2. complied with essential family planning norms (FP)	Borgou/Alibori	33.3%			34%	68.0%	Management Assessment
		3. complied with essential integrated management of child illness (IMCI) norms.	Borgou/Alibori	0%			41%	54%	Management Assessment
17	Health Worker Performance Index in Integrated Management of Child Illness	Proportion of observed client-provider encounters in which health workers complied with essential integrated management of child illness (IMCI) norms.	Borgou/Alibori	0%	0%	0%	21%		ERPA. Results for 1999, 2000 and 2001 were based on supervision reports, which in fact rarely included observations of clinical performance. In 2002 the data source was changed to a form of direct observation that will be overseen by PROSAF.

#	Indicator	Indicator Definition	Survey Area	Baseline	2000	2001	2002	2003	Data Source
18	Health Worker Performance Index in Family Planning	Proportion of observed client-provider encounters in which health workers complied with essential family planning norms.	Borgou/Alibori	0%	0%	0%	7%		ERPA. Results for 1999, 2000 and 2001 were based on supervision reports, which in fact rarely included observations of clinical performance. In 2002 the data source was changed to a form of direct observation that will be overseen by PROSAF.
19	Health Worker Performance Index in Prenatal Care	Proportion of observed client-provider encounters in which health workers complied with essential prenatal care norms.	Borgou/Alibori	0	0	5/5	2		ERPA. Results for 1999, 2000 and 2001 were based on supervision reports, which in fact rarely included observations of clinical performance. In 2002 the data source was changed to a form of direct observation that will be overseen by PROSAF. In 2001 very few prenatal consultations were observed, but those providers did fully comply with performance standards.
20	Health Center Team Performance Index	Composite index to measure planning, problem solving using available data and team work of the health team.	Borgou/Alibori	0%	0%	52%			COGEC monthly work plans, SNIGS, coaching reports (health center activity reports)
21	Knowledge of Modern Methods of Family Planning	Proportion of women who can name without prompting at least 3 modern methods of contraception.	Borgou/Alibori Concentration Zones		6%	28%	25%		KAP Survey Mini-KAP Survey
22	Knowledge of When to Seek Care for ARI	Proportion of mothers or caretakers of children 3 years of age who state that they would seek assistance from a provider if their child exhibits the signs and symptoms of acute respiratory infection (ARI).	Borgou/Alibori Concentration Zones		67%	91%	72%		KAP Survey Mini-KAP Survey
23	Knowledge of Infant Diarrhea Prevention	Proportion of women aged 15-49 who cite without prompting at least one correct method of preventing infant diarrhea.	Borgou/Alibori Concentration Zones		69%	48%	76.3%		KAP Survey Mini-KAP Survey

#	Indicator	Indicator Definition	Survey Area	Baseline	2000	2001	2002	2003	Data Source
24	Knowledge of STI Symptoms	Proportion of women aged 15-49 and men aged 15-64 who can identify without prompting two or more STI symptoms for their own gender.	Borgou/Alibori		Women: 6%		Women: 31.7%		KAP Survey
			Concentration Zones		Men: 23%	Women: 38%	Men: 51%	Men: 39.3%	Mini-KAP Survey
25	Knowledge of Methods to Reduce Risk of HIV Infection	Proportion of people aged 15 years and over who cite without prompting two or more correct methods for reducing risk of HIV infection.	Borgou/Alibori		60%		Women: 47%		KAP Survey
			Concentration Zones			64%	Men: 56%		Mini-KAP Survey
26	Knowledge of Malaria Prevention	Proportion of People aged 15 and over who cite without prompting, mosquito nets as a means of preventing malaria.	Borgou/Alibori		55%		Women: 59%		KAP Survey
			Concentration Zones			29%	Men: 76%		Mini-KAP Survey
27	Access to Health Messages	Proportion of women and men 15 years and over who report having heard a health message through any media during the last two weeks.	Borgou/Alibori		Women: 45%		Women: 47%		KAP Survey
			Concentration Zones		Men: 62%	Women: 42%	Men: 55%	Men: 53%	Mini-KAP Survey

Appendix 2. List of Documents and Tools Developed during PROSAF

Studies, Research, Evaluations, Plans, Reports

1. Evaluation de la qualité de la gestion du système sanitaire dans le Borgou. (15-28 août 1999).
2. Atelier de réflexion sur les stratégies IEC/CCC dans le Borgou. (Octobre 1999).
3. Orientation en assurance qualité : manuel du participant. Bénin (Février 2000).
4. Prise de décisions relatives à la santé et à l'affectation des ressources au sein des ménages du Borgou. Bénin, Population Council (22-26 mai 2000).
5. PROSAF enquête CAP : manuel d'instruction du superviseur. (Mai 2000)
6. Enquête sur les connaissances, attitudes et pratiques en matière de santé familiale. (21 mai-1er juin 2000).
7. Rapport narratif sur les activités de PROSAF au niveau communautaire. (Août 2000).
8. Rapport de l'atelier interdépartemental sur la décentralisation et ses implications pour le secteur de la santé. Parakou (12-13 septembre 2000).
9. Rapport de l'atelier de restitution de l'enquête CAP en matière de santé familiale et de l'enquête sur la prise de décisions relatives à la santé et l'affectation de ressources au sein des ménages. (Novembre 2000).
10. Prise de décisions relatives à la santé et l'affectation des ressources au sein des ménages du Borgou, Bénin. Population Council (Novembre 2000).
11. Enquête complémentaire sur l'allaitement maternel exclusif. (6-9 janvier 2001).
12. Enquête sur l'allaitement maternel exclusif. (Mars 2001).
13. Enquête sur les connaissances, attitudes et pratiques en matière de santé familiale au Bénin. (Avril 2001).
14. Stratégie de communication pour le changement de comportement. (Mai 2001).
15. Enquête qualitative sur les composantes de la santé familiale dans le Borgou et l'Alibori. (21-24 août 2001).
16. Pre-natal visit, vaccination & family planning in northern Benin: a report on qualitative research. (August 2001).
17. Enquête sur les connaissances, attitudes et pratiques en matière de santé familiale dans le Borgou et l'Alibori : mini CAP édition 1. (8-13 octobre 2001).
18. Institutionnalisation de l'assurance qualité dans les départements du Borgou et de l'Alibori au Bénin. (Mars 2003).
19. Evaluation de la qualité de la gestion du système sanitaire. (2 mars 2002).
20. Stratégie de formation et plan de mise en œuvre. (Mars 2002).
21. Training Strategy and Implementation Plan. (March 2002).
22. Plan pour le renforcement des capacités de gestion des responsables du système sanitaire. (Juin 2002).
23. Management Capacity Development Plan for Health System Managers. (June 2002).
24. Evaluation de la qualité de gestion du système sanitaire. Deuxième édition. (2003).
25. Enquête sur les connaissances, attitudes et pratiques en matière de santé familiale au Bénin. (Juillet 2003).
26. Rapport d'évaluation de la campagne de théâtre communautaire dans le Borgou/Alibori. (Juillet 2003).
27. Behavior Change Communication Lessons Learned Report. (December 2003).
28. Rapport d'évaluation de la campagne multi media sur la santé infantile. (Février 2004).
29. Atelier de consensus sur la gestion de la logistique et l'approvisionnement des produits de santé dans le Borgou et l'Alibori. (Juin 2000).

Tools Developed by PROSAF

1. Management Assessment tools:
 - Observation checklists for the quality of family health / primary health care provision
 - Facility assessment
 - Checklist for the functionality of the management support systems in the health services (intermediary and peripheral levels)
2. Assessment tools for the COGEC
3. Adaptation of FPLM logistics management tools to include essential medication, contraceptives and vaccines
4. Training standards handbook
5. Training curriculum in:
 - COGEC capacity building (in French and Bariba) :
 1. roles and responsibilities,
 2. how to hold an effective meeting and how to document decisions,
 3. how to develop by-laws,
 4. development of annual workplan and budget for the health center and COGEC
 - Roles and responsibilities of village health committees and local volunteer committees (in French)
 - Community-based services for village health workers (in French, Bariba, Dendi and Peul) including malaria (fever), diarrhea, family planning, HIV/STI prevention, nutrition, animation techniques and management
 - Family health protocols
 - Working with the traditional and popular media
 - Interpersonal communication
 - Introduction to quality assurance
 - Rapid problem solving methods (QA)
 - Infection prevention
 - Introduction to integrating family health services
 - Facilitative supervision for the health zone management teams
6. Training guides for the full-site training approach (coaching)
7. Radio spots for healthy behaviors : hygiene, diarrhea and oral rehydration therapy, family planning, malaria
8. Traditional and popular media songs, plays and “griot ballads” on hygiene for child health and family planning
9. A set of 26 images for counselling healthy behaviours to prevent and treat malaria (4 stories illustrated through counselling cards, handbooks for pregnant mothers and their husbands, posters and a job-aid for explaining chloroquine dosage)
10. Catalog of available IEC materials on family health in Benin
11. Literature review of the behavior and attitude studies regarding family health issues
12. Guide for monitoring indicators of performance at the zone, health center and community levels
13. Scoreboard of the essential indicators to be monitored at the zone hospital, health centers, and health zones
14. Community-based health service management information collection and preliminary analysis instruments
15. Guidelines for using the ZOPP (management by objectives) method in a workshop setting and a participatory process to develop the three-year strategic plans of the zones
16. A methodology for developing supervision tools at all stages of supervision
17. Supervision tools :
 - For community-based service workers
 - For integrated health services

Appendix 3. Summary of Training Participation

Number of Persons Trained by Topic, PROSAF 1999-2004, Benin

Topics	Number of Health Workers Trained	Number of Community Members Trained
Clinical IMCI	142	-
Coaching (Tutorat)	22	-
Family Health Protocols	60	-
Family Planning (Contraceptive Technology and Infection Prevention)	100	-
Clinical Emergency Obstetric and Neonatal Care	79	-
Community Emergency Obstetric and Neonatal Care	-	110
Norplant (Insertion and withdrawal)	13	-
Quality Assurance	108	210
Logistics and provision of supplies	118	-
Training Skills	32	-
Interpersonal Communication	287	-
Community-Based Services	-	402
Literacy	-	3,341

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