INTEGRATED FAMILY PLANNING SERVICE DELIVERY IN MALI:

A Review, Analysis, and Recommendations

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I. INTRODUCTION

The Family Planning Management Training Project (FPMT) was created in 1985 by AID (Population Division, Office of Information and Training) in order to provide training and technical assistance support to family planning programs, leaders, and managers. The Project is active worldwide, with an emphasis on Africa. To date, FPMT has worked in approximately 25 countries and has provided short- and long-term training in-country, regionally, and in the U.S. to over 1,100 persons. The five year project is directed by Management Sciences for Health, and carried out through a consortium consisting of the Center for Development of Population Activities (CEDPA), the Pathfinder Fund, and the Latin American Scholarship Program of American Universities (LASPAU). FPMT has also endeavored to develop collaborative ties with regional and in-country training and management institutes. In Africa, FPMT has worked extensively with the Centre for African Family Studies (CAFS) and the Pan African Institute for Development (PAID).

To assist FPMT in developing appropriate and effective approaches to management problems facing family planning programs in Africa, a regional advisory committee was formed in 1987. This committee, called the Francophone Regional Advisory Committee (FRAC), consists of family planning leaders from eight African countries: Burkina Faso, Cameroon, Mali, Morocco, Tunisia, Rwanda, Senegal, and Zaire. The FRAC meets yearly to discuss management issues of concern to their programs and to share different approaches to their resolution. At the first meeting, Mali was represented by Dr. Karim Sangare, founder and current President of the Association Malienne pour la Protection et la Promotion de la Famille, AMPPF. The second meeting, held in Marrakech in April 1988, was attended by Mr. Abdou Tounkara from AMPPF and Dr. Diallo Doucoure, Director of the Centre d'Application en Santé Familiale et Nutritionnelle in Bamako. The principal topic at the meeting was the issue of integrating family planning and maternal and child health services. The participants had the opportunity to visit the successfully integrated VDMS program in Morocco.

Shortly after the FRAC, USAID was requested by the Malian FRAC participants to invite FPMT to make a visit to Mali to look in greater depth at the issue of integrated MCH/FP service delivery in the Malian context. In a subsequent exchange of cables between USAID and FPMT, the scope of work for the visit was expanded to include a review of management training needs, primarily in the private sector (AMPPF). FPMT proposed a two person team consisting of Mr. Ken Heise, FPMT Deputy Director for Technical Services, and Dr. James Wolff, Director of Special Projects for FPMT and principal designer of the FRAC meeting on integrated services.

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The team arrived in country September 18th. Dr. Wolff departed September 29th, while Mr. Heise departed October 1.

The team was briefed by USAID/Bamako on the first day of the visit and stayed in close contact with the Mission throughout. It was made clear from the outset that the AMPPF would be the focal organization during our visit. The team spent the first three days with AMPPF staff and volunteers, learning about the organization and its role in family planning service delivery. Interviews were held with all division heads, both individually and in groups. The Executive Secretary, Mr. Sidibe, was especially generous of his time. The issue of integration was discussed in some depth with AMPPF staff and, at a later point, with representatives of the Ministry of Health, Division of Family Health (DSF). The team met with two AMPPF Regional Coordinators, one who happened to be in Bamako and one during the course of a field visit to the region of Segou. AMPPF's model family planning clinic in Bamako was visited, as were the MCH centers of Niarela (Bamako), Famoury Doumbia (Segou), the Centre d'Application en Santé Familiale et Nutritionnelle (Bamako), and the Hospital Nianankoro (Segou).

In addition to developing a framework for discussing integration in Mali, the team also gained an appreciation for the management issues currently facing the AMPPF. These issues came out in the course of discussions with senior staff and, subsequently, through a review of the results of a questionnaire developed by the team and distributed to senior staff (see Annex 4). The management problems facing AMPPF are discussed below and suggestions for improvements are made. The FPMT project is in a position to address some, though not all, of the management areas identified for improvement.

II. OVERVIEW OF HEALTH AND FAMILY PLANNING

A. Health and Demographic Data

With a population of 7.6 million people and an annual per capita income of 160 US dollars, Mali ranks among the poorest countries in the world (WBR report 1985). Basic data from the World Development Report in 1986 (see Annex 5) indicate the magnitude and severity of health problems.

Malaria, measles, tetanus, diarrheal diseases and respiratory infections are the most frequently registered causes of death in infants under one year. Cholera, leprosy, schistosomiasis and a wide variety of helminthic infestations are endemic. The vicious cycle of diarrhea, infectious disease and malnutrition is a major contributor to high infant and childhood mortality.

The health infrastructure, largely built during the colonial period, has deteriorated significantly since independence. Resources available for infrastructure improvements are severely limited. Estimates vary, but some sources indicate that the overall GRM expenditure for health is just 3.5% of the total budget. In per capita terms, it is estimated that funding from all sources for health (including donors) in 1985 equalled

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approximately $7.30, of which the GRM's contribution was $1.30. Donor support for health care may represent as much as 80% of the money spent on health in Mali.

The availability of health care is higher in urban than rural areas, with overall access estimated at a very low 30%. Health care personnel are unevenly distributed throughout the country with 50% or more in Bamako alone. During a visit to Segou region, it was noted that 47 of the 57 nurse midwives were working in the city of Segou, and the remaining ten were involved in a CARE project. Several health centers at the cercle level therefore had no nurse midwives at all. In addition to unequal distribution, the overall ratio of health care personnel to population is very low. Annex 6 gives a breakdown of health manpower as of 1984.

The Ministry of Health is divided into six Directorates (see Annex 3). The National Directorate for Public Health (DNSP) has four divisions: Curative and Laboratory Medicine, Epidemiology and Prevention, School Health and Sports, and the Family Health Division. The Family Health Division, which has responsibility for the family planning program, is in turn divided into four sections: MCH, Nutrition, Health Education, and ORT. The Regional Director for Health has responsibility for all health activities in the region. He reports immediately to the Director of the DNSP. Recently, however, the Family Health Division has posted a regional coordinator for maternal and child health and family planning activities in each region.

The rate of natural increase is estimated at 2.3% based on crude birth and death rates of 48% and 20% respectively as adjusted for an annual emigration rate of 0.4% per year. If this rate of population increase is maintained, Mali will double its population in approximately 30 years. The population density is extremely low: 6.1 persons per square kilometer, with the highest density (30) in the southwest and lowest (1.5) in the north. Approximately 80% of the total population lives in rural areas.

A health and demographic survey completed in 1987 by the Sahel Institute (CERPOD) and Westinghouse provides a good picture of current knowledge and use of family planning methods. Use of modern contraception was higher in urban areas (4.9%) than in rural (0.1%); overall use of modern methods was 1.3%. When combined with use of traditional methods of contraception, the percentage of use was 11.6% in urban areas, 2.3% in rural areas, and an overall rate of 4.6%. Use of contraception was higher among women under thirty, those having fewer than three children, and women having had secondary or higher education. The pill was the most common modern method in use, followed by the IUD, injectables, and barrier methods. Overall, 28.7% of the women surveyed knew of at least one modern method of contraception, while 22% knew where to find contraceptive supplies. Over half (54%) of the men knew of at least one modern method, while 18.6% approved of contraception.

Figures from AMPPF's Three Year Plan show that there were approximately 20,000 new and 43,000 continuing users of family planning in 1987. Given the weaknesses and delays in reporting, the true number of users is undoubtedly higher. Nonetheless, the family planning program remains small

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and largely confined to urban areas and towns. Attitudinal questions on the health and demographic survey revealed the potential size of the immediate target audience for family planning acceptors. Among married women of reproductive age nearly 16.5% indicated they wanted no more children, while 32.6% indicated their desire to delay their next birth for at least 24 months. These two sub-groups alone represent a large potential unmet demand for family planning services.

Adolescent pregnancy in urban settings appears to be a major problem. Between 1981 and 1985, AMPPF sampled 2,131 female students and determined that 1,191 had already given birth and 557 had had an abortion, despite the illegality of abortions.

B. History of Family Planning in Mali

While the government has never embraced an official population policy, it has advocated family planning in the form of child spacing, and has attempted to integrate family planning services into its MCH programs. Thus, family planning is seen in the context of improving maternal and child health, and not for the purpose of lowering fertility and population growth.

In 1972 Mali became the first Francophone West African country to repeal the 1920 French law restricting information about and access to contraceptives. In 1974, family planning was established as a component of maternal and child health services. In 1975, what is now called the Family Health Division was created within the Ministry of Health and Social Welfare to coordinate and expand family planning activities in the public sector. By 1981, roughly half of the MCH centers in Mali were providing family planning services. It is currently proclaimed that all of the MCH centers provide family planning, though this cannot be substantiated with with service statistics. The government programs have benefitted from external donor assistance primarily through UNFPA, USAID and U.S. Cooperating Agencies. This assistance has been in the areas of IEC training and materials support, strengthening of the infrastructure for service delivery, provision of equipment, supplies and contraceptives, strengthening of management systems such as MIS, logistics and training, and support for demographic, policy and operational research. In 1983, a Population Unit was created within the Division of Human Resources of the Ministry of Planning in order to integrate population policies within development plans. UNFPA continues to provide support to this unit.

The Association Malienne pour la Protection et Promotion de la Famille (AMPPF) was established in 1972. It became an IPPF affiliate in 1975. AMPPF provides information, education, training, and contraceptive supplies for its own and government programs. It runs its own family planning clinic in Bamako and has regional offices in five of the seven regions in the country. AMPPF is organized in a manner common to IPPF affiliates. It has a small complement of professional staff in the central office and in the regions whose salaries are paid by IPPF. The staff serves under the direction of the volunteer board of directors elected from the volunteer membership at large. Support for specific activities or projects may come from a variety of sources including USAID and its

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Cooperating Agencies (Family Health International, Population Communication Services, Association for Voluntary Surgical Contraception, and others).

III. CURRENT STATE OF MCH/FP ACTIVITIES

A. Clinical Service Delivery

Ministry of Health: Recently the DSF recruited and placed a medical coordinator for MCH/FP in each region. This coordinator reports directly to the DSF and has assumed responsibility for all MCH/FP services delivered through the clinic system. If family planning is offered in other facilities, responsibility for the service would come from the medical director of the region and not the medical coordinator from the DSF. From discussions, it seems probable that very few, if any, health centers at the level of the arrondissement or below offer family planning services at this time. One must assume that women living in rural areas, as the overwhelming majority do, are at present not being served, and it seems doubtful that services will reach them in the near future.

The Ministry's efforts to expand service delivery are being aided by projects funded by USAID, UNFPA, and the World Bank. The Family Health Division of the Ministry of Health is currently implementing the Integrated Family Health Services Project, funded by USAID. This project, scheduled to run through 1992, calls for the strengthening of integrated maternal and child health services, including family planning, in 15 MCH centers in Bamako and the Upper Valley region. The $8 million project will renovate 15 MCH centers and improve the administrative and managerial support systems necessary to build an effective integrated MCH/FP clinical delivery system. Special emphasis will be given to improving the delivery of family planning services, nutrition, ORT, and immunizations. The project has funds for large scale technical assistance and training as well. Project funds will also be used to build a new office for AMPPF, which will include a model clinic and sterilization services.

AMPPF very recently became a registered NGO with the government. AMPPF estimates that its model clinic alone serves more family planning clients than all other clinics combined. The model clinic in Bamako serves between 60 and 80 clients per day. AMPPF also supports surgical contraception in two hospitals in the capital. Support for AMPPF activities comes from a variety of sources, while staff salaries are paid for by IPPF London.

A number of other NGO's are involved in MCH/FP service delivery, including World Vision's Koutiala Health Project and Project Kaarta, financed by Canadian International Development Assistance. The nature and extent of their family planning component is not well documented, and their relationship with the DSF and AMPPF is not clear.

Multi-lateral donors are active in providing support for clinical service delivery. UNFPA has been a major contributor to integrated MCH/FP services and will continue to support these services under Phase II of its MCH/FP project through provision of equipment and supplies, IEC activities, and training. MCH centers in all seven regions of Mali will have received support by the end of Phase II. A Phase III of the project was under

consideration in 1987. The UNFPA project called for collaboration with AMPPF, but to date this has not occurred. The World Bank is active in MCH/FP activities through its Health Development Project, which works to strengthen services in western Mali. A second phase of this project, having a stronger family planning component, is scheduled to begin in FY 1989. AMPPF provided practical training in family planning delivery for the first phase of this project.

Although little information exists, there has been some nascent involvement of the private sector in family planning activities. The private sector may increase its role over the next few years because of a recent liberalization of the law restricting private medical practice. In essence, the GRM is allowing doctors an early retirement and providing them with funds to start up private clinics. USAID is in the process of developing a private sector initiative to encourage distribution of family planning commodities through private sector outlets. It is anticipated that some of the stronger unions, such as the Union Nationale des Femmes du Mali, will play a key role in the new project. In collaboration with AMPPF, the AID centrally funded Enterprise Project is expected to develop private sector initiatives as well through business channels.

A small but successful CBD family planning project in Katibougou financed by CEDPA has drawn attention to the the potential role of CBD for family planning service delivery. AMPPF also has tried, although unsuccessfully, to launch a CBD program.

B. Information, Education and Communication

It appears that the government has not developed any coherent strategy for family planning education. However, many organizations are working on educating the public on population matters. By far the most important of these is AMPPF. Through its IEC division and regional offices and in collaboration with the UNFM and MSP/AS midwives and nurses, it offers a program of IEC activities in the following major areas:

Community Awareness Raising Campaigns

IEC activities in support of Malian Population initiatives

Training of community field workers from Development and Social Affairs in family planning.

The USAID funded Population Communication Services of Johns Hopkins University has assisted AMPPF in the development of materials for family planning.

UNFPA has in the past funded some broad based rural development and women's group activity projects through the Ministry of Education and the Ministry of Agriculture, but these have generally devoted little emphasis to family planning.

C. Training

Multiple organizations are currently involved in family planning training. The Direction National de la Planification et de la Formation Sanitaire et Sociale (DNPFSS), Division de Formation, collaborates with INTRAH, AMPPF trains health professionals in their model clinic, AVSC collaborates with AMPPF and two hospitals to train doctors in surgical contraception, and UNFPA and other projects support in-service and pre-service training. US and third country training has been available through support from JHPIEGO. These multiple efforts do not seem to have created a critical mass of well trained family planning workers, and the overall impact has been weakened by high mobility of health personnel and a clustering of high level providers in Bamako. The baseline report done by FHI for the IFAHS project found that in the 15 PMI's in the project region, personnel in charge of family planning in 7 centers had not been trained in family planning. Most people with whom we talked have emphasized that except for the training in the AMPPF model clinic, family planning training is overly theoretical with too little attention paid to developing practical skills.

Because of poor record keeping, and the fact that there are many uncoordinated training activities in family planning, no complete record of people trained in family planning exists. Nonetheless, it appears that a substantial number of nurse midwives, nurses and doctors have received family planning training. The largest single training provider appears to be AMPPF. Between 1980 and 1988 they provided practical in-service training to approximately 450 health personnel. In addition, they have regularly provided practical training to nurses finishing their basic course of studies. AMPPF budget constraints have limited the number of persons able to receive training at the model clinic.

D. Logistics

A comprehensive review of the family planning logistics system and recommendations for improvement have recently been completed by the Family Planning Logistics Management Project. Provision of contraceptives to clinics has been a major constraint to the development of an effective family planning program and considerable efforts will be required before program performance improves. The current system now undergoing revision, has a number of major deficiencies. First, there is no coordinated procurement process. Currently at least three organizations (UNFPA, USAID, AMPPF) order contraceptives which appear to be destined for the same service delivery points. Second, distribution of contraceptives takes place on an uncoordinated and usually ad hoc basis. Except for AMPPF, which attempts to resupply its regional coordinators through the commercial transportation system, most contraceptives are distributed when regional staff of the MSP visit the DSF in Bamako. In the regions the medical director is responsible for distribution of regional stocks to clinical facilities. But this activity also occurs on an ad hoc basis. The proposed procurement distribution network coordinating AMPPF and DSF activities is attached in Annex 7.

The net result of a poor procurement system and an unorganized distribution network is frequent stockouts at clinical facilities. During the base line study for the IFAHS project, it was noted that 8 of the 15

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centers visited had had contraceptive stockouts during the preceding six month period. During our own visit to the Niarela PMI, located across the street from AMPPF headquarters, we noted that they had had a stockout in oral contraceptives from May through July of this year. In the regional capital of Segou, none of the ministry health facilities had oral contraceptives at the time of our visit.

E. Management Information

Family planning information is collected in Ministry of Health facilities on forms designed, tested, and distributed by AMPPF. These forms are attached in Annex 8. All clinics providing family planning services maintain a Registre de Consultation. This register provides the basic data on family planning that is forwarded upwards through the health system. Each clinic also keeps a client record form called the Fiche d'Admission which contains demographic and health information as well as a record of services provided. Clients are issued a Carte de Visite which is cross-referenced with the Fiche d'Admission. This card records follow-up appointments. Every three months, the AMPPF Regional Coordinator gets family planning user data from the Regional Medical Director's office and summarizes the information (new and continuing users by method and clinic) using a special form. The AMPPF Regional Coordinator also notes current levels of contraceptive stocks on hand and forwards the information to AMPPF national headquarters.

The Regional Medical Director's Office also forwards information on family planning to the Direction de Planification Sanitaire in Bamako. The Division de Santé Familiale has access to the family planning information at this point as well. Thus, multiple channels and organizations are involved in collecting and analyzing the family planning data generated in the clinics. This network is described in the diagram below:

Rural Dispensaries
(little current FP)

CS Arrondissement
(some current FP)

CS Cercle
("all" offering FP)

Direction Regionale
(aggregate MCH/FP data)

AMPPF Regional Coordinator
(collection every 3 months)

AMPPF Nat'l Coordinator
(FP data only)

DSF
(raw data only)

Dir. Planification Sanitaire
(End of loop: no feedback)

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Current use of family planning service information is limited. AMPPF uses data on services and stock levels when placing orders to IPPF for contraceptives. In the model clinic in Bamako, client record studies have been carried out to learn more about their client's demographic and health profiles. Other centers offering family planning are not apparently using service statistics for information or management purposes. AMPPF finds itself in the difficult position of not being able to obtain complete service statistics because of a deficient public health information system, and therefore unable to fully justify subsequent contraceptive procurement requests. Furthermore, AMPPF has no leverage or authority vis-a-vis the service delivery system, making it unlikely that AMPPF alone will be able to effect improvements in reporting for family planning. AMPPF estimates that only 65% of the clinics offering family planning provide statistics on a regular basis.

One likely reason for the under-reporting of family planning statistics is the heavy reporting burden for all MCH/FP activities imposed by the current system on health workers. To the extent that each service intervention (ORT, FP, pre-natal,etc.) has data gathering requirements, and that these are largely independent of each other, there is the potential for frequent duplication of information collected. In an effort to simplify and integrate the reporting process, the Family Planning Division of the Centre d'Etudes et de Recherche sur la Population pour le Developpement (CERPOD) is undertaking an ambitious project in nine Sahelian countries, including Mali, to develop standard MCH/FP reporting forms. CERPOD is currently working with the Family Health Division of the MOH to carry out this redesign process. AMPPF has not yet been consulted, even though they currently provide the family planning reporting forms in use throughout the country. CERPOD will also be involved in strengthening the evaluation and statistical capabilities of family planning programs in the region. This will be done through training programs and by setting up special units within ministries and family planning organizations in the region.

F. Supervision:

During our visit to the region of Segou, we had the opportunity to discuss the supervision system with several health center directors. As explained to us, a new supervision system has recently been developed. Supervision of MCH/FP activities at the health center level is now done by a multi-disiplinary regional team consisting of representatives from the DSF, the division of epidemiology, and pharmacy/laboratory. As planned, each health center at the cercle level would be visited once every three months. The health center at the cercle level is responsible for supervising the facilities at the arrondissement level and below. AMPPF is responsible for non-technical supervision of those private sector FP centers they have helped to create.

IV. INTEGRATION OF FAMILY PLANNING AND MATERNAL AND CHILD HEALTH CARE IN MALI

A. Overview of Integration in Mali

The Importance of Integration: Mali, like most of its Sahelian neighbors, has made integration of maternal and child health and family planning services a cornerstone of its health care delivery strategy. While the political commitment to integration is unequivocal, the implementation of an integrated service delivery system remains difficult and at times elusive. In April 1988, the FPMT Project held its yearly Francophone Regional Advisory Committee meeting in Morocco. This advisory group of family planning directors invited their maternal and child health counterparts to join them in a ten-day seminar to consider how integration of family planning and maternal and child health services could be strengthened. During that meeting, twenty four recommendations aimed at strengthening the management of integrated maternal and child health and family planning programs were proposed (see Annex 9).

Following the FRAC conference, a two-man team from FPMT was invited by the AMPPF to visit Mali to examine the integration question in greater detail and to provide recommendations for development of a national seminar aimed at improving management of integrated family planning and maternal and child health programs in Mali.

B. Integration Concepts

Coming to an agreement on the definition of integration is a difficult task. This is because integration as a concept is used to describe interactions at different levels and across a variety of areas. Family planning may be integrated into overall development policy, or it may be integrated into several ministries, or it may be integrated in both the public and private sector, or it may be integrated at the service delivery level with maternal and child health care or primary care. Our analysis of the Malian family planning and maternal and child health system will consider integration of family planning services into the maternal and child health clinical delivery system. We will also briefly touch on the integration of public and private sector family planning programs.

C. Integration of Family Planning into Maternal and Child Health Service Delivery Systems:

Integration of family planning into MCH at the clinical level has two components. The first is the service delivery component. In this discussion we will define integration of family planning service delivery into maternal and child health as the continuous provision by multi-purpose health personnel of family planning and MCH services in maternal and child health clinics. The second is the administrative component: those administrative functions that support family planning and maternal and child health service delivery, supervision, information systems, logistics, and training. We will define the administrative component as integrated if the support systems for MCH and family planning are planned and executed by the same personnel.

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The most integrated service delivery system will provide family planning and MCH services during any MCH consultation. Every patient would be seen in the general examination area. Rooms would be equipped with the material necessary to provide a full range of MCH/FP services. Nurses would be trained to search beyond the immediate chief complaint or reason for the visit and would provide an "integrated package" of services. Thus, for example, a mother could have her baby weighed, any necessary immunizations could be given, and all FP methods including IUD's could be delivered during the visit. If the initial primary care consultation revealed the need for acute treatment, the patient could be routed to a specialized treatment area.

There are a number of definite advantages to an integrated delivery system for MCH/FP:

- Every patient contact with the health system creates an opportunity to provide family planning services.

- A woman's or child's complete needs may be addressed in one visit to the center. This produces comprehensive care as opposed to fragmented care.

- Opportunities for family planning IEC are increased dramatically.

Integrated administrative support systems are critical to creating an integrated delivery system because:

- they help the health worker conceive of family planning as part of an "integrated package of services". This reduces the likelihood that family planning will be viewed as supplemental work requiring special incentives.

- they strengthen the health worker's understanding of the synergy between basic MCH and family planning interventions.

However, it must be recognized that integration is no panacea. As the FRAC participants observed after analyzing the state of integration in seven countries:

- there is no ideal model for integration.

- countries must organize their health systems based on their own resources, personnel, and particular strengths and constraints.

Within Mali, the nature and extent of integration of MCH and family planning service delivery will be determined by the human and material resource base available. The appropriate degree of integration for any given facility will depend in large part on the specific characteristics found in that facility.

The fully integrated system described earlier puts a premium on the availability of highly trained multi-purpose personnel and a greater number of completely equipped examining rooms. This particular form of integration is probably not practical currently in most facilities in Mali. The personnel are not adequately trained, equipment is in short

supply, and the patient volume for certain interventions is insufficient to permit full and continuous integration.

It is, however, interesting to note that while these constraints to full integration exist in many facilities, within Bamako, the Center for Family Health and Nutrition has developed and implemented an extremely integrated MCH/FP delivery system.

Private and Public Sector Integration: Public and private sector family planning activities are different for a number of reasons. They target different populations, they often have different sources of funding, they provide services through different channels, command different levels of infrastructure, and have different restrictions on their operation (fee for service, type of contraceptive provided, extent of government regulation, level of personnel, etc.). For purposes of this discussion we will define public and private sector integration as the effective development and coordination of all possible and appropriate family planning interventions.

D. State of Integration of FP/MCH: Organization of Service Delivery

Based on our discussions, observations, clinic visits, and the baseline study data from the IFAHS project, there are several generalizations that can be made about the state of service delivery integration of MCH/FP in Mali.

- The degree of integration in health facilities varies as a function of several factors: clinic leadership or direction, staffing, training, patient load, type of facility, and sufficiency of equipment and space.

- FP services are provided within MCH clinics, but only on certain days of the week and often only during the morning hours (Annex 10).

- FP services are offered in MCH clinics in a designated location.

- Nursing personnel tend to be specialized around one or two MCH interventions. Only a small proportion of staff have been trained in family planning in any given MCH clinic.

At present, a woman visiting an MCH clinic for reasons other than family planning will probably not be exposed to information about family planning services. If she happens to come to the clinic during a time when family planning services are offered and is independently motivated to seek those services, she will have to go through two separate clinic reception and registration systems and be seen by two different providers. If she happens to come to the clinic on the day the services are not offered, she will have to return to the clinic on a second occasion. The great advantage of integration is that it treats every MCH contact as a potential family planning acceptor. Unfortunately, the present organization of services is not sufficiently integrated to attain this benefit.

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An important exception to the generalized situation described above is the Center for Family Health and Nutrition in Bamako. This center provides highly integrated MCH/FP services, with a level of integration approaching the theoretical model described earlier. During our visit to this center, the critical elements necessary for an integrated delivery model were highlighted: leadership committed to the principal of integrated services delivery; adequate numbers of multi-purpose personnel convinced of the importance and capable of delivering an integrated package of services for every client; well-organized and systematic approach to integrated IEC within the clinic; efficient mechanisms for referral of patients for additional services; adequate space and equipment to carry out the interventions; and a volume of patients sufficient to permit the delivery of all MCH/FP services on a daily and continuous basis.

Already this clinic is used on a year round basis for training nurses, midwives, and doctors. Its potential to serve as both a training and operational research center for extending the integrated approach to MCH/FP in facilities throughout Mali is not only significant but exciting.

E. State of Integration of FP/MCH: Administrative Support Systems

Part of the effort to increase integration is through the organization of service delivery, but as we will see, this cannot be achieved in the absence of some degree of integrated support systems. Primarily in the areas of training, supervision, management information, and IEC, there is a need to strengthen the concept of the delivery of an "integrated package" of services. Training, supervising, using management data, and raising community awareness about MCH and FP activities in an integrated fashion helps the health worker more effectively address the multiple needs of the client. For effective program performance, it may not be necessary to have an integrated contraceptive logistics system because organization of the logistics system does not directly affect the "integrated package" concept.

1. Training for Family Planning:

Of all the administrative support systems for family planning, training is the single most important element in the development of an integrated MCH/FP program. Health workers must be trained to view every patient contact as an opportunity for delivering multiple and comprehensive services. The health worker must understand the inter-relationships among the different interventions, and the importance of providing the full range of services. This implies that the client's needs, and not the health worker's, are the driving force in the organization of services.

In spite of the advantages of integrated training, enough constraints usually exist to frustrate development of an integrated training program.

- An integrated approach is difficult to implement by health workers who have received integrated training because the on-going service delivery system is still non-integrated.

- There are few existing models for integrated service delivery.

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- Previous pre-service and in-service training may not have included family planning, and a special effort is required to add family planning to the existing service delivery system.

- Donors tend to fund training in a vertical fashion.

- In countries where family planning services are not well-developed, the client volume for family planning services is insufficient to develop integrated training sites.

There are a number of positive approaches being taken in response to the problems cited above. First, an integrated curriculum is being developed for introduction to in-service training programs. This curriculum, while it can deal separately with technical information and special skills for different interventions, can also contain a module that trains health workers to deliver the integrated service package. One could do this using a clinical case teaching method that allows the health worker to practice providing a full range of interventions for any number of specific chief complaints. Second, the Center for Family Health and Nutrition serves as a model clinic for integrated service delivery. Here, health workers practice the integrated approach to providing patient services. This model clinic might also serve as a test site for different types of service organization. Third, donors currently funding MCH/FP programs in Mali can be encouraged to support integrated training.

2. Supervision

The supervision system, at least as it pertains to the MCH/FP activities in the health centers that we visited, is not yet operational. We were unable to observe a supervision visit, and thus we cannot comment on either the supervision process or its content. As a result we are not able to determine if the new supervision system will support the integrated approach to MCH/FP.

3. Logistics

It is clear that the greatest obstacle to the delivery of family planning services at the present time is the completely inadequate logistics system. However, the integration of the logistics support system is of less importance than integration of other support systems. In fact, the argument can be made that a vertical logistics system for family planning may provide greater advantages even if the rest of the support systems are integrated. The vertical logistics system does not detract from an integrated approach to service delivery. In addition, it is likely that the present ministry logistics system is weak and would not be able to successfully undertake contraceptive products procurement and distribution. The advantage of a vertical logistics system is that it places control of logistics functions in the hands of the most interested and responsible party. This permits the system to be more responsive to changes in overall demand and product specific demand. Further, it allows for easier monitoring of program expansion and permits accountability for donor supplied products.

4. Management Information Systems

At present, Mali possesses a partially integrated information system; health workers collect information for all MCH and family planning interventions, summarize it on a single, standardized reporting form, and forward the form upwards through the health system. It is quite an achievement to already have a system that integrates multiple information collection activities at the clinic level. The system is least integrated during patient registration, as each MCH/FP intervention has its own registration book and client information which it uses for its own management and follow-up purposes. An integrated registration system keyed to health records, and containing essential information for each program, would reinforce the concept of integrated services and result in less duplication of information. However, in practice this type of system would be extremely difficult to implement because of the volume and detail of information needed for each MCH/FP activity and the complete change in clinic organization that it would require.

5. Information, Education, and Communication

IEC can be offered within the clinic setting and as an outreach service in the community. In the clinic, IEC is offered on a one to one basis as well as in the group setting. In our discussions, it appears that health workers are trying to integrate several MCH/FP themes or messages into their "causeries". The particular emphasis of the causerie will vary depending on clinic routines and schedules. However, these causeries have not been standardized or closely examined. A special review of these IEC sessions could be extremely useful and might lead to the development of a more effective integrated IEC intervention. In one on one consultation, it was difficult to judge the extent of an integrated message. A related issue to the one considered above is the integration of IEC for maternal and child health in the current family planning IEC outreach program delivered by AMPPF.

Second, the current clinical delivery system has no systematic IEC outreach beyond the IEC activities that take place in the clinic. Almost all IEC outreach for family planning is done by AMPPF through its network of regional staff and volunteers. Other structures for MCH/FP IEC exist, like the health education unit in the ministry, but these are reported to be extremely weak. The current family planning IEC activities are planned, implemented and evaluated without collaboration or consultation with the clinical service delivery system. Closer coordination with the service delivery structure, especially at the regional level, would permit some level of evaluation of IEC activities. For example, regional AMPPF staff could prepare their awareness raising sessions in collaboration with health center staff, setting objectives for FP program expansion in the clinic catchment area. Existing service statistics could then serve as baseline and impact measures of IEC outreach activities.

F. State of Integration: Private and Public Sector

Private sector initiatives in family planning are just beginning in Mali. There is a new law liberalizing regulations governing private medical

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practice that may represent the possibility for greater private sector family planning involvement over the long-term. In the past several years, the government has not been able to employ the entire complement of graduating nurses and physicians in the public sector. These unemployed health workers might serve as a resource for family planning promotion in the future. AMPPF, in collaboration with the Enterprise Project, has begun to collaborate with private industry to offer family planning services to employees. CBD programs have not yet gained a major foothold in Mali, but some current small efforts are encouraging. The new USAID private sector project will also explore ways of more effectively integrating family planning activities in the private and public sector.

AMPPF has perhaps the greatest role in integrating private and public sector activities, as it currently works in both. It has strong contacts both within the Ministry of Health and other public institutions as well as in the private sector. AMPPF could position itself in the next several years to integrate activities in both sectors and take the lead in pioneering private sector initiatives.

V. RECOMMENDATIONS FOR STRENGTHENING THE DELIVERY OF INTEGRATED MCH/FP SERVICES IN MALI

Family planning and maternal and child health services are integrated in Mali to different degrees within the health care system. This variance reflects different conceptual and practical models for integration as well as unequal distribution of human and material resources. Given that there is a clear national commitment to an integrated MCH/FP delivery system, and that room for significant improvement of this system exists, we offer the following recommendations to strengthen the organization, management, and delivery of integrated services.

1. The DSF's efforts to develop an integrated MCH/FP curriculum for in-service training should include a review by an outside expert. The consultant should examine whether the curriculum:

   - uses a clinical case-based method for training health workers in MCH/FP interventions;
   - places each health intervention in the context of the overall health needs of the client. Health workers should learn to systematically provide a full array of preventive services at the time of every patient contact;
   - includes the special technical information and skills for all MCH/FP interventions;
   - includes a large practical training component in which the integrated service delivery approach is well-developed and applied;
   - requires participants to plan how they would use their integrated skills in their place of work.

2. A national seminar should be organized after the integrated curriculum has been developed and tested. The seminar would serve several purposes: to promote the concept of an integrated approach to training and service delivery; to orient health officials to the key issues involved in integration, and; to officially launch the new training and service delivery program. This seminar would define integration in the Malian context, examine the current organization of MCH/FP services and make recommendations for improving integration of services. During the seminar, working groups for each administrative support area (logistics, IEC, supervision, etc.) could examine and develop recommendations, strategies and plans for strengthening integration in those areas.

3. In addition to the existing highly integrated Clinique d'Application en Santé Familiale et Nutritionnelle, the DSF should consider other model clinics where training for integrated service delivery could take place.

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4. The DSF should consider conducting operations research on key aspects of the integration of services. This research would explore different staffing patterns, client volume, available resources, etc. and their impact on the organization and delivery of integrated services. Data from these studies could be used to formulate different options for organizing and delivering integrated services.

5. AMPPF and the DSF should continue to work together for the immediate resolution of the problems currently experienced in ordering and distributing contraceptives. A vertical program, whether the responsibility of the DSF or AMPPF, would serve the needs of the family planning program better than a logistics system integrated into the MOH pharmaceutical logistics system.

6. Regional IEC workers from AMPPF should coordinate with health center staff in setting objectives for family planning program expansion in their clinic catchment area. Existing service statistics could then serve as baseline and impact measures of IEC outreach activities.

7. The DSF should undertake a special review of clinic IEC sessions to determine whether the IEC methods and the content of the message are reinforcing the integrated approach to service delivery.

8. All MCH/FP programs and organizations should communicate the importance of integrated training programs to donor agencies so that they will support these types of training efforts.

9. Staff at MCH/FP centers should make more effective use of existing service records for management and programmatic decision making. In so doing, MCH/FP centers could develop ways of monitoring the effectiveness of their efforts to integrate services. For example, health workers could keep track of FP referrals from other programs, monitor the frequency and family planning content of MCH causeries, etc.

10. AMPPF should take the lead in developing family planning services outside the MOH structure. Current efforts to introduce family planning into industrial and commercial settings should be reinforced. In addition, AMPPF should design programs to reach persons not routinely served through the formal health delivery system.

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VI. PROPOSAL FOR FPMT ACTIVITIES

1. Technical assistance to review and test the curriculum for integrated training. FPMT would identify an expert in the field of integration who would work with the DSF over a three week period to review the curriculum for integrated training and, as appropriate, propose modifications to strengthen it. Ideally, this review would involve testing the curriculum during a training event in addition to a theoretical and technical review.

2. National Seminar on integration of family planning and MCH.

   Purpose: To provide a forum for the introduction and promotion of the new integrated curriculum and to place it in the context of Mali's strategy for developing an integrated service delivery system.

   Objectives:

   - Define integration in the Malian context.
   - Examine the administrative support systems for MCH/FP (training, logistics, supervision, management information systems, IEC) and discuss their impact on the integration of services.
   - Present the new training curriculum and show how it supports and strengthens the strategy for integrated service delivery.
   - Examine the current organization of the MCH/FP delivery system and its impact on the integration of services.
   - Make recommendations for improving integration of MCH/FP services.

   Audience: 20 key decision makers from DSF, AMPPF, regional health centers, and donor agencies.

   Outputs:

   - Improved understanding of the concepts of integration and their importance for improving integrated MCH/FP services in Mali.
   - Development of a strategy for improving the delivery of integrated services.
   - Development of specific plans for improving administrative and managerial support systems in the delivery of integrated services.
   - High level support for and commitment to the curriculum for integrated training.

The one week seminar will be sponsored jointly by the DSF and AMPPF and should be held in Bamako. It is proposed that the seminar take place in March or April, 1989.

FPMT contribution:

Collaboration on conceptual design of the seminar, provision of technical experts and/or facilitators as required, funding support for participants, materials development, supplies and equipment, and other miscellaneous expenses. FPMT will also contribute to writing, producing and distributing the final report.

Follow-up to seminar:

Based on recommendations from the national seminar, FPMT could provide follow-up technical assistance to improve management of integrated programs. These areas would have to be defined in consultation with other organizations and projects providing technical assistance to the MCH/FP program in Mali.

3. Study tours under the new USAID private sector project

There may be a role for FPMT in organizing and conducting study tours for future family planning leaders in the UNFM, Jeunesse et Sports, or other institutions identified during the design of the new private sector family planning program. Study tours would expose participants to alternate delivery strategies for family planning and help participants adapt the lessons learned to their own programs. Study tours would be preceded by carefully planned briefings, and participants would be guided through the process of developing action plans for their own activities upon completion of the tour.

4. Follow-up training in management information systems for recent participants to the MSH microcomputers and MIS course.

Whenever possible, FPMT endeavors to provide technical assistance follow-up to the participants sponsored for short-term training by FPMT, such as those attending the MSH Micro-Computer and MIS course. The purpose of this follow-up is to assist the participants in the application of skills acquired during the course to the problems they face in their work environment. A further aspect of the follow-up is to help the participants move forward on the projects they initially developed in training. Mr. Magassa of AMPPF is interested in using management information from the model clinic to improve the quality of services, while Mr. Traore of the MOH has plans to develop a training data base for participant tracking and follow-up and to assure a more rational approach to participant selection.

5. Collaboration with CERPOD on MIS section of African Family Planning Managers Handbook.

FPMT is currently producing an African Family Planning Manager's Handbook. This book will contain an MIS section. CERPOD is currently reviewing and improving MIS systems for MCH and FP in nine countries in the Sahel. Preliminary discussions with CERPOD have indicated their potential interest in collaborating on this project.

6. Strategic Planning with AMPPF

During our visit we developed a questionnaire to identify areas of strategic interest and importance to AMPPF. This questionnaire is currently being distributed to central senior staff and regional staff. The completed questionnaires will be sent to us in Boston for analysis. This analysis could form the basis for the development of an ongoing management improvement program with AMPPF. AMPPF has indicated its interest in examining its strengths and weaknesses for the purpose of more clearly defining its future role in the promotion of family planning in Mali. If deemed appropriate FPMT could assist AMPPF in development of a long term strategic plan for the organization. This activity corresponds with IPPF London's interest in strategic planning for its affiliates.

7. Workshops for AMPPF board and volunteer orientation and motivation.

The feeling was frequently expressed that at present the volunteers are not well motivated, are poorly oriented to their potential role, and are often ill equipped to contribute to expanding family planning services in their areas. This workshop would have as its major theme an examination of how volunteers can be motivated to make an effective contribution to family planning programs."

8. Management workshop for regional AMPPF teams

FPMT has collaborated with the Centre for African Family Studies to design and deliver a management workshop for family planning personnel in Francophone Africa. Two members of the AMPPF staff have attended these workshops in Lome, Togo and have indicated that they found them worthwhile and relevant to their jobs. As a cost-effective means of following-up with past trainees and extending management training to new participants, FPMT can attempt to collaborate with CAFS to do in-country management training for AMPPF regional teams.

9. Short-term US or third country Training

- Under its mandate FPMT is able to provide sponsorship to a limited number of participants to appropriate management courses. Participants have taken courses in the past in the areas of MIS, Human Resource Management, Child Survival, Safe Motherhood, Women in Management, etc. If appropriate candidates are identified and proposed by USAID and the GRM, FPMT will endeavor to sponsor this training.

- FRAC III: The third meeting of the Francophone Regional Advisory Committee is proposed for February-March 1989 in Dakar, Senegal. The one week meeting will focus on the theme of community involvement in family planning programs. One or two participants from Mali will be invited to attend.

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10. Provision of Management Training Materials to AMPPF and the DSF

During the past three years FPMT has assembled a basic bookshelf for family planning organizations containing a complete management reference library in French. FPMT will send two shipments, one each for AMPPF and the DSF, via diplomatic pouch to USAID Bamako. The shipment will be sent in November, 1988.

ANNEX I: LIST OF PERSONS CONTACTED

USAID BAMAKO

MR. DENNIS BRENNAN, MISSION DIRECTOR
MR. NEIL WOODRUFF, POPULATION OFFICER
MR. TATA SANGARE, POPULATION ADVISOR
MS. CAROL HART, USAID LIASON WITH CERPOD

MINISTRY OF HEALTH AND SOCIAL AFFAIRS

DR. SUZANNE BOCOUM, DIRECTOR FAMILY HEALTH DIVISION
DR. DIALLO DOUCOURE, MEDICAL DIRECTOR, FAMILY HEALTH TRAINING CENTER
DR. SANGARE, OB/GYN, FAMILY HEALTH TRAINING CENTER
DR. MARYSE PIERRE-LOUIS, TECHNICAL ADVISOR
MR. OUMAR TRAORE, HEAD OF TRAINING AND PLANNING DIVISION
DR. SOUMALIA DIAKITE, REGIONAL MEDICAL DIRECTOR, SEGOU
DR. FELIX SIDIBE, TECHNICAL COORDINATOR, AND AMPPF REGIONAL VICE PRESIDENT, NIANANKORO HOSPITAL
DR. AIDARA DIALLO, OB/GYN FOR NIANKORO
MS. DIAKITE ASTAN TRAORE, ASSISTANT TO DSF REGIONAL DIRECTOR
DR. BAMBI BA, MCH DIRECTOR, CENTRE DE SANTE FAMORY DOUMBIA

MALIAN FAMILY PLANNING ASSOCIATION (AMPPF)

DR. KARIM SANGARE, PRESIDENT
MR. LANSINA SIDIBE, EXECUTIVE DIRECTOR
MR. ABDOU TOUNKARA, NATIONAL PROGRAM COORDINATOR
MR. AMADOU ROUAMBA, DIRECTOR OF IEC PROGRAM
MR. SOULEYMANE COULIBALY, DIRECTOR OF FINANCE AND ADMINISTRATION
MR. DIADIRA MAGASSA, MEDICAL AND CLINICAL DIRECTOR
MS. DIALLO ADAMA DIAKITE, IEC PROGRAM
MR. SIAKA SANGARE, ADMINISTRATIVE SECRETARY
MR. AMADOU DIARRA, REGIONAL COORDINATOR KOULIKORO
MR. MALICK COULIBALY, REGIONAL COORDINATOR FOR SEGOU
MR. MOUSTAPHA NIANG, REGIONAL AMPPF PRESIDENT
MS. AYAWOVIE SANTOS, IPPF REGIONAL PROGRAM OFFICER
MR. SANGARE, ASSISTANT SECRETARY GENERAL, AMPPF BOARD
MS. SY, VICE PRESIDENT, AMPPF BOARD

PRITECH

DR. ADAMA KONE, REGIONAL ADVISOR
MS. JUDY BENINATI
MS. JUDY AUBEL (CONSULTANT, AED)

SOMARC

MS. LINDA DEAN
MR. ALAN HANDYSIDE

CERPOD

DR. MARIAM MAIGA, DIVISION OF FAMILY PLANNING
DR. KHADIDIATOU MBAYE, DIVISION OF FAMILY PLANNING
MS. SIDIBE NAFISSATOU DIOP, COMPUTER DIVISION

ANNEX II: SCHEDULE OF VISITS

SUNDAY, SEPTEMBER 18

17:00 ARRIVAL OF HEISE AND WOLFF

MONDAY, SEPTEMBER 19

8:00 BRIEFING WITH MR. NEIL WOODRUFF, USAID
9:00 BRIEFING WITH MR. TATA SANGARE, USAID
9:30 LOGISTICAL ARRANGEMENTS FOR VISIT
10:45 INITIAL MEETINGS WITH AMPPF SENIOR STAFF
15:00 MEETING WITH TATA SANGARE
16:15 MEETING WITH CAROL HART

TUESDAY, SEPTEMBER 20

8:30 MEETING WITH MR. MAGASSA, CLINIC DIRECTOR AMPPF
9:30 MEETING WITH MR. ROUAMBA, IEC DIRECTOR AMPPF
11:30 MEETING WITH MR. SIDIBE, EXECUTIVE DIRECTOR AMPPF
17:00 MEETING WITH CERPOD, DIVISION OF FAMILY PLANNING

WEDNESDAY, SEPTEMBER 21

9:00 MEETING WITH DR. SANGARE, PRESIDENT OF AMPPF
11:00 MEETING WITH MR. SIDIBE, EXECUTIVE DIRECTOR OF AMPPF
12:30 MEETING WITH MR. ROUAMBA, IEC
13:30 MEETING WITH MR. SANGARE AND MR. AMADOU DIA
14:30 MEETING WITH MR. WOODRUFF AND MR. SANGARE, USAID

THURSDAY, SEPTEMBER 22 (INDEPENDENCE DAY, NATIONAL HOLIDAY)

DEVELOPMENT OF FIRST DRAFT OF REPORT AND PROPOSED ACTIVITIES

FRIDAY, SEPTEMBER 23

9:00 LOGISTICS FOR WEEKEND DEPARTURE
10:00 VISIT TO NIARELA PMI, BAMAKO
11:00 DISCUSSION WITH MR. TOUNKARA, AMPPF

SATURDAY, SEPTEMBER 24

9:00 MEETING WITH MR. TOUNKARA, AMPPF
12:00 CONTINUED DEVELOPMENT OF REPORT

SUNDAY, SEPTEMBER 25

10:00 CONTINUED DEVELOPMENT OF REPORT
14:00 LEAVE FOR REGION OF SEGOU
16:30 ARRIVAL SEGOU

MONDAY, SEPTEMBER 26

8:00 VISIT TO AMPPF REGIONAL OFFICE
9:00 VISIT TO REGIONAL MEDICAL DIRECTOR
10:00 VISIT TO ASSISTANT TO DSF MEDICAL COORDINATOR
10:30 VISIT TO NIANANKORO HOSPITAL
11:30 VISIT TO FAMORY DOUMBIA MCH CENTER
12:30 MEETING WITH AMPPF REGIONAL PRESIDENT AND STAFF
14:30 DEPARTURE TO BAMAKO
18:00 CONTINUED DEVELOPMENT OF REPORT

TUESDAY, SEPTEMBER 27

9:00 VISIT TO CENTRE D'APPLICATION, DR. DOUCOURE
14:30 MEETING WITH CERPOD STAFF
16:00 FURTHER DEVELOPMENT OF REPORTWEDNESDAY, SEPTEMBER 28

WEDNESDAY, SEPTEMBER 28

8:00 DEBRIEFING WITH AMPPF STAFF
13:00 WORKING LUNCH WITH M. TOUNKARA, DR. DOUCOURE
16:00 DEBRIEFING WITH USAID
23:30 DEPARTURE OF WOLFF FOR THE U.S.

THURSDAY, SEPTEMBER 29

11:00 MEETING WITH DSF DIRECTOR AND TECHNICAL ADVISOR
16:00 DEBRIEFING WITH USAID MISSION DIRECTOR
19:00 WORKING DINNER WITH DSF TECHNICAL ADVISOR

FRIDAY, SEPTEMBER 30

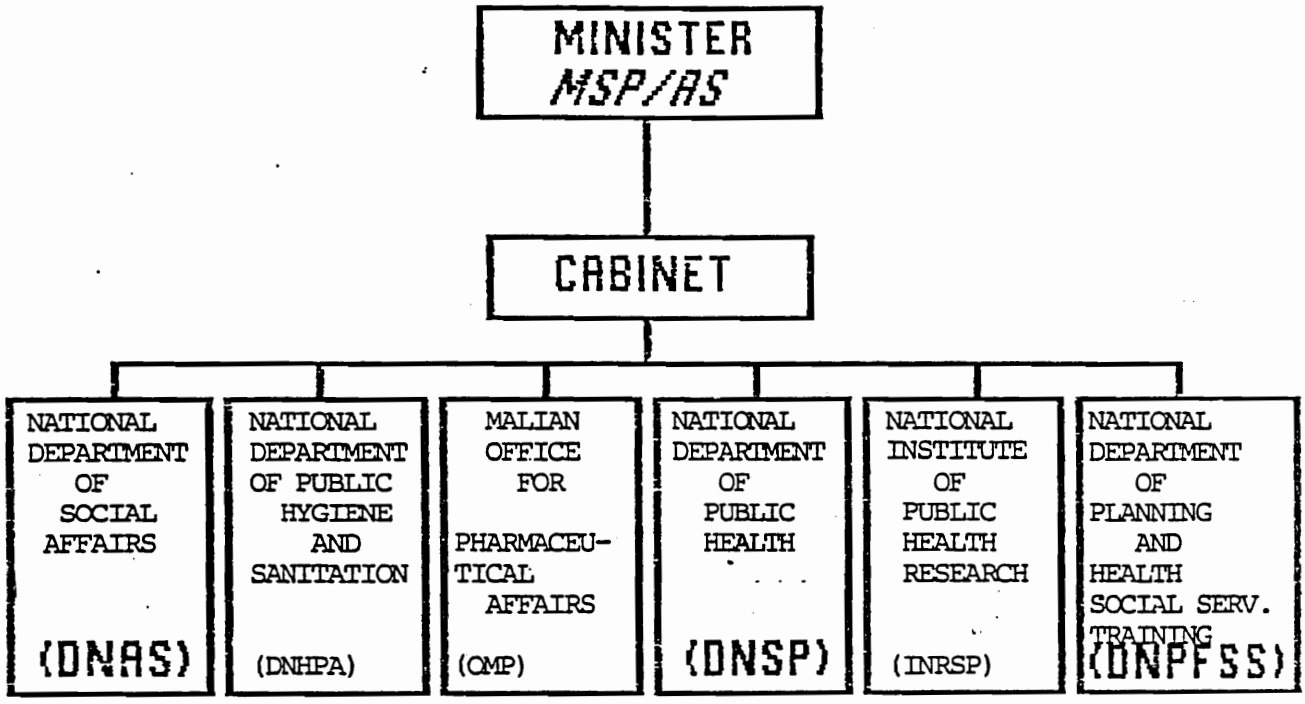
9:00 DEBRIEFING WITH AMPPF BOARD
13:00 FINAL MEETING WITH CERPOD
16:00 FINAL DEBRIEFING WITH USAID

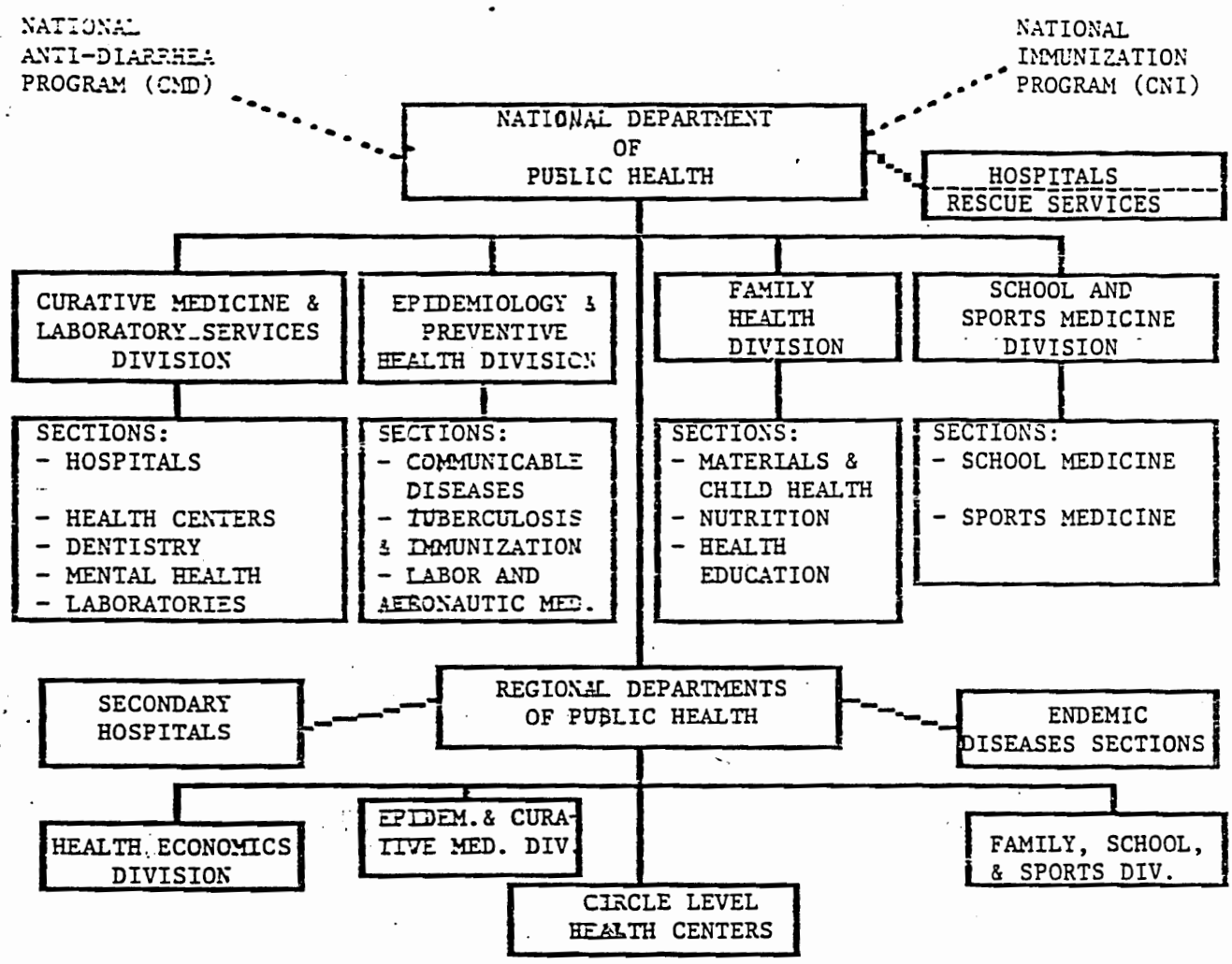
SATURDAY, OCTOBER 1

11:30 HEISE DEPARTURE FOR OUAGADOUGOU

ORGANIZATIONAL CHART

MINISTRY OF PUBLIC HEALTH AND SOCIAL AFFAIRS





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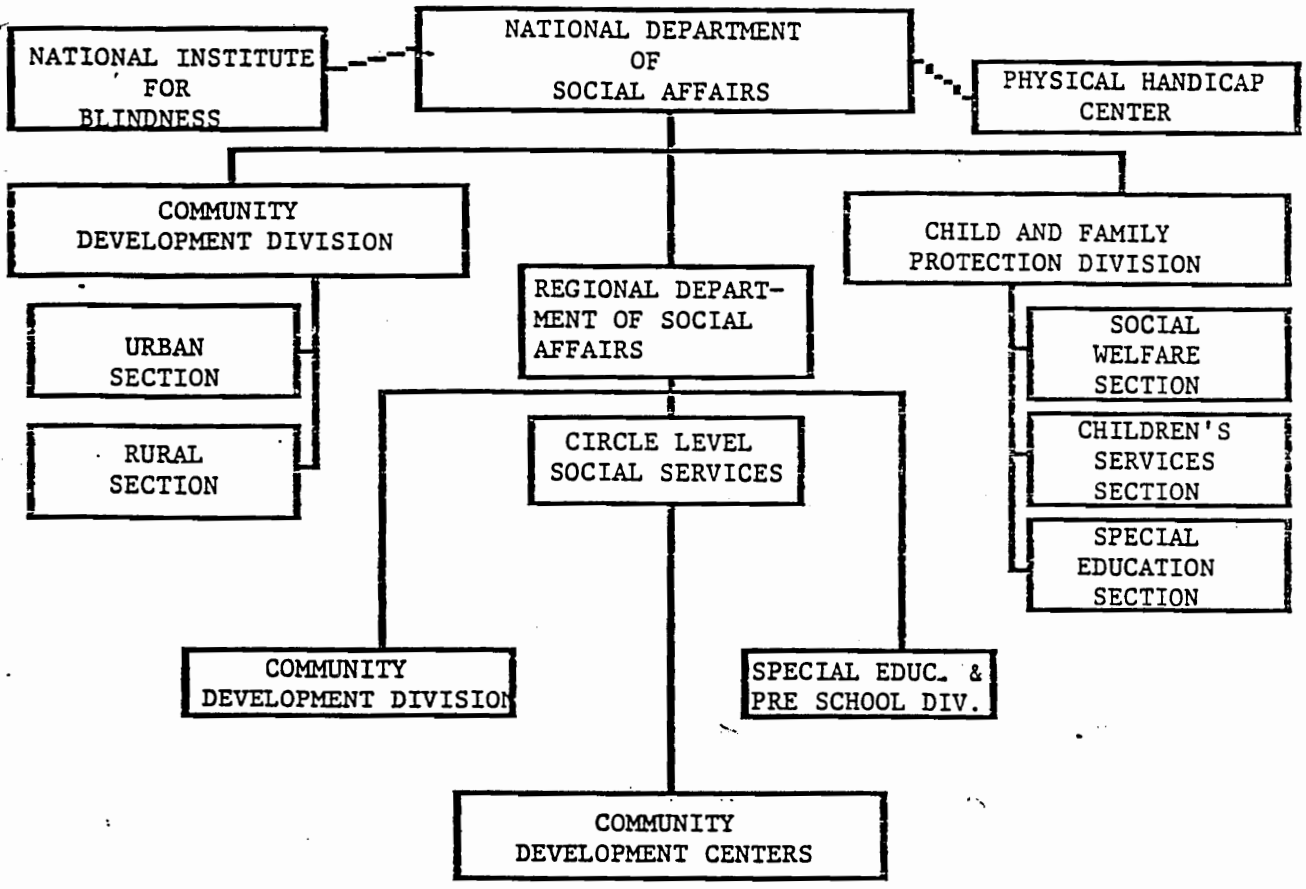
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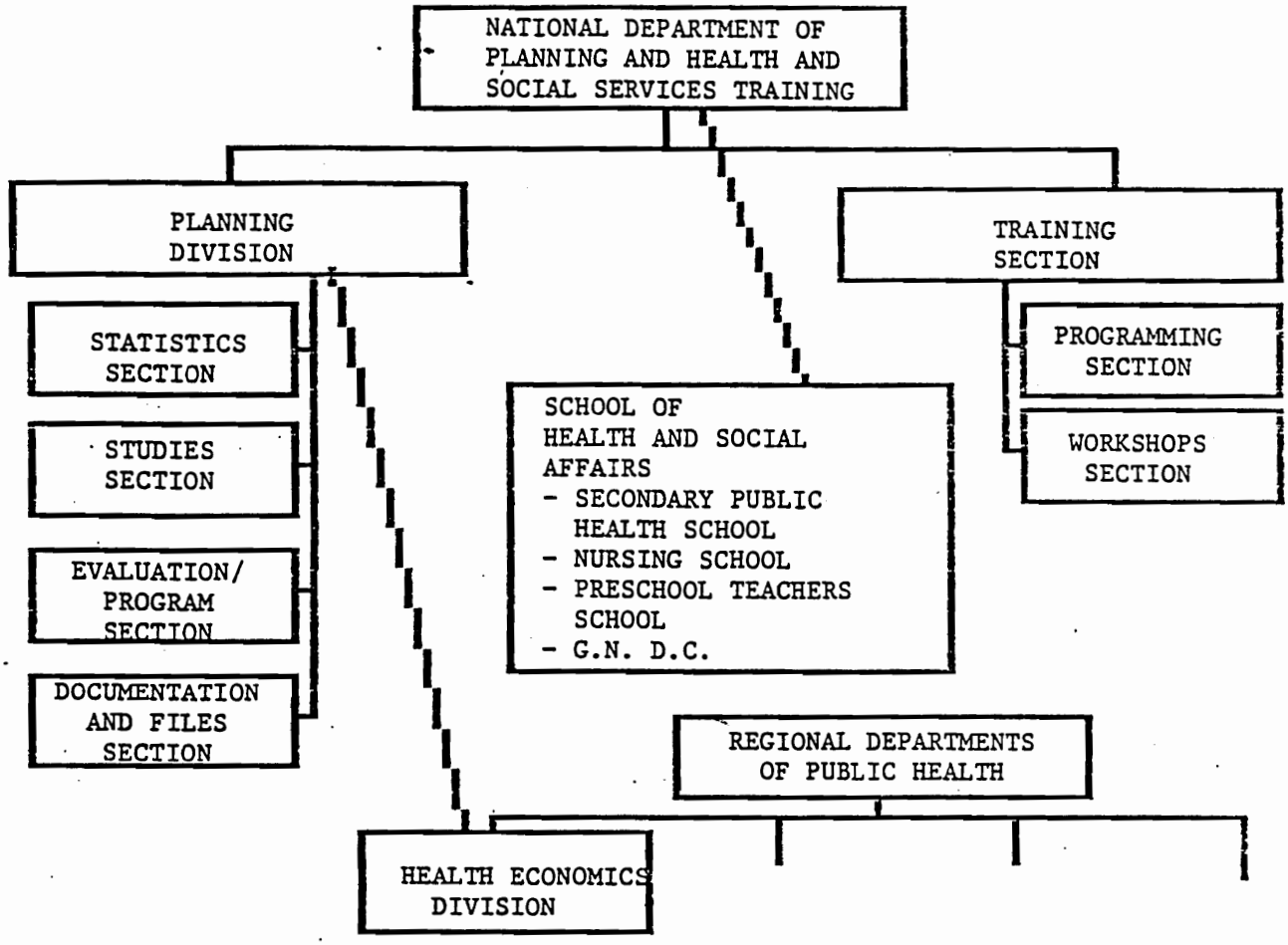
NATIONAL DEPARTMENT OF SOCIAL AFFAIRS
PHYSICAL HANDICAP CENTER
COMMUNITY DEVELOPMENT DIVISION
CHILD AND FAMILY PROTECTION DIVISION
REGIONAL DEPARTMENT OF SOCIAL AFFAIRS
URBAN SECTION
RURAL SECTION
SOCIAL WELFARE SECTION
CHILDREN'S SERVICES SECTION
SPECIAL EDUCATION SECTION
CIRCLE LEVEL SOCIAL SERVICES
COMMUNITY DEVELOPMENT DIVISION
SPECIAL EDUC. & PRE SCHOOL DIV.
COMMUNITY DEVELOPMENT CENTERS


NATIONAL DEPARTMENT OF PLANNING AND HEALTH AND SOCIAL SERVICES TRAINING
PLANNING DIVISION
TRAINING SECTION
STATISTICS SECTION
STUDIES SECTION
EVALUATION/ PROGRAM SECTION
DOCUMENTATION AND FILES SECTION
PROGRAMMING SECTION
WORKSHOPS SECTION
SCHOOL OF HEALTH AND SOCIAL AFFAIRS
- SECONDARY PUBLIC HEALTH SCHOOL
- NURSING SCHOOL
- PRESCHOOL TEACHERS SCHOOL
- G.N. D.C.
REGIONAL DEPARTMENTS OF PUBLIC HEALTH
HEALTH ECONOMICS DIVISION

ANNEX IV: QUESTIONNAIRE A L'INTENTION DE L'AMPPF

Nous voudrions identifier avec vous les domaines ou une assistance technique en management pourra offrir les plus grands benefices a votre organisme. Durant nos discussions avec vous, nous avons deja identifie certaines domaines qui apparaissent interessants et importants. Cette questionnaire nous aidera a preciser les problemes et a identifier les champs d'actions futurs.

Veuillez indiquer, pour les domaines ou fonctions suivantes, l'importance pour votre organisme, en utilisant une echelle de 1 a 3:

1= peu d'importance, peu d'urgence
2= important, mais peu d'urgence
3= grand importance, grand urgence

On vous demande aussi de faire une petite commentaire concernant la situation actuelle en notant les points forts et faibles, et vos suggestions pour l'amelioration du processus. On a laisse une espace apres chaque rubrique pour les commentaires.

Veuillez indiquer a quel niveau vous travaillez:

au siege___ au niveau regional___

* Preparation d'un plan strategique et etablissement des objectifs

- definition de la mission, buts, objectifs de l'AMPPF___
- determination des priorites organisationelles et inter-divisionnelles___
- analyse des diverses options pour les services offerts par AMPPF___
- exploration de l'impact qu'un changement des relations avec les donateurs aurait sur la viabilite des strategies de l'AMPPF___
- mise au point d'une strategie de diversification des sources de fonds___

* Preparation des plans operationnels

- collecte et analyse des donnees pour la planification___

- fixation des objectifs realistes, quantitatifs et classes par ordre de priorite pour la prestation des services a tous les niveaux___

- creation des plans de travail operationnels qui specifient le materiel, la formation et les ressources financieres necessaires a la realisation de ces objectifs___

- developpement d'un systeme de supervision pour appuyer l'execution des activites ___

* Gestion des Ressources Humaines

- identification des besoins et priorites de formation pour les categories de personnel suivantes: volontaires___; staff au niveau central___; staff au niveau regional___; personnel de l'etat___; autres (specifier)_____

_____

- revision des techniques utilisees pour motiver et superviser toutes les categories de personnel___

- mise au point des systemes de gestion des ressources humaines comprenant:

  - l'analyse des taches___
  - les profils des postes (volontaires et staff)___
  - systemes d'evaluation de performance___
  - la planification des carrieres___
  - les systemes de remuneration du personnel___

- developpement d'une strategie de recrutement, orientation, et utilisation des volontaires___

- developpement d'un systeme de communication efficace et continue entre les differents niveaux de volontaires___

* Etablissement du Budget et Controle Financier

- preparation des budgets conformes aux plans de travail annuels___

- mise au point des systemes de controle financier mensuels et trimestriels___

- mise au point d'un systeme comptable pour la recuperation des fonds generes par les programmes___

* Systeme d'Approvisionnement

Estimation des besoins___
Controle de stock___
Distribution___

* Systemes d'Information en Matiere de Gestion

- simplification des systemes internes de tenue des dossiers___
- recueil des informations appropriees pour la prise de decision___
- identification et developpement des applications des micro-ordinateurs pour ameliorer la gestion___
- formation et motivation du personnel pour la collecte des donnees___

* Controle et Evaluation

- etablissement des procedures servant a controler, d'une facon continue, l'etat d'avancement du programme vers les objectifs___
- developpement des strategies pour l'evaluation des programmes___

* Systemes Alternatifs de Prestation des Services

- identification d'autres systemes possibles pour la prestation des services et la distribution du materiel de planning familial___
- etude des procedures servant a developper des programmes pilotes en vue de tester ces autres programmes alternatifs___

* Coordination avec autres organismes du Planning Familial (Gouvernement, bailleur des fonds, autres ONGs, etc.)___

ANNEX V

MALI

Basic Data*

Population	7.3 million
Annual Rate of Growth of Population (percent)	2.3
Per Capita Income (U.S.$)	170
Area (thousand km2)	1,240
Population Density (per km2)	6
Percentage Urban	20
Crude Birth Rate (per 1,000)	48
Crude Death Rate (per 1,000)	20
Rate of Net Emigration (percent)	0.5
Infant Mortality Rate	160
Life Expextancy at Birth	46.5
Total Fertility Rate	6.5**
Maternal Mortaliity Rate	17**

*Source: EIU 1988-89; data for 1985-86 except where noted with **

ANNEX VI

REGIONS		PERSONNEL				POPULATION
		Médecins	Sages-Femmes	Infirm. d'Etat	Infir. Santé	
- Kayes	Nombre Ratio	34 1/30736	10 1/104503	55 1/19001	117 1/8932	1 045 034
- Koulikoro	Nombre Ratio	20 1/55395	19 1/58310	36 1/30775	91 1/12175	1 107 893
- Sikasso	Nombre Ratio	34 1/38825	12 1/110004	51 1/2157	126 1/10477	1 320 043
- Ségou	Nombre Ratio	33 1/39525	17 1/76725	63 1/20704	115 1/11342	1 304 328
- Mopti	Nombre Ratio	26 1/51980	22 1/61431	50 1/27029	119 1/11357	1 351 472
- Tombouctou	Nombre Ratio	19 1/30602	5 1/116289	36 1/16151	63 1/9229	581 447
- Gao	Nombre Ratio	19 1/23157	8 1/55002	39 1/11282	69 1/6377	440 014
- District de Bamako	Nombre Ratio	287 1/2464	249 1/2840	454 1/1558	753 1 / 939	707 166
ENSEMBLE DU MALI	NOMBRE RATIO	473 1/16 612	342 1/22 975	784 1/10 022	1453 1/5 408	7 857 397

Source: WHO/Mali travel report 1985

ANNEX VII

SYSTEME GENERAL DE
DISTRIBUTION DES CONTRACEPTIFS
ROLE DES INTERVENANTS DANS LA DISTRIBUTION NATIONALE

RESEAU DE L'A.M.P.P.F.	SCHEMA GENERAL DU SYSTEME : ROLE DES INTERVENANTS	RESEAU DE LA D.S.F.
	* Reception produits	
Depot AMPPF Bamako	- donations AID/FNUAP - donations IPPF	Depot DSF Bamako
	* Entreposage des stocks nationaux recus	
Depot AMPPF Bamako	- donations AID/FNUAP - donations IPPF	Depot DSF Bamako
(A)	Entreposage des approvisionnements Programme - produits AID/FNUAP - produits IPPF	(B)
Clinique Bamako + Bureaux Regionaux AMPPF	* Approvisonnements niveaux intermediaires Trimestriellement par moyens Regions	DSF Region
Clinique Rurale + O.N.G.	Mensuellement par moyens locaux disponibles	DSF Cercles
	Mensuellement par moyens locaux disponibles	DSF Arrondissements

LEGENDE :

— Produits AID/FNUAP
.. Produits IPPF
=== Ensemble Produits

Commandes/approvisonnements entre DSF ET AMPPF :
(A) selon consommation enregistree AMPPF et ONG
(B) selon consommation enregistree DSF, secteur

Family Planning Logistics Management Project, 1988

ANNEX VIII: AMPPF DATA COLLECTION FORMS

Carte de Visite

Clinique _____

N° du Dossier _____

Nom _____

Prénoms _____

_____

Adresse _____

_____

Date de la 1ère Visite _____

Hotesse _____

RENDEZ-VOUS

ANNEE			
JANVIER			
FEVRIER			
MARS			
AVRIL			
MAI			
JUIN			
JUILLET			
AOUT			
SEPTEMBRE			
OCTOBRE			
NOVEMBRE			
DECEMBRE			

FICHE D'ADMISSION

N° du Dossier: [ ][ ][ ][ ][ ] 1-5

1. Nom de la Clinique: _____ [ ][ ][ ][ ] 6-9

2. Date d'Admission: [ ][ ] [ ][ ] [ ][ ] 10-15
Jour *Mois* *Année*

3. Nom et prénom: _____

4. Nom du mari: _____

5. Adresse: _____
_____ [ ][ ][ ] 16-18

6. Age: _____ [ ][ ] 19-20

7. Motif de la 1ère Visite:
1) Stérilité _____
2) Contraception _____
3) Gynécologie _____ [ ] 21

8 Source de Référence :
1) Centre Social _____
2) PMI _____
3) Maternité _____
4) Personnel Médical _____
5) Voisin (e) ami (e) _____
6) Famille _____
8) Autre, préciser _____ [ ] 22

9. Etat Matrimonial:
1) Mariée, Monogame _____
2) Mariée, Polygame _____
3) Célibataire _____
4) Veuve _____
5) Divorcée _____ [ ] 23

10. Niveau d'Education: _____ [ ][ ] 24-25

11. Profession: _____ [ ][ ] 26-27

12. Ethnie: _____ [ ][ ] 28-29

13. Antécédents Obstétricaux
Nombre total de grossesses _____ [ ][ ] 30-31
Nombre d'enfants vivants:
garçons _____ filles _____ total _____ [ ][ ] 32-33
Nombre d'enfants décédés _____ [ ][ ] 34-35
Nombre d'avortments _____ [ ][ ] 36-37
Nombre de mois écoulés depuis la dernière grossesse _____ [ ][ ] 38-39
Nombre d'accouchements normaux _____ [ ][ ] 40-41
Nombre d'accouchements pathologiques _____
Décrire _____
_____ [ ][ ] 42-43

14. Lactation
Allaite à présent
00) Non _____
Oui, préciser la durée en mois _____ [ ][ ] 44-45

15. Contraception antérieure
Avez vous déjà utilisé une méthode
00) Non _____
Oui, préciser la méthode _____ [ ][ ] 46-47
la durée d'emploi _____ [ ][ ] 48-49

16. Raison de l'abandon
1) Intolérance médicale _____
2) Raison personnelle _____
3) Grossesse désirée _____
4) Echec de méthode (grossesse) _____
8) Autre, préciser _____ [ ] 50

17. Contraceptif Accepté
1) Stérilet: Type _____ Taille _____
2) Pilule: Type _____
Nombre de Cycles _____
3) Injectable: Type _____ [ ][ ] 51-52
8) Autre: Type _____ [ ][ ] 53-54

18. Référée pour stérilisation:
00) Non _____
Oui, préciser nom de l'hôpital _____ [ ][ ] 55-56

19. Referée ailleurs pour: Non Oui
1) Stérilité: _____ _____
2) Grossesse: _____ _____
3) Soins: _____ _____
4) Autre, préciser: _____ _____ [ ] 57
Nom de l'institution _____ [ ][ ] 58-59

20. Nom du personnel médical:
_____ [ ][ ] 60-61

PREMIERE VISITE

ANTECEDENTS PATHOLOGIQUES DIVERS

	Non	Oui.
Respiratoires, Asthme		
Cardiovasculaires		
Rhumatismes aigus		
Rénaux		
Digestifs		
Sanguins		
Anémie		
Foie/ictères		
Système nerveux		
Diabète		
Autre, Préciser		

Poids_____kg

Tension Artérielle_____/_____

Etat de Santé Général Satisfaisant		

Si non, Préciser _____

ANTECEDENTS GYNECOLOGIQUES

Dernières Règles Date_____

Durée_____

Saignements en dehors des règles		
Règles rapprochées		
Saignements post-coïtaux		
Varices		
Congestion des seins		
Examen gynécologique normal		

Si non, préciser _____

RENDEZ-VOUS

ANNEE	JANVIER	FEVRIER	MARS	AVRIL	MAI	JUIN	JUILLET	AOUT	SEPTEMBRE	OCTOBRE	NOVEMBRE	DECEMBRE

CONSULTATION DE SUIVI

Date	OBSERVATIONS (effets secondaires changement de méthode etc.)	RESULTATS C=Continue N=Nouv. méth. A=Abandonne	Prescriptions Traitments

FICHE de STATISTIQUES TRIMESTRIELLES de PLANNING FAMILIAL

Région de _____ Trimestre _____ 19____ Fiche remplie par : _____

No. d'Ordre	CENTRES	CONSULTS/TES			STERILET							PILULE						INJECTABLE			SPERMICIDES				CONDOM				CONSULTATIONS POUR Stérilité, Sous-fécondité	VISITES Pr. d'Autre RAISONS		
		Nouveaux/les	Anciens/nes	TOTAL	Nouvelles ds.la méthode	Expulsions	Réinsertions	Grossesse avec D.I.U.	Retraits	Visites de Contrôle	TOTAL (6+7+10+11)	Nouvelles ds.la méthode	Renouvellements	Visites liées à la méthode	TOTAL	Nbre. de Cycles donnés: Aux Nouvelles	Nbre. de Cycles donnés: Aux Anciennes	Nouvelles ds.la méthode	Renouvellements	TOTAL	Nouvelles ds.la méthode	Renouvellements	TOTAL	Nbre. d'Unités données	Nouveaux ds.la méthode	Renouvellements	TOTAL	Quantités données		Tests de Grossesse	Frottis	Informations
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
1																																
2																																
3																																
4																																
5																																
6																																
7																																
8																																
9																																
	TOTAUX																															

T.S.V.P.

COMMENTAIRES

Indiquer le nombre de changements de méthode :

DE STERILET à :	(Pilule..... ____	DE PILULE à :	(Stérilet..... ____
	(Injectable.. ____		(Injectable... ____
	(Spermicides. ____		(Spermicides.. ____
INJECTABLE à :	(Stérilet.... ____	SPERMICIDES à :	(Stérilet..... ____
	(Pilule..... ____		(Pilule..... ____
	(Spermicides. ____		(Injectable... ____

ACTIVITES CLINIQUES PENDANT LE TRIMESTRE

		Journée Complète	Demi-Journée
	(a. d'Activités Cliniques	____	____
NOMBRE de JOURS (où au moins	(b. un Médecin est présent	____	____
	(c. une Sage-Femme est présente.	____	____
	(d. un Infirmier d'Etat est présent	____	____
	(e. de Planning	____	____

SITUATION du PERSONNEL MEDICAL et PARA-MEDICAL

	Nombre	Mi-Temps	Plein Temps	Changement pendant le trimestre (1)
- Médecin	____	____	____	____
- Sage-Femme	____	____	____	____
- Infirmier d'Etat ..	____	____	____	____
- Infirmier	____	____	____	____
- Infirmière	____	____	____	____
- Assistante Sociale.	____	____	____	____
- Hotesse d'Acceuil..	____	____	____	____
- Autre Personnel Para-Médical	____	____	____	____

SITUATION de STOCKS

	Pilules	Stérilets	Injectables	Spermicides	Condoms
- Début du Trimestre....	____	____	____	____	____
- Réçu en cours du Trimestre	____	____	____	____	____
- Fin du Trimestre.....	____	____	____	____	____
- B é s o i n s	____	____	____	____	____

OBSERVATIONS :

A ____ le ____

Signé par ____

(1)- Préciser : Nouveau, Retraité, Muté etc...

Best Available Document

43

ANNEX IX: FRAC RECOMMENDATIONS ON INTEGRATION

1. Former le personnel clinique en matière d'IEC pendant que le personnel d'instruction continue d'exécuter ses tâches habituelles;

2. Créer un comité consultatif en matière d'IEC pour la santé, composé de tous les intervenants afin d'harmoniser les messages sur le planning familial;

3. Former un personnel sanitaire polyvalent (personnel apte à fournir toute une gamme de services) afin d'offrir tous les soins de planning familial et de protection maternelle et infantile;

4. Intégrer le planning familial à l'"ensemble des services liés à la protection maternelle et infantile" dès l'inclusion dans le programme de la formation aux soins sanitaires de base;

5. Susciter un changement d'attitude du corps médical à l'égard de la nécessité d'examens complémentaires avant d'ordonner des contraceptifs par:

   - la recherche opérationnelle (résultats accidentels provenant de prescriptions incorrectes, efficacité et utilité des examens médicaux...);

   - des voyages d'étude, et

   - sa participation à des conférences et à des séminaires nationaux et internationaux

6. Effectuer des recherches opérationnelles en vue de déterminer le volume de travail des pourvoyeurs de services;

7. Intégrer l'instruction en matière de planning familial dans une formation plus générale afin qu'elle ne soit pas conçue par les pourvoyeurs de services comme une activité supplémentaire;

8. Renforcer le système sanitaire avant d'y intégrer un volet de planning familial;

9. Faire participer toutes les autres organisations et créer un réseau de soutien pédagogique aux services de planning familial;

10. Elargir le programme de planning familial afin d'y inclure le secteur hospitalier, notamment par le biais des programmes post-partum et des programmes liés aux activités des autres départements hospitaliers (pédiatrie, gynécologie, salles de maternité);

11. Développer des contacts entre les hôpitaux, les centres de santé et autres postes de santé;

12. S'adresser aux sages-femmes traditionnelles pour l'enseignement de la protection maternelle et infantile et le planning familial, le réapprovisionnement en pilules et la distribution des préservatifs à domicile;

13. Etendre les services de protection maternelle et infantile et de planning familial aux secteurs constitués par les usines et les complexes industriels et les autres groupes sociaux;

14. Dispenser aux superviseurs une formation technique polyvalente orientée sur la protection maternelle et infantile et le planning familial afin de préserver leur crédibilité et leur autorité techniques vis-à-vis de leurs subalternes;

15. Etablir des protocoles de supervision polyvalents allégés afin de faciliter leur intégration au système de supervision existant;

16. Assurer la formation des superviseurs en matière de supervision;

17. Séparer la collecte des données et l'évaluation des visites de supervision;

18. Eviter la multiplicité des superviseurs et des visites de supervision par service ou par agent;

19. Améliorer l'élaboration des plans et des objectifs pour encourager une plus grande adhésion de la part des bailleurs de fonds;

20. Faire participer les communautés locales et régionales aux programmes de planification du planning familial;

21. Proposer, au besoin, des stratégies provisoires de réapprovisionnement avant l'entrée en vigueur de la politique d'intégration;

22. Utiliser l'information disponible afin d'assurer un programme de vérification et de gestion des stocks autogéré qui renforce le système de planification au niveau périphérique;

23. Mettre en place un système d'information plus acceptable en organisant une rétro-information du niveau central vers la périphérie et en encourageant l'analyse locale de certaines données recueillies, par l'établissement de protocoles appropriés;

24. "Démédicaliser" la prescription du contraceptif au profit des autres agents de santé compétents.

ANNEX X

Activités en SMI (rapportées) et leur fréquence/semaine

Centre	Pré-natale	Post-natale	Plan Fam.	Gyn.	Bébés Bien-Port.	Enf. Malades	Vacs.	R.O.	Démo. Nut.	Educ. en Santé	Niv.	Visites à Dom.	Act. Commu.
PMI Centrale	5	-	6	5	5	7	5	6	1	5	1	2	1
Badalabougou	5	5	1	5	2	6	2	6	1	6	1	2	-
Quartier Mali	1	-	-	3	2	-	2	-	-	-	-	5	-
Djikoroni	3	2	1	2	6	6	3	6	-	6	6	-	-
Hamdallaye	3	6	2	6	1	6	5	6	-	2	6	-	-
Lafiabougou	4	4	2	6	1	6	4	6	2	6	1	-	-
Korofina	3	1	2	4	1	6	5	6	-	-	-	-	-
Niarela	6	-	2	6	3	6	3	6	-	6	-	-	-
Missira	5	5	1	-	2	5	2	6	2	6	6	-	-
Sogoniko	3	3	6	-	2	6	5	6	2	-	-	-	-
Koulikoro	3	1	1	-	2	6	4	-	4	6	-	-	-
Banamba	2	1	1	-	1	-	1	-	1	-	-	-	-
Dioila	1	-	6	-	1	6	1	-	1	1	-	-	-
Kangaba	1	6	1	6	1	6	1	-	-	5	-	-	-
Kati	3	-	2	-	1	-	2	-	1	2	-	-	-

Etude des Données de Base

Projet Intègre des Services de Santé Familiale

Family Health International, September 1987

ANNEX XI: SUMMARY OF MCH/FP ACTIVITIES IN MALI

Clinic-based delivery of MCH/FP services

MOH clinic system (SMI)
MCH/FP services thru MOH, ongoing since mid-70's

Integrated Family Health Services Project

MOH, AMPPF
Upgrade MCH (FP, Nut, Immuniz, ORT) in Bamako and Koulikoro region,
USAID, 1986-1992, $8,000,000

Koutiala Health Project
Child survival Project in Koutiala
Immunizations, ORT, nutrition, butno family planning
World Visiion, 1988-91, $600,000

Projet Kaarta
Addition of natural FP methods to existing health activities
Canadian international development Assistance

UNFPA Phase I MCH/FP Project
integrating FP into MCH into 12 MCH centers in three administrative regions and Bamako
MOH MCH centers
79-84

UNFPA Phase II MCH/FP Project
integrating FP into MCH into additional four administrative regions- will provide training, equipment,
MOH MCH centers
85-88

World Bank Health and Population Project (PDS I)
integrated MCH/FP, improving health system, upgrading facilities, nutrition and family planning with MOH
To start 1989, PDS II $25,000,000

Clinic-based delivery of MCH services

Nutrition surveillance Project
UNDP, simple surveillance and intervention
1987-89, $648,000

Macina Health Project
CARE, 163 villages in 3 arrondissements in Macina cercle,
ORT, Immuniz, Health Worker Training
1987-89, $500,000

Save the Children
Rural PHC project

Banamba Health Project
Plan International, primarily an immunization program with ORT and nutritional surveillance added.
1987-89, $200,000

Clinical FP service Delivery only

AMPPF- Model Clinic Bamako
Provides clinic based FP services
1972-present,

AVSC
Surgical contraception at Hopital Gabriel Toure and maternity
USAID/AVSC

Vertical MCH Interventions

Pritech ORT Project
Management Sciences for Health, MOH
support for national anti-diarrheal program through training HW's, promoting ORT in community, local production and distribution ORS packets, education of mothers
1986-88, $300,000

Centre National Immunizations
MOH, UNICEF

FP non-clinical

CEDPA CBD family planning project in Katibougou
Rural Family planning service delivery project
87-89, $45,000

AMPPF/ENTERPRISE
family planning in the workplace, thru Unions

SOMARC

Social Marketing
under development

IEC

AMPPF/PCS IEC Program
AMPPF
IEC for promtion of FP services
86-87, $53,000

UNFPA initiatives
for women: thru Ministry of Education, family life education, $190,000
artists cooperatives in Bamako with MOH: FP, Population education, literacy training: $145,000
rural cooperatives: thru Ministry of Agriculture, literacy and FP and pharmaceutical products, $200,000

TRAINING

AMPPF model clinic
AMPPF provides both in-service practical training and pre-service theoretical training for nurses and nurse midwives in family planning

INTRAH, PAC I, PAC II
Currently on hold, expected to start up again soon
Training for MOH personnel
87-88, $60,000

JHPIEGO
Training MOH in reproductive health
73-91, $100,000

LOGISTICS

Contraceptive commodities supplied by UNFPA, IPPF, and USAID. Both MOH and AMPPF have responsibility for distribution to clinics. Family Planning Logistics Management project has undertaken study of commodity requirements and logistics needs and has been asked to do training in late 1988.

MANAGEMENT INFORMATION SYSTEMS

Separate MIS for service statistics exist at AMPPF and MOH. The Family Planning Division of CERPOD is undertaking a project to simplify and standardize collection of MCH/FP statistics and to provide training in support of new systems and procedures. CERPOD also plans to help develop research and evaluation units within AMPPF and MOH.