



PISAF – INTEGRATED FAMILY HEALTH PROGRAM

FINAL REPORT

MARCH 2006 – NOVEMBER 2012



FEBRUARY 2013

PISAF, the Integrated Family Health Program (Projet Intégré de Santé Familiale), is managed by University Research Co., LLC, in collaboration with Abt Associates under USAID Cooperative Agreement N°680-A-00-06-00013-00. The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

PISAF

On the cover:

Top left: Basile was diagnosed with severe malaria at 11 months old by PISA F-trained community health worker Cossi Dansou (center). Basile's mother (right) and older brother (left) look on. Cossi's rapid intervention probably saved Basile's life.

Lower left: CHW demonstrates how to hang and use a bed net

Top right: Pamphlets on Family Planning and Fistula

Lower right: A pediatrician trained in ETAT examines a child admitted to HOMEL hospital



Benin

Integrated Family Health Program



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Acronyms

| | | | | | |
|--------|---|------|---|--------|---|
| ACT | Artemisinin-based combination therapy | EEZS | Zonal Supervision Team | PBI | Performance-Based Incentives |
| ALDIPE | Association for Integrated Development and Environmental Protection (Association de Lutte pour un Développement Intégré et pour la Protection de l'Environnement) | EONC | Essential Obstetric and Newborn Care | PIHI | High Impact Interventions Package (Paquet d'Intervention à Haut Impact) |
| AMTSL | Active Management of the Third Stage of Labor | ETAT | Emergency Triage, Assessment, and Treatment | PIIHI | Integrated Package of High Impact Interventions |
| ANC | Antenatal Care | FP | Family Planning | PISAF | Integrated Family Health Project (Projet Intégré de Santé Familiale) |
| ARV | Antiretrovirals | HC | Health Center | PMI | President's Malaria Initiative |
| BACAR | African Office for Support and Advice for Achievements (Le Bureau d'Appui – Conseils d'Afrique pour les Réalisations) | HRM | Human Resource Management | PMTCT | Prevention of Mother-to-Child Transmission of HIV |
| BCC | Behavior Change Communication | HZ | Health Zone | PROSAF | Integrated Family Health Program (Programme de Promotion Intégrée de Santé Familiale dans le Borgou et l'Alibori) |
| CHW | Community Health Worker | IEC | Information, Education, Communication | QA | Quality Assurance |
| COGEC | Communal Management Committee (Comité de Gestion de la Commune) | IMCI | Integrated Management of Childhood Illness | QIT | Quality Improvement Team |
| DDS | Departmental Health Director (Directeur Départemental de la Santé) | IP | Integrated Package (Paquet Intégré) | RAMU | Universal Health Insurance Plan (Régime d'Assurance Maladie Universelle) |
| DRH | Human Resources Unit (Direction des Ressources Humaines) | IPC | Interpersonal Communication | RDT | Rapid Diagnostic Test |
| DRZ | Zone Distribution Warehouse (Dépot Répariteurs de Zone) | IPT | Intermittent Preventative Treatment | RMIS | Routine Malaria Information System |
| | | IR | Intermediate Result | SO5 | Strategic Objective 5 |
| | | ITN | Insecticide-treated bed nets | URC | University Research Co., LLC |
| | | LLIN | Long-Lasting Insecticide-Treated Mosquito Net | USAID | United States Agency for International Development |
| | | MOH | Ministry of Health | | |
| | | NGO | Nongovernmental Organization | | |
| | | NMCP | National Malaria Control Program | | |



Introduction

University Research Co., LLC (URC), in collaboration with Abt Associates, has provided technical assistance to the Ministry of Health (MOH) of Benin since March 2006 through the USAID-funded Integrated Family Health Project or PISAF (*Projet Intégré de Santé Familiale*). PISAF has supported the Government of Benin's national health policies and strategies and USAID's health objective: to increase the use of health services, products, and preventive measures in a supportive policy environment. The project improved the health status of the Beninese through collaboration with government agencies, other donors, and USAID projects, communities, and the private sector, as well as with nongovernmental organizations (NGOs).

The project has had several distinct phases. Emphasis during the first five years was on strengthening the health system and service delivery in the Departments of Zou and Collines, with limited support in the Borgou/Alibori Departments—a continuation of the predecessor project, PROSAF (*Promotion Intégrée de Santé Familiale dans le Borgou et l'Alibori*). In 2008 the project expanded significantly with the addition of funds provided under the President's Malaria Initiative (PMI), adding

malaria-focused activities to the project work plan at the central level and in all health departments. In 2010, PISAF received additional funding to reduce the incidence of obstetric fistula in Zou and Collines.

A one-year extension (2011-2012) changed the project's emphasis with two new foci: to scale up best practices in integrated family health to the Atlantique/Littoral Departments and to strengthen national leadership for quality improvement and institutionalization of best practices. Work under the extension also included professionalizing community-based health insurance schemes or *mutuelles* and enhancing community-facility linkages in Zou/Collines.

This final report presents the achievements in family health and health systems indicators. It highlights the major implementation strategies used and presents more detailed outcomes for each of the program's three intermediate results. The report is available in English and in French.

Major Achievements

Zou/Collines 2006–2011

| Indicator | 2007 | 2011 |
|--|-------------------------|-------------------------|
| % of target population with access to (i.e., receiving at least one element of) the family health services package | 24% | 37% |
| Number of couples (of reproductive age) with protection provided by contraceptive methods during a one-year period, based on the volume of all contraceptives sold or distributed free of charge to clients during that period | | 14,860 |
| % of health centers that received at least four formative supervision visits per year | 54% | 81% |
| % of health zone supervision teams (EEZS) that executed at least 75% of their annual action plan | 78% | 100% |
| Availability of family health products | 78% | 85% |
| Number of contraceptive products distributed in public health facilities | | 49547 |
| Number of people within target population with access to family health services | 318209 | 569575 |
| Mothers using any modern method of contraception* | Zou 14% Collines 26% | Zou 32% Collines 26% |
| Children less than 5-years old that slept under a bed net the night before* | Zou 25% Collines 24% | Zou 98% Collines 96% |
| Pregnant women that slept under a bed net the night before* | Zou 21% Collines 26% | Zou 92% Collines 44% |
| HIV testing among pregnant women* | Zou 23% Collines 9% | Zou 71% Collines 38% |
| Women who could cite at least 2 postpartum danger signs* | Z/C 63% | Z/C 91% |
| Women who could cite at least 3 newborn danger signs* | Z/C 40% | Z/C 73% |
| Women who could cite at least 3 sick child danger signs* | Z/C 25% | Z/C 73% |

* Data for 2006 from the DHS, Data from 2010 from the PISAF EQGSS Survey

Zou/Collines 2011–2012

| Indicator | 2010 Baseline | 2012 |
|---|---------------|------|
| % of all women delivering at participating health facilities receiving all three steps of AMTSL (Data from first 3 quarters of each year for comparability) | 79% | 87% |
| % of CHWs who have received a quarterly supervision visit from the health zone supervision team | 40% | 100% |
| % of children 0-59 months triaged upon admission to hospital*** | 44% | 68% |
| Child mortality rate in the first 24 hours in emergency ward of six participating ETAT hospitals*** | 17.5% | 9.7% |
| Number of fistula cases who were referred for a fistula operation | 65 | 103 |

* Data for 2012 represent Quarter 1 (September-December 2011), Quarter 2 (January-March 2012), and Quarter 3 (April-June 2012)

** MOH data for Children 0-11 months in Zou/Collines who completed immunization calendar in 2010 was 93%.

*** Baseline data averaged from 2010 data. 2012 data from Q1 of FY2012.

Atlantique/Littoral 2011-2012

| Indicator | Baseline (From Rapid Assessment in 2011) | 2012* |
|---|--|-----------|
| Total number of women delivered at participating health facilities by a qualified health worker | 2,273 | 5,646 |
| % of all women delivering at participating health facilities receiving all three steps of AMSTL | 39% | 70% |
| Integrated Package Indicators | October 2011 | June 2012 |
| % of all women attending ANC who were assessed correctly for pre-eclampsia/eclampsia | 9% | 77% |
| % of newborns for whom monitoring norms were respected in the first 6 hours of life | 2% | 78% |
| % of infants completely and correctly vaccinated before their 1st birthday | 24% | 48% |
| % of clients of reproductive age who came for any consultation who received FP counseling by a qualified staff member | 2% | 37% |

* Data for 2012 represent Quarter 1 (September-December 2011), Quarter 2 (January-March 2012), and Quarter 3 (April-June 2012)

* Implementation period ran from January 2012-October 2012

PMI (2008-2011)
ETAT data from 12 hospitals

| Indicator | Average level before ETAT (May-July 2010) | Average level with ETAT (August 2010-June 2011) |
|--|--|--|
| % of children 0-59 months triaged upon arrival | 2.4 % | 62% |
| % adherence to ETAT standards | 24.9% | 62% |
| Mortality rate in the first 24 hours of emergency care | 19.0% | 14.7% |
| % adherence to Severe Malaria standards | 54.2% | 66% |
| Severe malaria mortality rate | 9.5% | 6% |

Implementation Approaches/Strategies

PI SAF applied a systemic quality management approach to improve the overall performance of the health system— quality of care provided and efficiency of management support systems. In the implementation regions of Zou/Collines and Borgou/Alibori, emphasis was on improving teamwork at health facilities, developing systems to improve the use of data for decision making, and introducing continuous quality improvement to upgrade the quality of care and health outcomes. The collaborative improvement approach successfully brought together large numbers of health facilities and staff to develop and test, as well as to rapidly scale up, the use of best practices. This approach employed four major strategies:

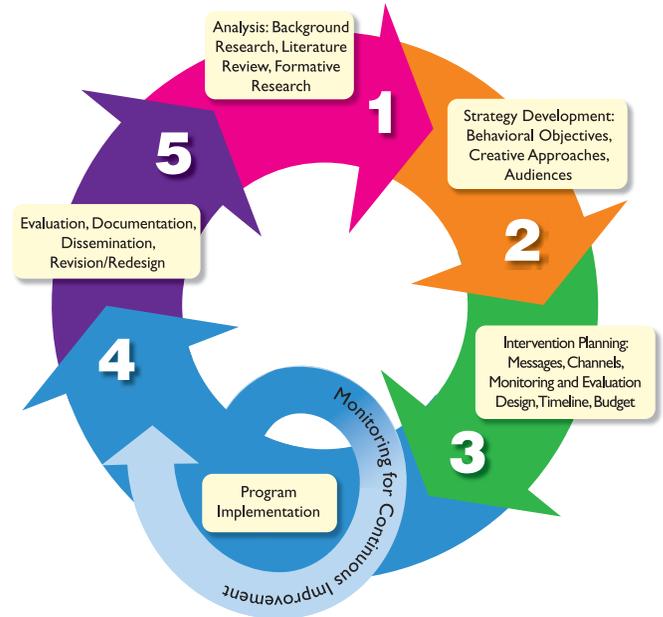
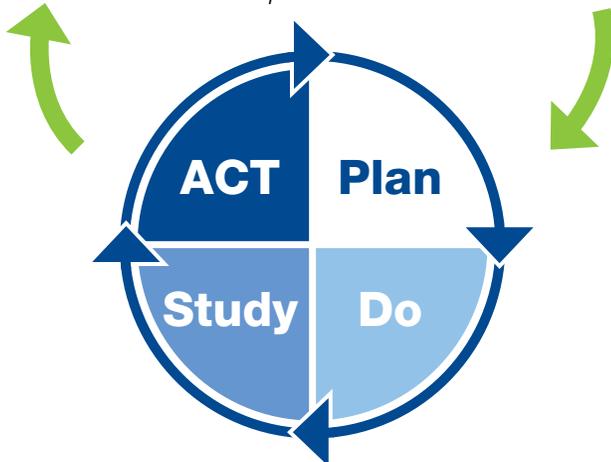
1) **training and cross-fertilization** through **Plan-Do-Study-Act (PDSA)** cycles to improve healthcare providers' knowledge and ensure compliance with norms and standards in essential maternal and newborn care, family planning, and both simple and severe malaria;

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?



The **communication interventions cycle** is designed to guide staff as they develop strategic behavior change and communication programs.

- 2) **health systems strengthening** to ensure that reliable data for decision making are available on a timely basis, that good forecasting can be done to procure health products, and that human, financial, and material resources are managed well;
- 3) **behavior change communication (BCC)** targeted at the population to increase knowledge, help clients take responsibility for their own health, and increase demand for health services;
- 4) **community-based health insurance schemes (*mutuelles*)** to increase financial access of the poorest households to health services.

Crosscutting strategies that proved particularly productive were:

- **Involving government and strengthening government capacity at all levels:** All activities were planned and implemented in close collaboration with the MOH staff; central-level involvement increased with the success of



quality improvement for both maternal care and malaria. The Ministry demonstrated their commitment to scale-up and began to institutionalize beyond the regions where PISAF worked;

- **Involving civil society and the private sector:** Several components of PISAF placed a strong emphasis on involving civil society: mutuelle creation and strengthening, COGEC training and support, and community theater. Benin's NGO sector grew more robust in the later years of PISAF, with

several NGOs becoming strong implementing partners in the obstetric fistula work. Private sector health providers in Zou/Collines also profited from a number of clinical and management trainings.

- **Gender mainstreaming** that focused on representation of women in all civil society activities, notably the Communal Management Committee (COGEC; *Comité de Gestion de la Commune*) and the mutuelle (see success story in Annex 5).

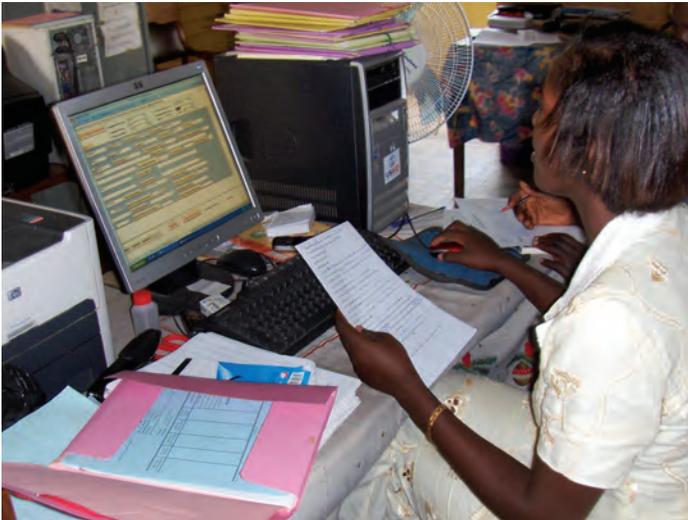
IR 1: Create a supportive implementation environment

| Intermediate Result 1 | What did we hope to accomplish? | Key Achievements |
|---|---|---|
| <p>Create a supportive implementation environment</p> | <ul style="list-style-type: none"> • A favorable policy environment for better access to quality health care and services • Strengthened decentralization • Institutionalization of quality management • Promotion of community involvement | <ul style="list-style-type: none"> • Ministry of Health institutionalized human resource management software (LogiGRH) • Strengthened management capacity of health zones for implementing planning, budgeting, and activities • Ministry of Health validated and adopted an Integrated Package of High Impact Interventions (PIIH) for family health • Finalized National Policy and Strategy on the Professionalization of Mutuelles following the National Strategic Plan for Mutuelles • Extensive evaluation and research studies on mutuelles contributed to the evidence base for the role of mutuelles in the Universal Health Insurance Plan (RAMU) • Initiated national dialogue on the need for a national Quality Assurance Framework (NQAF) • Strengthened managerial capacity of the National Malaria Control Program (NMCP) through formative supervision • Improved supervision system for malaria case management • Established Routine Malaria Information System (RMIS) |

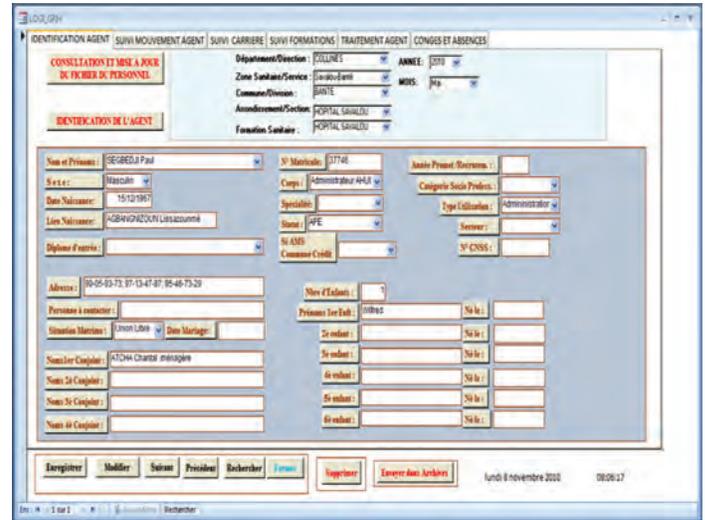
A supportive implementation environment is critical to achieving access to quality health care for the citizens of Benin. PISAF used a top-down and bottom-up approach to policy and advocacy, creating healthy interaction and dialogue between the different levels of the healthcare system, in which each level plays its role effectively. Improved management of the healthcare system was placed front and center through the development and provision of effective tools and processes that contribute to high performance of health facilities.

Institutionalized human resource management (HRM)

Benin's health sector faces continuing challenges in human resource management (HRM), including an insufficient number of skilled health workers and suboptimal management of existing personnel. To address these problems, PISAF applied the quality improvement model of collaborative improvement to HRM in Zou/Collines health facilities. Human resource managers and supervisors were trained so that each individual understood the importance of maintaining personnel files and elements needed to improve the personnel files. Best practices for managing and tracking personnel files were established (see box of key components of human resource management) and implemented at 12 sites in Zou/Collines including the Departmental Health Unit, the departmental



Training of health personnel on electronic data entry



Screen shot of LogiGRH software

hospital, six health zone offices, and four zonal hospitals. During the final year of the project, these best practices were also implemented at 13 sites in Atlantique/Littoral.

While each health center and hospital in the targeted departments had a systematic method for maintaining and tracking personnel files, they lacked a mechanism for sharing information across sites. PISAF, in close collaboration with the Zou/Collines Director of Health, developed software to manage personnel data. This software, called LogiGRH, tracks key information such as job description, performance review, hire date, and training received, and enables all personnel files to be managed electronically. The centralized feature of the software allows the electronic file to follow individuals if they move to other facilities within the Department. PISAF provided training to human resource managers and supervisors for using the software to forecast personnel needs as well as for managing electronic human resource data.

At a central level, the Human Resources Unit (DRH) wanted to update their systems to address weaknesses in their existing software. PISAF advocated for the use of LogiGRH, and a subsequent field visit allowed the Director of Human Resources and

PISAF, in close collaboration with the Zou/Collines Director of Health, developed software to manage personnel data. This software, called LogiGRH, tracks key information such as job description, performance review, hire date, and training received, and enables all personnel files to be managed electronically.

his team to compare the capabilities of LogiGRH and the existing software and determine whether LogiGRH could fulfill the needs of the Department. The original LogiGRH software had been developed for only one zone, so modifications were required to meet needs at the national level. PISAF technical advisors worked closely with the DRH to prepare the software and training manual for nationwide scale-up, including a validation workshop conducted with PISAF staff, DRH, and human resource managers to build consensus on their approach to LogiGRH scale-up. Training in the use and maintenance of LogiGRH was provided to 23 central-level managers from the MOH and rolled out using cascade training sessions. The MOH is now in a position to collect, analyze, and continually update human resource data and to make better-informed decisions about personnel needs.

Components of Human Resource Management

- Presence of a job description
- Documentation of annual performance evaluation
- Management of personnel files
- Training of personnel
- Management of computerized personnel files

Strengthened Management Capacity of Health Zones

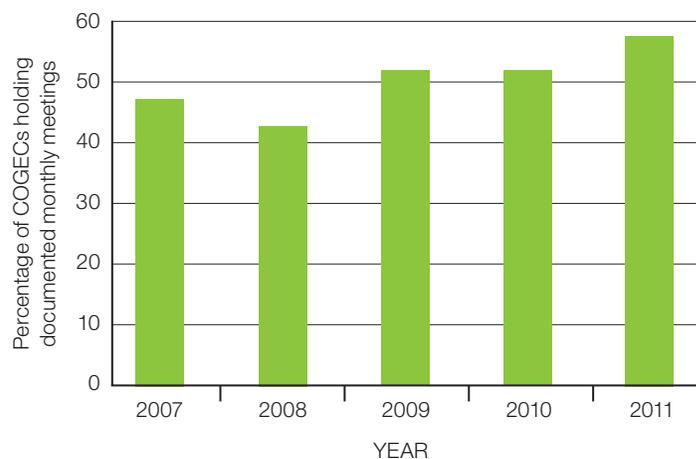
The policies and decrees of Benin's Ministry of Health enable effective decentralized planning, facilitate financial and human resource management of health zones, and foster the allocation of health budgets by local governments. PISAF has nurtured implementation of these policies, building competencies at local levels to effectively carry out their new responsibilities – including ascendant planning – and continuing dialogue with central-level actors on how to oversee and support these decentralized actors in their job performance.

PISAF supported decentralization in Zou/Collines through:

- Disseminating decentralization and ascendant policies to all health levels
- Ascendant planning
- Management training and tools
- Routine supervision

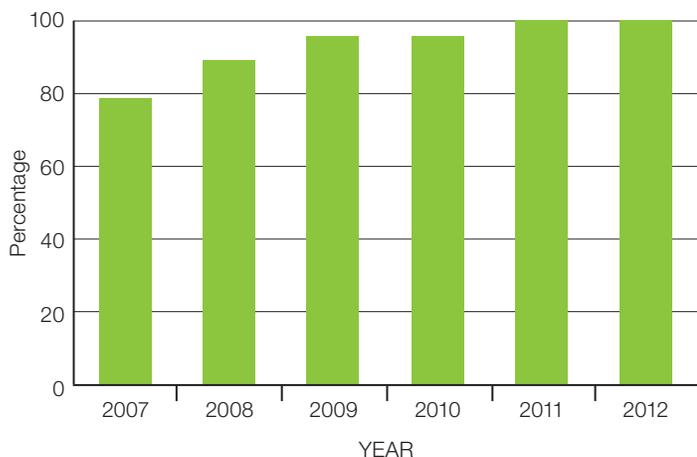
PISAF, in collaboration with the Departmental Health Director (DDS) and District Chief Medical Officers, disseminated decentralization guidelines and a manual for integrated ascendant planning procedures. These guidelines and manual provided stakeholders with a better understanding of what decentralization entails, clearly defining the purpose of

Figure 1: Proportion of COGECs that held documented monthly meetings during the quarter, PISAF, 2007-2011, Zou/Collines



ascendant planning and how its implementation would lead to improved management of and coordination between health services and the larger healthcare system. Local management bodies, known as Communal Management Committees (COGECs), play a key role in decentralization and ascendant planning. The 2006 Management Assessment conducted by PISAF revealed that these bodies needed strengthening in order to adequately carry out their responsibilities. Fewer than 50% of COGEC members knew the criteria used in their appointment. While 60% of COGECs participated in preparing action plans, fewer than 30% were involved in implementing those action plans. PISAF supported the Zou/Collines DDS for training COGEC members in their roles and responsibilities, planning, and budgeting. COGEC members also received training in facilitation and documentation techniques, in order to conduct and lead efficient meetings and make informed decisions based on documentation. With PISAF and local DDS support, COGECs were able to prepare action plans for their local health center. These trainings and routine supervision contributed to better overall engagement of the COGECs with the healthcare system. Figure 1 shows improvements made in the frequency of COGEC meetings in Zou/Collines.

Figure 2: Proportion of Zonal Supervision Teams (EEZS) implementing at least 75% of their annual action plan, Zou/Collines, 2007-2012



During this time, PISAF also worked with zonal level supervision teams, providing instruction in action planning as well as tools for financial management and supervision to assist in implementing those action plans. To ensure that action planning was understood across all levels of the healthcare system, PISAF supported the Ministry in developing standardized planning facilitation modules. The final modules were disseminated to zonal management staff to use in their work. These efforts contributed to dramatic improvements in the execution of zonal action plans (2007 to 2012), as shown in Figure 2.

The ascendant planning process begins at the health facility. Routine supervision was critical to ensure that health centers were developing appropriate micro-plans for implementing their planned activities, and that staff were in compliance with government-approved policies. To this end, PISAF organized quarterly reviews of action plans, jointly with the DDS, to monitor performance and to support health centers' micro-planning for the next quarter. These supportive on-site supervisions also provided opportunities to reinforce staff knowledge and skills and ultimately to improve performance and quality of services.

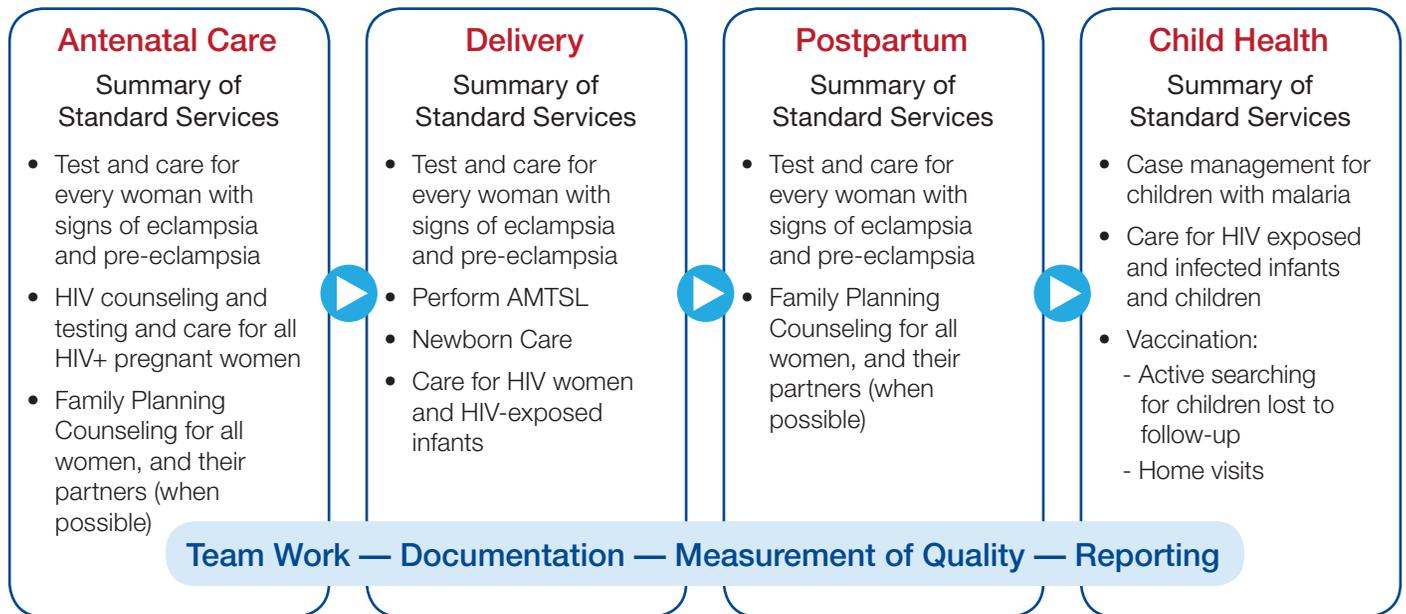
Institutionalized Integrated Package of Quality Family Health Practices

Initially PISAF's quality improvement work was organized by disease or area of care: for example, the family planning collaborative, uncomplicated malaria collaborative, and essential obstetric and newborn care collaborative. In 2010, the project synthesized its learning from these targeted collaboratives to develop an integrated package of quality family health services. The synthesis enabled health teams to achieve quality improvement by focusing on a key set of family health practices. This set of evidence-based interventions was tested in all 126 health facilities throughout the Zou/Collines departments, with an emphasis on integrating the various technical components of family health (essential obstetric and newborn care, prevention of mother-to-child transmission of HIV/AIDS, family planning, HRM, treatment of uncomplicated malaria, and *mutuelles*) in an environment of ongoing quality improvement. The integrated package model is represented in Figure 3. This experience identified several best practices for implementing the integrated package of services and set the stage for scale-up.

These best practices were applied in the extension year when the Integrated Package of High Impact Interventions, also referred to as PIIHI (Paquet Intégré d'Intervention à Haut Impact), was incorporated into the MOH's new primary healthcare High Impact Interventions Package (PIHI; Paquet d'Intervention à Haut Impact). PISAF, in close collaboration with the MOH, applied those best practices to rapidly scale up the PIIHI to 36 public health centers and 11 private health facilities in the Atlantique/Littoral Departments. Details of this work are provided under IR2.

Figure 3. Integrated Package of Family Health Services

Every client who comes to a health facility for Antenatal Care, Labor and Delivery and Postpartum visits will receive high-impact, integrated health services according to guidelines.



Cross-cutting support activities

Ensure availability of drugs and supplies

MEDISTOCK

Posted health workers motivated by an effective management system

HUMAN RESOURCE MANAGEMENT

Accessibility care and prevention services with the full participation of communities

CHW, MUTUELLES, COMMUNITY MOBILIZATION

Facilitated policies and strategies to improve financial access to quality health services

In 2008, the Government of Benin began to develop a Universal Health Insurance Plan and in 2010 identified existing *mutuelles* as a possible mechanism through which RAMU might reach the most remote areas and communities. *Mutuelles*, or community health insurance schemes, have existed in Benin since the 1990s but always in an informal manner. *Mutuelles* provide health insurance coverage to clients in hard-to-reach communities where members pay a monthly/annual fee and, in return, access local health services for no charge or at very subsidized rates. Pooled funds from the members create a smaller and shared risk. However, to play a key role in implementation of RAMU, *mutuelles* would need a more formal infrastructure and management system.

Mutuelle policy and strategy activities

- Finalized and disseminated National Strategic Plan for *Mutuelle* Health Organizations
- Conducted midterm evaluation of health *mutuelles* supported by USAID in Borgou/Alibori
- Conducted the following studies:
 - 1) Indigent health funds and *mutuelles*
 - 2) Role of *mutuelles* in promoting community health
 - 3) Factors associated with *mutuelle* member loyalty
 - 4) Professionalization experiences of *mutuelles*
- Declared Universal Health Insurance Scheme
- Held 1st National Forum on *Mutuelle* Health Organizations for ongoing and improved quality of services and health care in Benin
- Finalized National Policy and Strategy on Professionalization of *Mutuelles*.

Professionalization Strategy Vision

“By 2017, Benin will have a network of large, well-structured, law-abiding, nationally, regionally, and internationally credible mutuelles which respect their commitments to their members and healthcare workers.”

To gain a clearer understanding of the current status of *mutuelles* in the country, PISAF conducted an assessment of the professionalization experiences of existing *mutuelles*. At the same time, PISAF created a national movement around *mutuelles* through information dissemination and public discussions such as the 1st National Forum on *Mutuelle* Health Organizations for ongoing and improved quality of services and health care. This 2010 forum enabled participants to exchange ideas on: basics of professionalization, factors influencing client loyalty, contribution of *mutuelles* to use of health care/services and promoting health, and the synergies of activities between *mutuelles* and other mechanisms for protection from the risk of disease.

With PISAF’s financial and technical support and strong collaboration with implementing partners such as the World Bank and the Belgian Technical Cooperation, a National Policy and Strategy on the Professionalization of Mutuelles was finalized in August 2012, formally recognizing mutuelles and their role in the health system.

The National Forum made it evident that, in order for *mutuelles* to professionalize, they needed clear guidance in the form of a policy, and the State and implementing partners had a large role to play. With PISAF’s financial and technical support and strong collaboration with implementing partners such as the World Bank and the Belgian Technical Cooperation, a National Policy and Strategy on the Professionalization of *Mutuelles* was finalized in August 2012, formally recognizing *mutuelles* and their role in the health system. The Strategy includes: a

mission, scope, a conceptual framework for professionalization, a baseline study on professionalization, a vision for *mutuelles* through 2017, and professionalization implementation and financing strategies. With this recognition comes the need to build the technical, financial, and operational capacity of *mutuelles* as well as the management capacity of those who run them. While PISAF's work cleared a path for *mutuelles*, the momentum and political will of the government and partners are necessary to ensure that *mutuelles* are successful in providing health insurance to those who need it most and in their new role within the RAMU.

Initiated national dialogue on a National Quality Assurance Framework

Toward the end of the project, PISAF organized a Round Table and an Open Door Day to share the breadth of project achievements from case management of severe malaria to logistics management. Materials from the event can be found in Annex 6. Participants came from all levels of the MOH departments as well as the national and international partners working in the health sector in Benin. PISAF used the event to advocate for institutionalizing best practices within the MOH in order to sustain achievements in the longer term. During the events, the Minister of Health expressed her commitment to scale up PISAF's evidence-based practices and results beyond Zou/Collines to other departments nationwide. Based on this commitment, and on the Minister's specific request, PISAF organized a July 2012 workshop on leadership and management of quality assurance programs, geared to senior level managers within the MOH central and departmental levels. The workshop offered opportunities to summarize the various Quality Assurance approaches used in Benin and to highlight the complementarity of the different approaches. The workshop served as a catalyst to reinvigorate work on the National Quality Assurance Policy, in the making for many years, through developing a draft framework.

Strengthened Managerial Capacity of the National Malaria Control Program (NMCP)

PISAF worked to strengthen the NMCP's management capacity focused on the supply chain management of malaria control inputs (MCI). In order to identify weaknesses, PISAF collaborated with the NMCP to conduct a needs assessment of the entire inputs supply chain, analyzing procurement, distribution, orders, and inventory management. The needs assessment identified two priority areas: 1) strengthening logistics with the distribution warehouses at the health facility and health zone levels, and 2) logistical management of MCI at the Central Medical Stores level in Cotonou and its two regional warehouses.

These priority areas were addressed through training central and health zone staff in logistics management software and monitoring of malaria control inputs, hiring a Supply Chain Management advisor based within the NMCP, and building skills with the NMCP on annual integrated work planning.

Improved supervision system for malaria case management

PISAF trained public and private providers on updated 2007 guidelines for case management of uncomplicated malaria. To complement this training, PISAF worked with the NMCP to update their curriculum for formative supervision and to ensure integration of updated details of malaria-specific supervision. The updated curriculum was made available to all staff throughout the healthcare system, in both public and private sectors. In total, PISAF trained 34 health zone supervision teams on these updated supervision curricula. With PISAF funding, all departments were supported to conduct routine supervision.

Established Routine Malaria Information System (RMIS)

To compare Benin's malaria performance indicators with global malaria morbidity and mortality indicators, and to improve monitoring of malaria cases at every level of the health system, PISAF supported the MOH to establish the RMIS and a routine surveillance procedure manual. Data management staff were trained on RMIS to improve the quality and completeness of routine malaria data collection. Systematic post-training follow-up ensured the correct implementation of RMIS.

Key indicators in treatment of malaria—such as the proportion of pregnant women receiving Intermittent Preventive Therapy (IPTp) and the proportion of children under 5 with a positive rapid test who were correctly treated with ACTs—did not exist previously in the RMIS; but these were integrated with PISAF support. Due to the new malaria information system, Benin's NMCP was able, for the first time, to complete and submit standardized data charts on morbidity and mortality, prevention, and inputs management to the World Health Organization for inclusion in their malaria control bulletin.



Due to the new malaria information system, Benin's NMCP was able, for the first time, to complete and submit standardized data charts on morbidity and mortality, prevention, and inputs management to the World Health Organization for inclusion in their malaria control bulletin.

IR 2: Increase access to quality services and products

| Intermediate Result 2 | What did we hope to accomplish? | Key Achievements |
|---|---|---|
| Increased access to quality services and products | <ul style="list-style-type: none"> • Improve availability of family health products • Improve quality of family health services • Increase financial access to health services | <ul style="list-style-type: none"> • Developed and scaled up comprehensive logistics management software, Medistock • Improved quality of integrated family health services in all 147 health facilities in Zou/Collines • Made Intermittent Preventative Treatment available for all pregnant women in the 12 departments throughout Benin • Trained 542 private sector providers in malaria case management policy – ACTs and Rapid Diagnostic Tests (RDTs) • Trained 288 health workers in clinical Integrated Management of Childhood Illness (IMCI) throughout all departments in Benin • Implemented Emergency Triage, Evaluation, and Treatment for malaria in all 12 hospitals nationwide • Established 59 new health mutuelles in Zou/Collines and Alibori • Established 9 networks of health mutuelles in Zou/Collines and Alibori • Piloted the use of performance-based incentives for improved quality of care. |

PISAF embraced Quality Assurance and the institutionalization of ongoing improvements to ensure that health workers will be able to sustain quality after the project ends and will continue working to meet the needs of the population. The following elements constitute the core of PISAF's QA approach.

1) **use of data for decision making:** Emphasis on data began with a comprehensive management assessment at project initiation, which identified improvement priorities. Health Zones and Departments were trained in and routinely managed key performance indicators, especially those linked to the collaborative improvement initiatives and, later, the scale-up of the integrated package.

2) **strengthened clinical, management, and communications skills:** Healthcare providers and health services managers must understand standards in order to practice them. PISAF provided technical and financial support for training in: a) active management of the third stage of labor (AMTSL), b) essential newborn care, c) the new protocol for treating simple malaria with ACTs and the proper use of rapid diagnostic tests, d) prevention of mother-to-child transmission of HIV (PMTCT) and biological surveillance of pregnant women with HIV, e) contraceptive technology and interpersonal communication, f) drug management, and g) completing the new health information system tools. PISAF also trained community radio stations and theatrical and folklore companies to prepare messages on family health themes in local languages. COGEC members were trained in QA to support health facilities in implementing collaboratives.



AVLAME Health Center before renovation



AVLAME Health Center after renovation

3) **improve care and the care environment:** PISAF provided basic medical supplies and equipment to health facilities where they were lacking. Due to poor infrastructure conditions at some health facilities, support was provided to the Health Department for renovations.

4) **reorganize care provision systems:** Reorganization involved making all components of the family health package available five days a week, which necessitated teamwork and reorganization of patient flows; better systems of referral and counter-referral to communities to ensure seamless continuity of care; and greater community involvement, notably through COGECs.

Improved logistics management (Medistock)

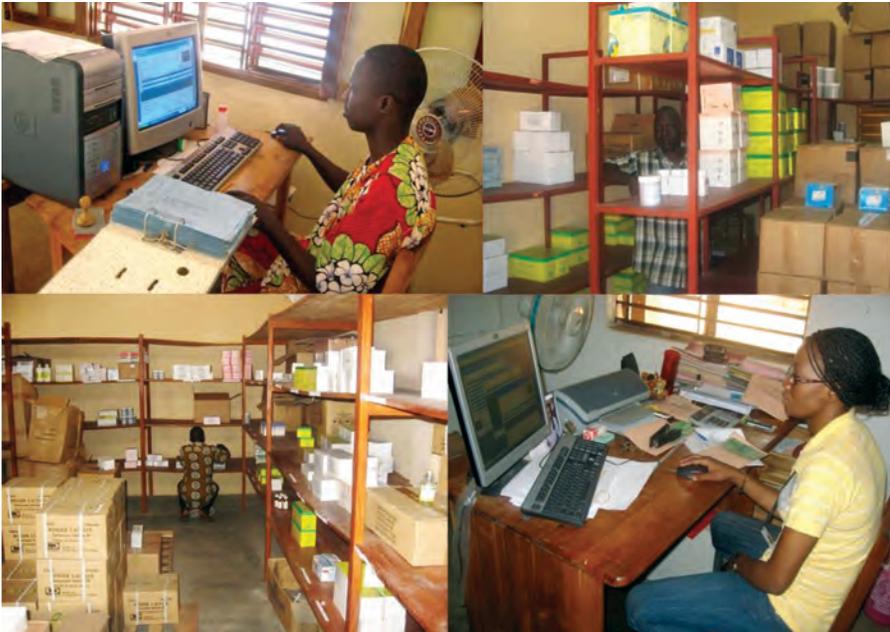
The baseline Management Assessment revealed large variations in the percentage of providers trained in logistics: 7% in one zone and 38% in another, with a Zou/Collines departmental average of 16%. To strengthen the logistics system and improve distribution of family health products in Zou/Collines, PISAF established departmental warehouses, provided them with equipment, and built the capacity of DDS and health zone drug managers. Drug managers received training in the use of family health product management tools and skills

including: forecasting, ordering, and on-time information sharing and distribution. While the project facilitated systems improvements at department and zonal levels, national level stock-outs remained a periodic challenge.

While training drug managers on management tools, PISAF also adapted the existing drug inventory software used at the Central Medical Stores (CAME). The new software, Medistock, was created through a close collaboration between technical project staff, and Zou/Collines Department and pharmaceutical management staff. To ensure the proper use of Medistock, PISAF trained a master set of trainers from the DDS and health zones who, in turn, trained lower-level personnel. The formative supervision was conducted as a joint effort of PISAF and DDS staff; it strengthened the capacity of actors to improve the organization of supply and management of drug stocks, ensured effective use of Medistock in real time, ensured the quality of logistical data used in decision making, and ensured compliance with standards for logistical management. Shortly

One depot manager in Savalou reported:

"We rarely have stock-outs in the health centers now—Medistock helps us to better see the big picture, predict stock needs further in advance, and prevent drug waste."



Drug managers were trained in forecasting, ordering, and on-time information sharing, contributing to improved availability of family health products in the Departments.

Medistock expands to monitor malaria drugs

Under PMI, the needs assessment identified weak management of malaria control inputs (MCI). PISAF addressed this gap by training 74 DDS members from all 34 health zone distribution warehouses in Medistock use and using the software to improve monitoring of MCI management. To ensure the transfer of skills to all health zone levels, PISAF trained 9 NMCP senior staff members and an additional 150 Medistock trainers from all 12 departments.

after Medistock's creation it became evident that, although individual warehouses could manage their health product inventory, necessary data on inventory and forecasting were not reaching the central level in time. In May 2010, PISAF introduced a web-based exchange platform called Medistock.web. The new platform enabled faster and more secure access to supply-chain data between the distribution warehouses in Zou/Collines, so health zones could more easily redeploy any drug overstocks.

Medistock contributed greatly to improved availability of essential drugs in health facilities over the life of the project. In the first five years of PISAF, Medistock was scaled up in all six Zou/Collines distribution warehouses and was expanded to Atlantique/ Littoral and Borgou/Alibori during the extension year. The software was adapted by partners such as ESTHERAID to manage antiretroviral (ARV) stocks and by the National Malaria Control Program to monitor malaria control inputs in 34 health zone warehouses across the country. More details on the Medistock work can be found in Annex 5.

Improved delivery of integrated family health services

PISAF introduced quality improvement in all 136 health facilities of Zou/Collines, using a collaborative improvement approach.

As shown in the graphic below, health workers initially focused on improving one or several elements of the family health package—essential obstetric care, malaria, and later family planning and PMTCT—thus acquiring skills in monitoring quality, identifying solutions, and testing for improvement. Improvement collaboratives were also started to link *mutuelles* with quality of care and HRM. Subsequently, health workers embraced the application of quality improvement to the whole package of services for integrated family health, which entailed more substantial changes in clinic flow, multitasking, and engaging with clients and communities.

Timeline of the collaborative phases and number of sites

| | 2008 | | | | 2009 | | | | 2010 | | | | 2011 | |
|----------------------------|------|----|----------|----|----------|----|-----------|-----------|------|-------------------------------|----|----|------|---------------|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| EONC/AMTSL | | | 17 sites | | | | +22 sites | | | +20 sites | | | | +67 sites |
| Uncomplicated Malaria | | | | | 16 sites | | | +42 sites | | +20 sites | | | | +62 sites |
| Severe Malaria | | | | | | | | | | 5 sites (Z/C) + 8 other sites | | | | |
| Family Planning | | | | | | | 14 sites | | | +20 sites | | | | +92 sites |
| PMTCT | | | | | | | 22 sites | | | +8 sites | | | | +12 sites |
| Mutuelles | | | | | | | 14 sites | | | | | | | +45 mutuelles |
| Human Resources Management | | | | | | | | | | 13 sites | | | | |

Light color = Demonstration phase

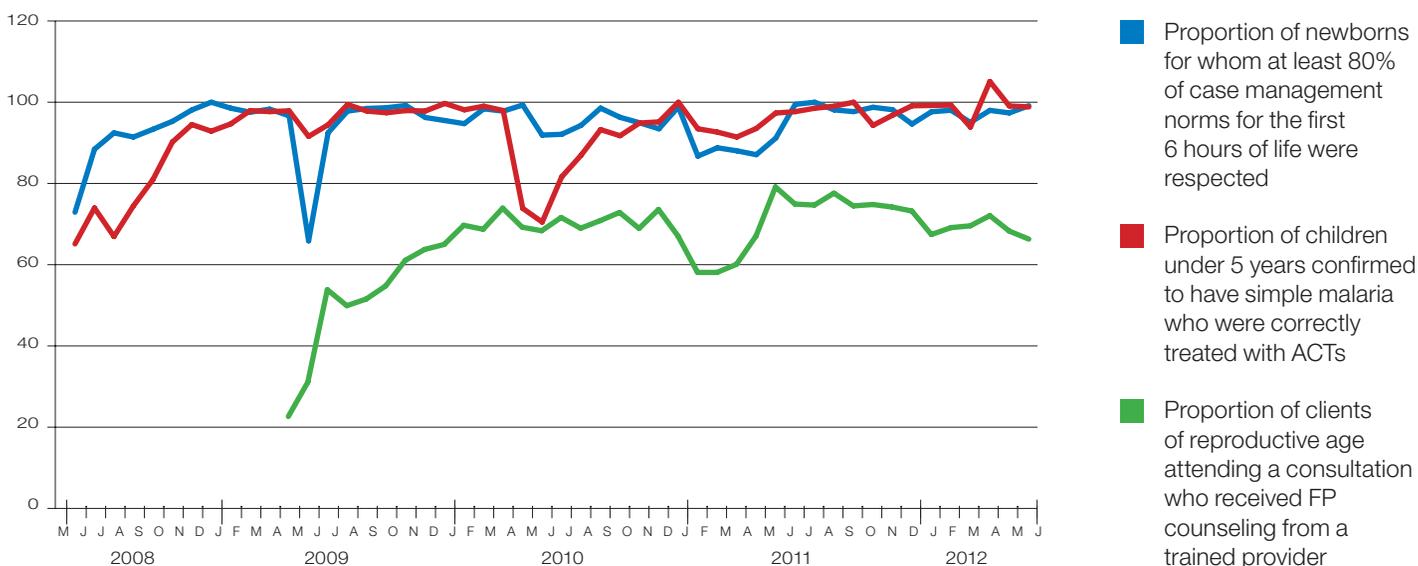
Color with dark stripes = Second extension phase

Dark color = Extension phase

..... = Scale-up phase of the integrated package in Zou/Collines

Results for key indicators are presented below.

Figure 4: Evolution of key indicators for the integrated package in Zou/Collines (May 2008 – June 2012)



Source: Collaborative Data

Figure 5: Impact of AMSTL in reducing occurrence of postpartum hemorrhage in Zou/Collines, (May 2008 – December 2010)

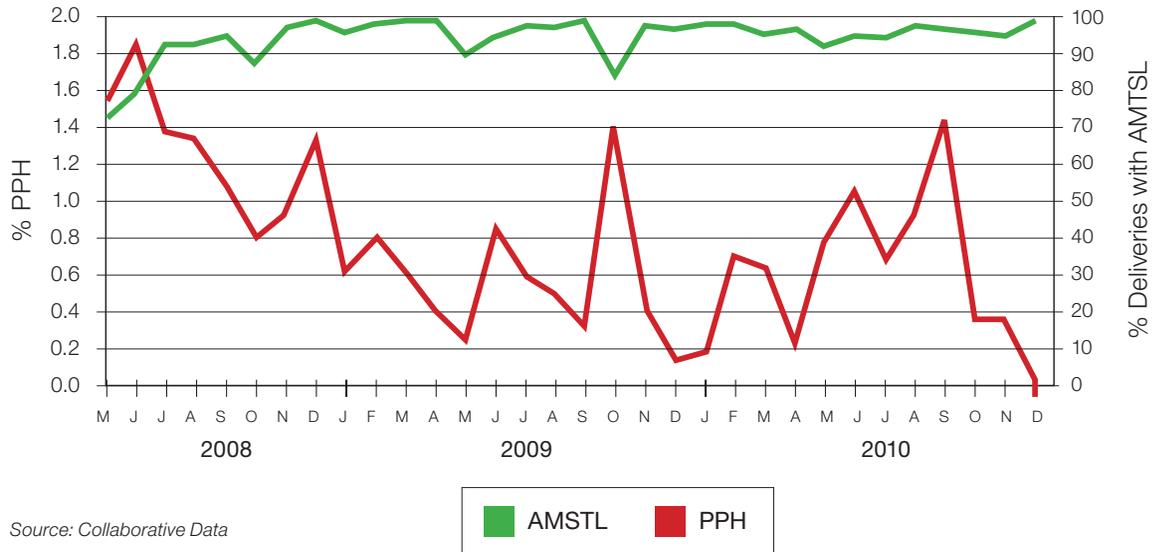


Figure 6: Evolution of health worker performance scores by clinical category, Zou/Collines, 2006 and 2010

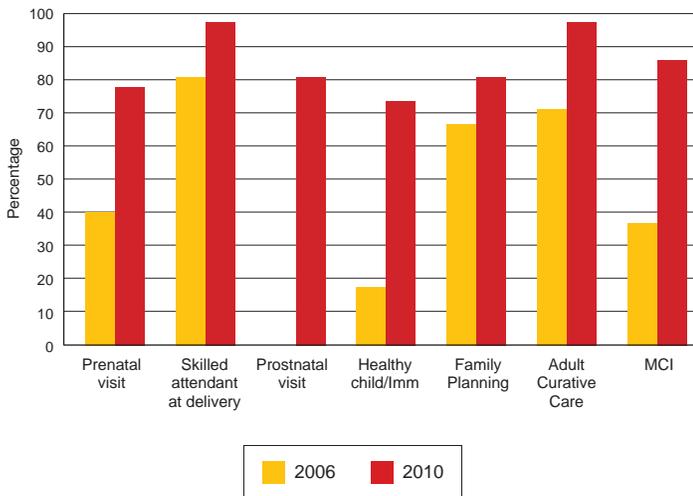


Figure 7: Evolution of key health system indicators, Zou/Collines, 2006 and 2010

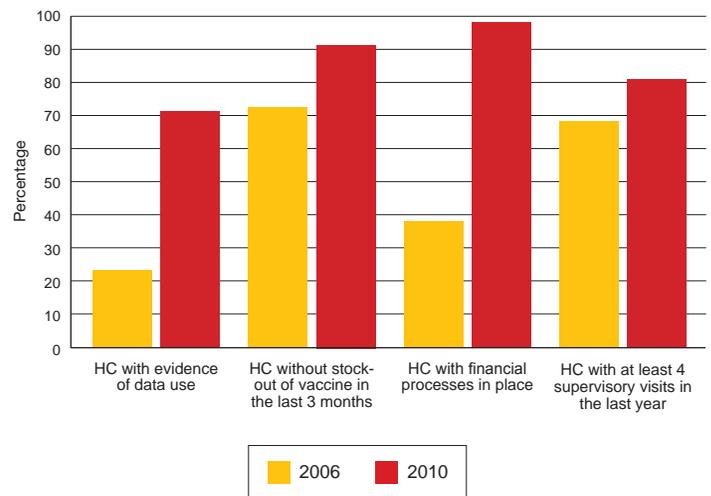
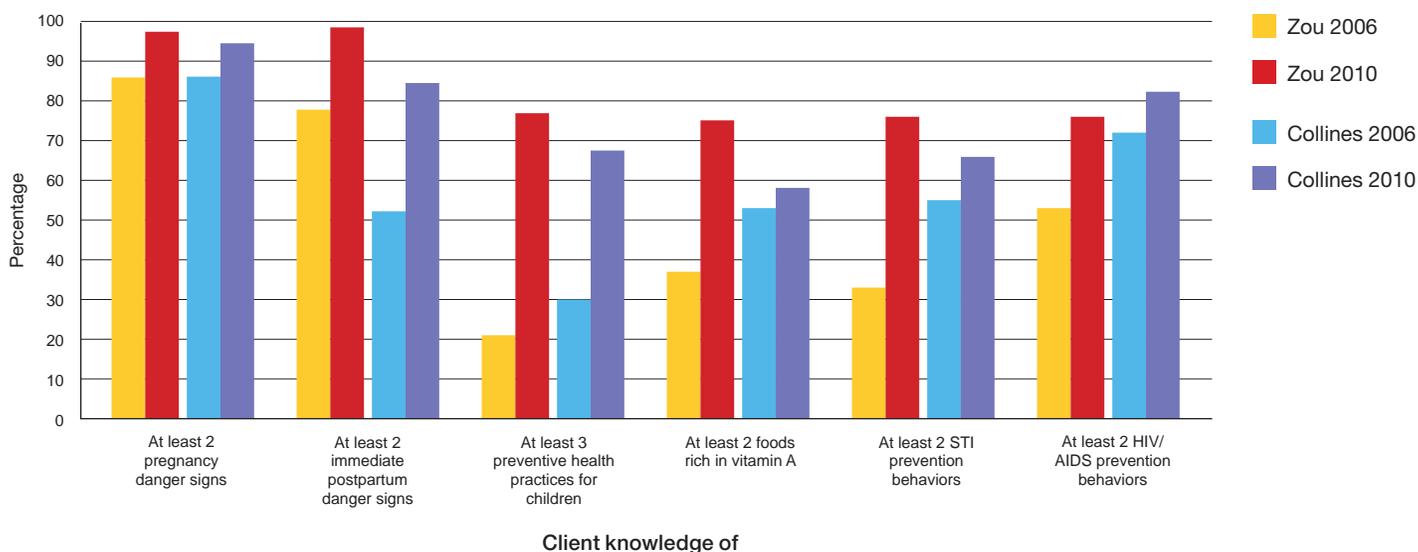


Figure 8: Evolution of client knowledge, Zou / Collines, 2006 and 2010



In 2011, PISAF developed a manual and job aid for coaches, documenting the experiences and lessons learned with its pool of coaches.

Coaching for Quality improvement

Coaching played a key role in reinforcing the changes identified through collaborative learning sessions. During the project, PISAF developed a pool of 106 coaches in Zou/Collines and 20 in Borgou/Alibori to provide on-site, post-training follow-up for health clinic personnel to support the integration of newly learned skills into their work environment. The coaches themselves were trained health personnel who had demonstrated qualities essential for a coach and who had been identified jointly by PISAF and the Department. Coaches received subsequent training in QA, interpersonal communication, and clinical updates in order to provide effective coaching to Quality Improvement Teams (QITs). In collaborative improvement methodology, coaches provide ongoing reinforcement of the QIT's role and its function through: continued on-site clinical and QA training and refreshers, verification and application of data monitoring, addressing any interpersonal team dynamics that could hamper the team, and moral support for team members.

Figure 9: Proportion of children under 5 years confirmed to have simple malaria who were correctly treated with ACTs, Cotonou 1&4 and AZT Health Zones



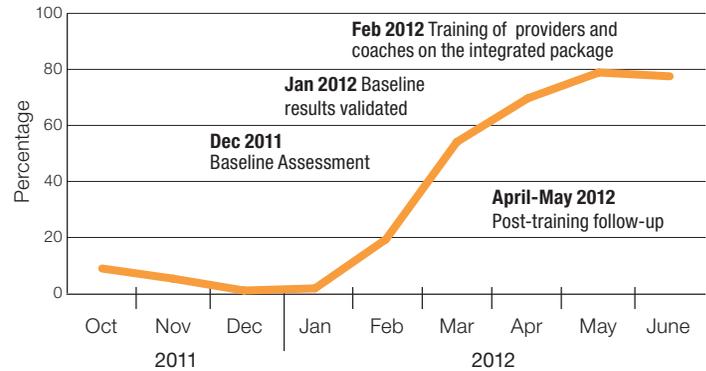
Coaches were initially identified for one clinical area, to correspond with the collaboratives. However, with development and implementation of the integrated package of family health services, 83 coaches were retrained to provide effective support for the integrated package in Zou/Collines.

In October 2011, PISAF developed a manual and job aid for coaches, documenting the experiences and lessons learned with its pool of coaches. The manual describes both the theoretical and practical aspects of coaching, as well as reinforcing coaches' roles and responsibilities; the pocket job aid reminds coaches of key questions and phrases to use with QITs during on-site visits. Both tools were field tested with PISAF coaches and distributed for their use.

Scale-up

In September 2011, PISAF received a one-year extension to implement a series of innovative activities. Included in this package was the scale-up of best practices for the integrated family health package to the Atlantique/Littoral Department. The lessons learned from developing and implementing the integrated package in Zou/Collines were synthesized into a set of targeted activities that would allow the integrated package to be implemented much more quickly and efficiently in the scale-

Figure 10: Proportion of women in ANC screened for pre-eclampsia/eclampsia, Cotonou 1&4 and AZT Health Zones



up zones. This process was guided by staff from the key central-level Directorates of the MOH with technical support from PISAF. The MOH took the lead in planning and implementing the scale-up, thus ensuring ownership of the scale-up by the Ministry from the outset. Such ownership increases the likelihood of longer-term institutionalization of the integrated family health package and the related use of quality improvement as an essential element of the implementation strategy.

Key strategies applied for scale-up included:

- Provision of technical assistance to the MOH to develop and carry out a scale-up plan:** PISAF coordinated with the MOH to identify the key activities to be scaled up to Atlantique/ Littoral in the extension year, and to develop a detailed scale-up plan to achieve rapid results. Key activities included the integrated package, the human resources database, and Medistock.
- Introduction of the integrated family health package:** PISAF worked with departmental and zonal health teams and facilities to rapidly introduce the PIHI and QA approaches in the two scale-up zones, based on best practices and lessons learned from implementation in Zou/Collines. The MOH at the national level led all activities including orientation on QA concepts and the integrated package and development of the work plan. A November 2011 workshop

for departmental and zonal stakeholders resulted in a set of 24 activities for the scale-up process. Skilled master coaches from Zou/Collines participated in the February 2012 training of coaches and health center personnel.

In just nine months, family health indicators in the scale-up health zones increased dramatically. See Figures 9 and 10.

Improved preventative and curative malaria services for women and children

To increase access to malaria services and products, PISAF worked in four main areas:

- 1) ensuring that Intermittent Preventative Treatment was available to pregnant women in all 12 departments;
- 2) introducing the new malaria case management policy in the private sector;
- 3) ensuring that all public hospitals in the target departments of Zou/Collines, Borgou/Alibori, and Atlantique/Littoral were trained in the new treatment protocol for severe malaria;
- 4) introducing clinical IMCI in selected public health facilities.

Intermittent Preventative Treatment

Using a rapid assessment to identify gaps in provision of Intermittent Preventative Treatment (IPT) during antenatal care (ANC), PISAF developed targeted IPT interventions for pregnant women, as well as a facilitator's guide to train health workers serving in ANC on the provision of IPTp. A total of 1,787 qualified and unqualified health workers from the public and private sectors were trained in Antenatal Care/Intermittent Preventative Treatment.



A pregnant women takes her IPT at a health facility

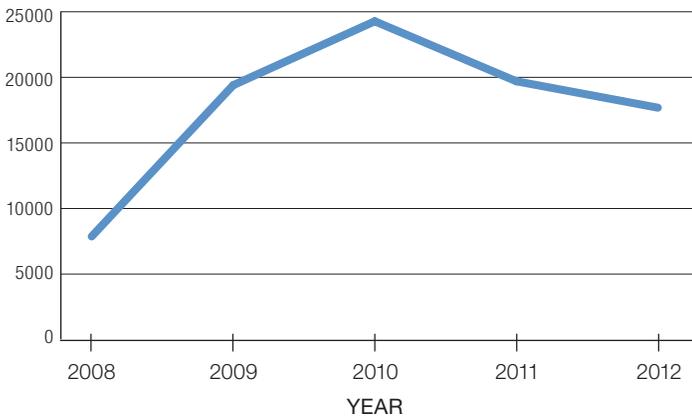
Malaria Case Management Training for Private Sector Providers

The private sector accounts for almost 60% of health facilities in Benin; these facilities often do not receive clinical updates on new MOH policy. PISAF updated the malaria case management training curriculum to reflect the 2008 malaria case management policy and developed a general training manual, as well as manuals for use with private sector providers targeting nurses, doctors, and pharmacists. In all, 542 private health facility workers received training in treating uncomplicated malaria. Post-training follow-up was done with each health worker to ensure their understanding of the guidelines.

IMCI Training

Malaria case management is an essential piece of Integrated Management of Childhood Illness (IMCI), particularly in a malaria-endemic country like Benin. From 2008 to 2010, PISAF supported the Mother and Child Health Directorate (DSME) to train 288 qualified health workers, from public health facilities in all departments in Benin, in clinical IMCI. The training package consisted of clinical training for workers with direct post-training follow-up to ensure that lessons from the training were correctly implemented in the field.

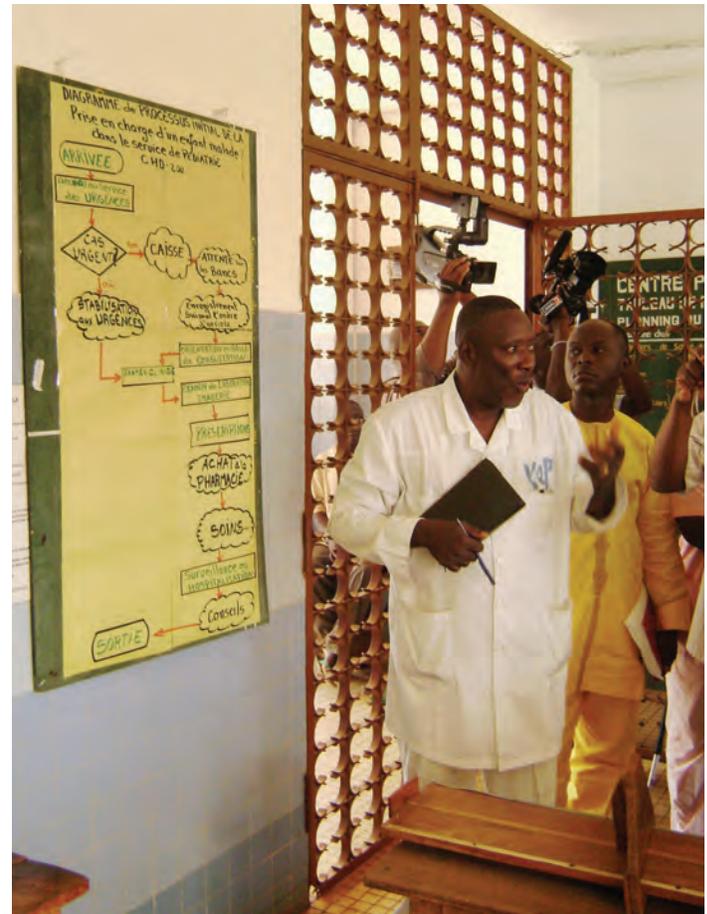
Figure 11: Number of pregnant women receiving 2 doses of SP



Emergency Triage, Assessment, and Treatment of Severe Illness

Deaths in hospitals often occur within 24 hours of admission. Many of these deaths, including those caused by severe malaria, can be prevented if the sickest children are identified on arrival at the health facility and treatment is started immediately. With the goal of decreasing the mortality rate of severe malaria among children under 5, PISAF collaborated with the MOH to implement the Emergency Triage, Assessment and Treatment (ETAT) approach. ETAT is a systematic, efficient, and integrated approach developed by the World Health Organization. The approach details the essential actions for hospital management of children under 5 with serious illnesses, including severe malaria. Systematic triage and classification into one of three categories are used for all children under 5-years old on their arrival at the hospital:

- Urgent care: Requires emergency case management and rapid stabilization
- Priority care: Requires prompt management to avoid becoming an urgent case
- Routine Care: Not life threatening, can wait in line to see health personnel.

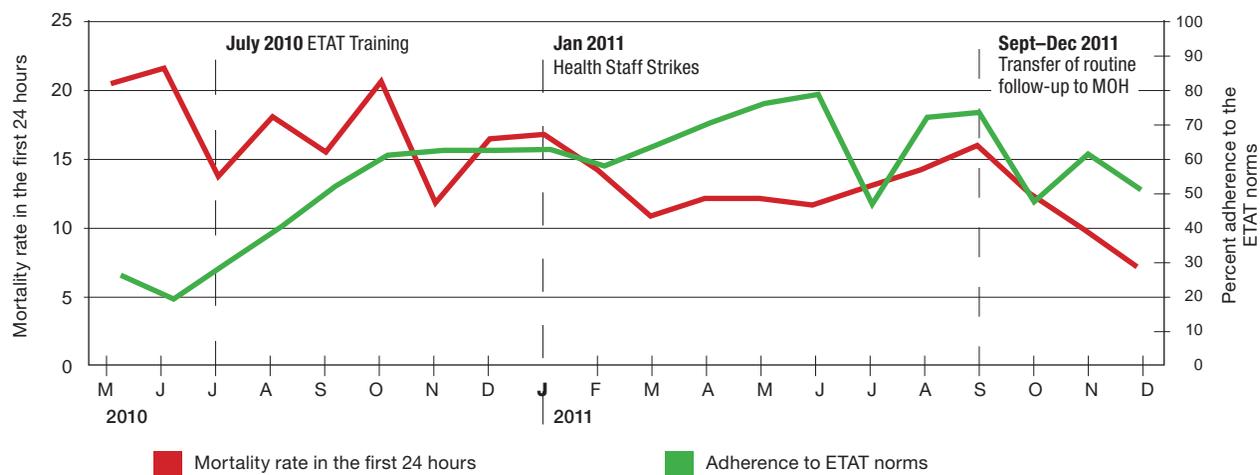


A hospital staff member describes the ETAT process diagram

Improvement Areas Initiated by Quality Improvement Teams in ETAT collaborative

1. Hospital organization
2. Skills reinforcement
3. Logistics strengthening
4. Organization of care

Figure 12. Evolution of mortality rate within 24 hours of admission as compared to adherence to the ETAT norms in the 12 ETAT collaborative hospitals, May 2010 to Dec 2011



PISAF utilized an ETAT improvement collaborative for severe malaria to improve the quality of care for severely ill children at 12 public hospitals in Zou/Collines and Borgou/Alibori. Final data show that, with increasing adherence to ETAT norms, the 24-hour mortality rate trended downwards. During the extension year, ETAT was expanded to six additional hospitals in the Atlantique/Littoral Department. However, coaching and supervision were reduced at the 12 initial hospitals during the extension year, which resulted in challenges to maintaining ETAT successes (Figure 12).

To facilitate training and implementation of the ETAT approach, PISAF developed and validated ETAT guidelines, a severe-malaria job aid, and a training curriculum, as well as introducing coaching and monitoring tools. PISAF also furnished hospitals where ETAT was implemented with emergency treatment equipment—specifically, oxygen concentrators.

Mutuelles

To increase financial accessibility of quality health care for the poor, PISAF worked directly with *mutuelles* in Zou/Collines and Alibori, as well as with healthcare providers and health zones. PISAF supported the creation of new *mutuelles* and provided organizational and management capacity building for existing *mutuelles*. Managers received training in concepts and tools including: health insurance, internal organization and membership management, dues, the provision of care, and problems members face when seeking care. In addition, PISAF supported implementation of useful management tools such as membership cards, a beneficiary registry, and a financial bookkeeping system. PISAF also facilitated linkages between a micro-credit organization (Fédération des Caisses d’Épargne et de Crédit Agricole Mutuel (FECECAM)) and *mutuelles*, in order to improve the contributive capacity of mutuelle members and make *mutuelles* attractive to new and existing members. While the partnership did not become fully functional during the project, the foundations were laid for a strong future partnership.

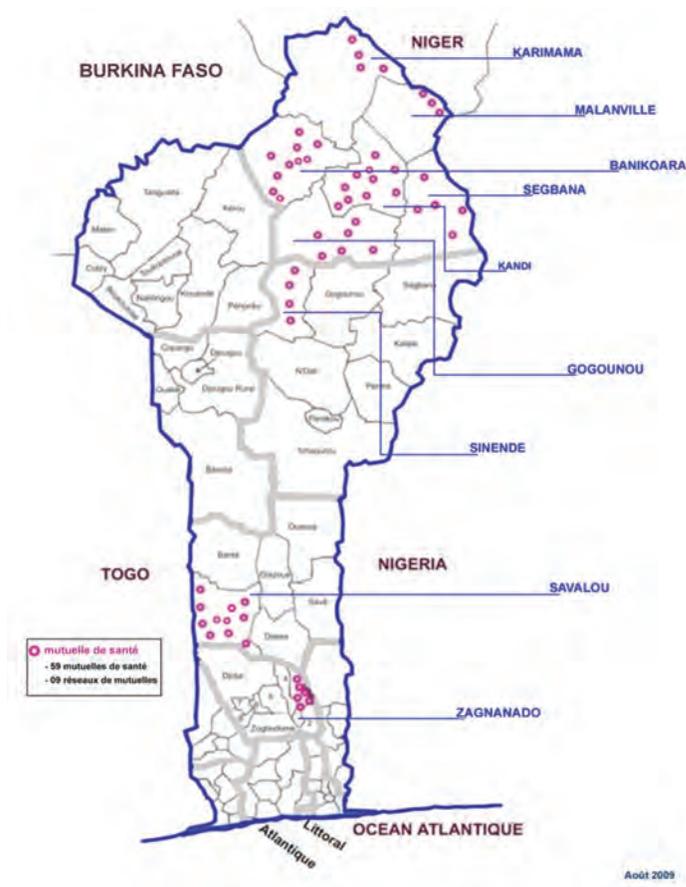
Mutuelle successes

- 59 new health mutuelles established in Zou/ Collines and Alibori
- 9 networks of health mutuelles established in Zou/Collines and Alibori
- 29,694 total beneficiaries, 29% of whom were up-to-date with their dues (as of the end of 2010)
- 5,841 beneficiaries (19%) benefited from free or subsidized care, with an average cost of 1144 francs CFA (as of the end of 2010)

The nine created networks allow mutuelles to pool their resources to increase their financial security and to expand service coverage for members.

To strengthen the financial security of *mutuelles*, PISAF promoted the creation of mutuelle health networks. The nine created networks allow *mutuelles* to pool their resources to increase their financial security and to expand service coverage for members. To ensure that mutuelle members could receive subsidized services at higher level health facilities, PISAF advocated for partnership agreements between mutuelle networks and zonal hospitals; and to strengthen the relationship between *mutuelles*, their members, and healthcare providers, the project helped establish 14 mutuelle collaboratives in Borgou. These collaboratives worked to increase mutuelle membership rates; to increase the quality of care for users; and to increase adherence to regular dues. Through the collaborative, the project was able to promote collaboration between the QIT members, health providers, mutuelle managers, and COGECs members.

MAP OF MUTUELLES SUPPORTED BY PISAF



PISAF facilitated the dissemination of studies of *mutuelles* to zonal health officials and stakeholders in order to raise awareness of the importance of *mutuelles* for providing care at the community level. One study showed that mutuelle members are from two to six times more likely than nonmembers to use curative services at a health center, clearly demonstrating that *mutuelles* can contribute to improving access to health services for their members. To promote the sustainability of *mutuelles*, PISAF worked in conjunction with health zone officials to conduct supervisory visits and monitor performance levels.

Performance-Based Incentives (PBI)

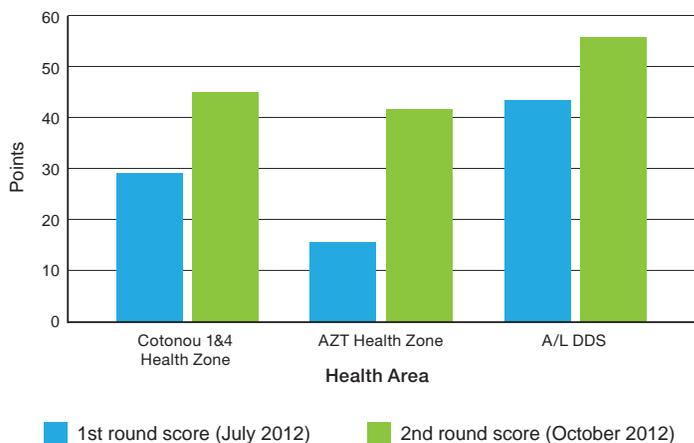
During the extension year, PISAF took on an ambitious activity to implement a performance-based incentives strategy in Zou/Collines and Atlantique/Littoral, building on previous national experience with performance-based contracting by UNICEF, Belgian Technical Cooperation (CTB), and the World Bank. In consultation with these implementing partners, and in collaboration with health departments and zones, PISAF developed processes and indicators to implement the strategy. Performance indicators were developed based on the following criteria:

- Results of clinical family health service
- Management of human resources and essential drug supply
- Routine formative supervision of health services
- Execution of action plans.

PBI committees were set up in the health zones and departments to facilitate communication. The first round of assessment took place for January-June 2012. Data were collected for health facilities, zones, and departments of Zou/Collines and Atlantique/Littoral. Based on the level of achievement on each indicator, which contributed to an overall performance “score,” the department, zone, or facility was awarded a certain amount of credit. This credit could be traded in for three types of incentives: nonfinancial support, maternal and equipment grants for specific items, and opportunities for career development and continuing education.

Results from PBI assessments were presented in each zone during quarterly data review meetings. The strategy was very well received by departmental and zonal MOH staff. Due to

Figure 13. Evolution of scores for health areas where performance-based motivation strategy was implemented



PISAF’s focus in the Atlantique/Littoral health department in the second half of 2012, the second round of incentives (which assessed third quarter 2012 performance) was only conducted in the Atlantique/Littoral. Evolution of scores for the health zones where the strategy was implemented is shown in Figure 13.

This project, which implemented a performance-based incentives strategy, successfully applied lessons learned from other performance- and results-based incentive pilots in Benin and should be considered a promising approach to improving health system performance in the country. More detailed documentation of PISAF’s PBI experience is presented in Annex 5.

IR 3: Increase demand for health services, products, and prevention measures

| Intermediate Result 3 | What did we hope to accomplish? | Key Achievements |
|---|---|--|
| Increased demand for health services, products, and prevention measures | <ul style="list-style-type: none"> • Improve community knowledge, practices, and attitudes toward preventive measures and services • Promote adoption of appropriate family health-seeking behaviors • Improve community engagement through community health workers and collaborate with community organizations • Carry out implementation research | <ul style="list-style-type: none"> • Improved health-seeking and health behaviors by successfully leveraging radio spots, community theater, songs, and individual counseling • Exposed over 400,000 people to family health information • Developed comprehensive set of job aids on FP, HIV/AIDS, mutuelles, fistula, PMTCT, severe malaria, rapid diagnostic tests, and coaching; made them available to communities and healthcare providers • Improved CHW engagement through use of Community Health Worker Assessment and Improvement Matrix tools • Increased awareness, identification of fistula cases, and social reintegration of treated women in collaboration with two NGOs • Distributed 211,210 LLINs during national malaria campaign • Carried out implementation research studies on an intervention focused on job aids to improve quality of counseling, understanding of care for mothers and newborns, and factors contributing to retention of mutuelle members. |

PISAF's Behavior Change Communication activities were guided by a comprehensive Behavior Change Communication (BCC) Strategy developed at the beginning of the project. This strategy was based on consultations with community actors, NGOs, women's groups, and BCC partners; baseline information was collected through the PISAF Management Assessment.

The goals of the strategy were:

- 1) to reinforce the capacity of and to support the DDS and partners in planning, coordinating, and evaluating BCC activities;
- 2) to improve the technical knowledge, interpersonal communication and counseling, and negotiation skills of health providers and other actors;

- 3) to improve individual, household, and community health behaviors by increasing knowledge, encouraging positive changes in attitudes, and improving healthy practices.

PISAF used a variety of materials to implement the strategy, along with message development and dissemination, community mobilization, and capacity building at various levels of the government and within the private sector. All BCC activities were carried out in close collaboration with departmental and zonal community mobilization/BCC point persons to promote institutionalization and capacity building, ultimately leading to formation of a BCC unit within the Department Health Office of Zou/Collines.



Traditional musician sings about HIV/AIDS at a middle school on World AIDS Day 2006



A traditional theater troupe performs a skit about family planning

Used mass media to promote family health behaviors

To promote healthy behaviors among more remote populations, PISAF used a variety of mass media platforms including local radio stations, community theater groups, and folkloric music groups. Through culturally appropriate and language-specific (Fon, Idaatcha, and Tchabe) messaging, these groups reached more than 400,000 people during the project. To strengthen the capacity of these groups to continue incorporating health messages into their work beyond the life of the project, PISAF trained three theater groups and five folkloric music groups in Zou/Collines to develop plays and songs with family health themes. These groups produced and disseminated 24 popular songs and 22 plays covering family health topics including malaria, family planning, community emergency obstetric and newborn care, STI/HIV/AIDS, and *mutuelles*.

The community theater and folkloric music groups were invited to perform during large awareness campaigns, such as World AIDS Day and World Malaria Day, as well as during community gatherings.

Improved healthcare worker interpersonal communication (IPC)

The PISAF Management Assessment's section on observation of interpersonal communication revealed weaknesses in the IPC skills of healthcare workers.

The workers were evaluated against a set of IPC "norms" that included greeting the client, asking if the client had any questions, etc. Family planning, healthy child, and postnatal consultations were identified as having the lowest scores. To increase demand for health services, PISAF placed an emphasis on improving healthcare workers' IPC skills as well as integrating IPC norms into healthcare workers' training and supervision. While IPC training was initially provided as a stand-alone training, it was eventually integrated into the larger Integrated Package training. Both public and private healthcare workers were trained, and PISAF staff provided post-training follow-up to ensure that key communication messages were being integrated into everyday work.

| Severe Malaria | Convulsions | Coma | Shock | Severe Anemia | Acidosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <p>1) 10mg/kg quinine diluted in 5-10ml of G10 for 4 hours. Repeat quinine three times per day - every 8 hours.</p> <p>2) Check for hypoglycemia - Give G10 if needed.</p> <p>3) Check vital signs every 8 hours: pulse, temperature, respiratory rate, blood pressure.</p> <p>4) Carefully record everything the child takes and eliminates daily 24 hours a day.</p> | <p>GIVE NOTHING ORALLY</p> <p>1) IR Diazepam (Phenobarbital preferred for newborns < 4 weeks).</p> <p>2) Check blood glucose - Give G10 by bolus as needed.</p> <p>3) Repeat IR Diazepam after 10 minutes if convulsions continue.</p> <p>4) If convulsions still continue after 10 minutes, give a third dose of IR Diazepam or Phenobarbital IV or IM.</p> | <p>(Benzyl 0 to 3, or EVDI + 0)</p> <p>1) Lay patient down with head to the side and aspirate.</p> <p>2) Bolus of G10 5ml/kg by IV (or glucose solution by NG tube).</p> <p>3) After 30min, check blood glucose.</p> <p>4) If hypoglycemia presents - Repeat G10 bolus.</p> | <p>(Cold hands with capillary refill time >3 seconds and rapid and weak pulse)</p> <p>Well-nourished child:</p> <ol style="list-style-type: none"> Give bolus (burst) of Ringer's Lactate or SS9% as fast as possible. Administer oxygen. Repeat IV bolus up to three times if there is no improvement. If there is no improvement, administer 20ml/kg of blood in 30 minutes (preorder blood bag, administer appropriate dose). <p>Severely malnourished child:</p> <p>(Visible severe weight loss or edema in both feet)</p> <ol style="list-style-type: none"> Take and record pulse and respiratory rate (RR). Try to give fluids or insert an NG tube with HeSOMal or F10. If impossible, weigh the child and place an IV. Give a mixture of one-half Ringer's Lactate and one-half G6 at 15ml/kg in 1 hour. Measure pulse and RR every 5-10min. <ul style="list-style-type: none"> If condition worsens during perfusion (increased RR of 5/min, or pulse of 25/min), stop perfusion. If improvement (drop in pulse or RR), Repeat Ringer/G6 for 1 hour. then give HeSOMal or GRS diluted by half. If pulse and RR are unchanged: transfuse whole blood at 10ml/kg slowly over 3 hours. | <p>(s Hw <4g/dl or Hb between 4-6g/dl PLUS respiratory distress)</p> <ol style="list-style-type: none"> Measure and record pulse and respiratory rate (RR). Administer 1mg/kg of furosemide by IV as start of transfusion. Give whole blood slowly at 10ml/kg over 3 hours. <p>If pulse or RR increase (increased RR of 5/min or pulse of 25/min): slow down transfusion.</p> <p>OR</p> <p>If the child presents signs of heart failure (swollen neck veins, rales, crackles, hepatomegaly, and increased pressure in the jugular vein).</p> <p>If pulse or RR remains stable: Repeat the dose of blood 1-2 hours later without diuresis.</p> <p>If pulse or RR accelerates: Slow down the transfusion to prevent pulmonary edema.</p> <p>If there is no improvement after 2 hours, give bicarbonate solution.</p> | <p>(Slow and deep breathing)</p> <p>If Hb is <6g/dl:</p> <ol style="list-style-type: none"> Give 20ml/kg of isotonic glucose solution by IV in 30 min. Give oxygen. <p>If Hb is <6g/dl:</p> <ol style="list-style-type: none"> Take and record pulse and respiratory rate (RR). Give oxygen. Give 10ml/kg whole blood in 30min. Check pulse and RR every 15min. If pulse or RR remains stable: Repeat the dose of blood 1-2 hours later without diuresis. If there is no improvement after 2 hours, give bicarbonate solution. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>FOLLOW-UP:</p> <ul style="list-style-type: none"> Repeat quinine at 8H, 16H, 24H, 32H, etc. After 48 hours of perfusion, reduce quinine to 5-7mg/kg for 4 hours. Oral route as soon as possible: oral quinine 10mg/kg every 8 hours for 7 days. Check again for parasitemia at DC, D7 and D14. <p>Example:</p> <p>First dose for a child weighing 7kg - Give 70mg of quinine added to 5-10ml of G10 for 4 hours.</p> | <p>DIAZEPAM (10mg/2ml solution)</p> <table border="1"> <thead> <tr> <th>Age or Weight</th> <th>Dosage (Add 1-2ml of Distilled Water)</th> </tr> </thead> <tbody> <tr> <td>2 weeks to 2 months (4-6kg)</td> <td>0.5ml</td> </tr> <tr> <td>From 2 months to 4 months (4 to 6kg)</td> <td>0.5ml</td> </tr> <tr> <td>From 4 months to 12 months (8 to 10kg)</td> <td>1.0ml</td> </tr> <tr> <td>From 12 months to 3 years (10 to 14kg)</td> <td>1.25ml</td> </tr> <tr> <td>From 3 years to 5 years (14 to 18kg)</td> <td>1.5ml</td> </tr> </tbody> </table> <p>PHENOBARBITAL IV or IM</p> <table border="1"> <thead> <tr> <th>Age</th> <th>Dosage</th> </tr> </thead> <tbody> <tr> <td>Newborn</td> <td>20mg/kg</td> </tr> <tr> <td>1-20 months</td> <td>15mg/kg</td> </tr> <tr> <td>31 months to 6 years</td> <td>10mg/kg</td> </tr> <tr> <td>Over 6 years</td> <td>5mg/kg</td> </tr> </tbody> </table> | Age or Weight | Dosage (Add 1-2ml of Distilled Water) | 2 weeks to 2 months (4-6kg) | 0.5ml | From 2 months to 4 months (4 to 6kg) | 0.5ml | From 4 months to 12 months (8 to 10kg) | 1.0ml | From 12 months to 3 years (10 to 14kg) | 1.25ml | From 3 years to 5 years (14 to 18kg) | 1.5ml | Age | Dosage | Newborn | 20mg/kg | 1-20 months | 15mg/kg | 31 months to 6 years | 10mg/kg | Over 6 years | 5mg/kg | <p>G10 IN BOLUS</p> <table border="1"> <thead> <tr> <th>Age/Weight</th> <th>Volume of G10 (ml/kg)</th> </tr> </thead> <tbody> <tr> <td>Less than 2 months (6kg)</td> <td>15ml</td> </tr> <tr> <td>2-4 months (4-6kg)</td> <td>20ml</td> </tr> <tr> <td>4-12 months (5-10kg)</td> <td>40ml</td> </tr> <tr> <td>1-3 years (10-14kg)</td> <td>60ml</td> </tr> <tr> <td>3-5 years (14-18kg)</td> <td>80ml</td> </tr> </tbody> </table> <p>DEFINITION OF HYPOLYCEMIA</p> <table border="1"> <thead> <tr> <th>Nutritional Status</th> <th>Definition of Hypoglycemia</th> </tr> </thead> <tbody> <tr> <td>Well-nourished child</td> <td><2.5mmol/l or 45mg/dl</td> </tr> <tr> <td>Severely malnourished child</td> <td>< 3mmol/l or 55mg/dl</td> </tr> </tbody> </table> | Age/Weight | Volume of G10 (ml/kg) | Less than 2 months (6kg) | 15ml | 2-4 months (4-6kg) | 20ml | 4-12 months (5-10kg) | 40ml | 1-3 years (10-14kg) | 60ml | 3-5 years (14-18kg) | 80ml | Nutritional Status | Definition of Hypoglycemia | Well-nourished child | <2.5mmol/l or 45mg/dl | Severely malnourished child | < 3mmol/l or 55mg/dl | <p>BOLUS RINGER'S</p> <table border="1"> <thead> <tr> <th>Age/Weight: Well-Nourished Child</th> <th>Volume of Ringer's Lactate or SS9% (20ml/kg) in BOLUS</th> </tr> </thead> <tbody> <tr> <td>2 months (4-6kg)</td> <td>75ml</td> </tr> <tr> <td>2-4 months (4-6kg)</td> <td>100ml</td> </tr> <tr> <td>4-12 months (5-10kg)</td> <td>150ml</td> </tr> <tr> <td>1-3 years (10-14kg)</td> <td>200ml</td> </tr> <tr> <td>3-5 years (14-18kg)</td> <td>250ml</td> </tr> </tbody> </table> <p>MIXTURE OF RINGER AND G6</p> <table border="1"> <thead> <tr> <th>Weight</th> <th>Mixture: 16 RL (or SS 9%) and 1% G5%</th> </tr> </thead> <tbody> <tr> <td>4kg</td> <td>60ml</td> </tr> <tr> <td>6kg</td> <td>90ml</td> </tr> <tr> <td>8kg</td> <td>120ml</td> </tr> <tr> <td>10kg</td> <td>150ml</td> </tr> <tr> <td>12kg</td> <td>180ml</td> </tr> <tr> <td>14kg</td> <td>210ml</td> </tr> <tr> <td>16kg</td> <td>240ml</td> </tr> <tr> <td>18kg</td> <td>270ml</td> </tr> </tbody> </table> | Age/Weight: Well-Nourished Child | Volume of Ringer's Lactate or SS9% (20ml/kg) in BOLUS | 2 months (4-6kg) | 75ml | 2-4 months (4-6kg) | 100ml | 4-12 months (5-10kg) | 150ml | 1-3 years (10-14kg) | 200ml | 3-5 years (14-18kg) | 250ml | Weight | Mixture: 16 RL (or SS 9%) and 1% G5% | 4kg | 60ml | 6kg | 90ml | 8kg | 120ml | 10kg | 150ml | 12kg | 180ml | 14kg | 210ml | 16kg | 240ml | 18kg | 270ml | <p>BICARBONATE SOLUTION</p> <table border="1"> <tbody> <tr> <td>If 42%</td> <td>2.300/kg</td> </tr> <tr> <td>If 14%</td> <td>500/kg</td> </tr> </tbody> </table> | If 42% | 2.300/kg | If 14% | 500/kg |
| Age or Weight | Dosage (Add 1-2ml of Distilled Water) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 weeks to 2 months (4-6kg) | 0.5ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| From 2 months to 4 months (4 to 6kg) | 0.5ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| From 4 months to 12 months (8 to 10kg) | 1.0ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| From 12 months to 3 years (10 to 14kg) | 1.25ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| From 3 years to 5 years (14 to 18kg) | 1.5ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Age | Dosage | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Newborn | 20mg/kg | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1-20 months | 15mg/kg | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31 months to 6 years | 10mg/kg | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Over 6 years | 5mg/kg | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Age/Weight | Volume of G10 (ml/kg) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Less than 2 months (6kg) | 15ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2-4 months (4-6kg) | 20ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4-12 months (5-10kg) | 40ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1-3 years (10-14kg) | 60ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3-5 years (14-18kg) | 80ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nutritional Status | Definition of Hypoglycemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Well-nourished child | <2.5mmol/l or 45mg/dl | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Severely malnourished child | < 3mmol/l or 55mg/dl | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Age/Weight: Well-Nourished Child | Volume of Ringer's Lactate or SS9% (20ml/kg) in BOLUS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 months (4-6kg) | 75ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2-4 months (4-6kg) | 100ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4-12 months (5-10kg) | 150ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1-3 years (10-14kg) | 200ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3-5 years (14-18kg) | 250ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Weight | Mixture: 16 RL (or SS 9%) and 1% G5% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4kg | 60ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6kg | 90ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8kg | 120ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10kg | 150ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12kg | 180ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14kg | 210ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16kg | 240ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18kg | 270ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If 42% | 2.300/kg | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If 14% | 500/kg | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Job Aid on Severe Malaria Treatment for Children < 5 years

Developed Tools and Job Aids

The PISAF Management Assessment revealed many gaps in health knowledge, attitudes, and practices among health providers and their clients. To complement ongoing capacity-building activities, PISAF developed, produced, and disseminated information, education, and communication (IEC) and BCC materials such as fliers, brochures, counseling cards, and job aids. These tools:

- 1) supported facility- and community-level providers in providing quality counseling and services;
- 2) educated users in preventive and curative services and behaviors, with the goal of stimulating demand for services.

Selected BCC materials and job aids are presented for the purposes of this report. For a complete list of materials developed during the project, see Annex 4.

Treatment of Severe Malaria

Under PMI, PISAF supported the implementation of emergency triage, assessment, and treatment (ETAT) of children presenting with severe illness, including severe malaria, by training hospital providers in management of severe malaria cases. To support training efforts and harmonize with case management for severe malaria, a job aid developed by URC was adapted for Benin's national guidelines for malaria and was validated by the MOH. The effort to adapt the job aid involved meetings with key stakeholders and provided a unique opportunity to reach consensus on treatment protocol. The job aid (see graphic) takes providers through the steps of identifying symptoms and determining the best course of action for treating severe malaria and its five most common symptoms; 258 providers were trained in the ETAT approach, with very positive results (Figure 12). Please see IR 2 for further discussion of PISAF's severe malaria work.

Table 1: Summary of Community Health Worker Activities by Health Zone (2010)

| Health zones of Zou/Collines: | Dagla | Sao | Saba | Cozo | TOTALS |
|--|--------|-------|--------|-------|--------|
| Number of cases referred by CHWs | 149 | 97 | 14 | 158 | 418 |
| Number of ACTs sold by CHWs | 11,432 | 1,626 | 1,416 | 1,269 | 15,743 |
| Number of monthly discussion groups organized by CHWs | 459 | 250 | 1,682 | 540 | 2,931 |
| Number of women who were sensitized by CHWs through educational sessions | 5,646 | 2,143 | 20,596 | 5,063 | 33,448 |
| Number of women who were sensitized by CHWs through home visits | 2,124 | 1,034 | 4,860 | 1,645 | 9,663 |

Trained and equipped Community Health Workers (CHWs)

As part of PISAF's effort to increase access to healthcare services at the community level, PISAF worked closely with community leaders and stakeholders to identify and train 145 community health workers in Zou/Collines. These CHWs serve a population of approximately 361,528 – of whom 65,075 are children under 5 and 86,767 are women of reproductive age. Despite the initial lack of a defined package of services that CHWs could provide, collaboration with the MOH, USAID, UNICEF, Africare, and Population Services International enabled PISAF to define a package of care and to focus on scaling up that package to CHWs in four health zones of Zou/Collines: Dagla, Saba, Cozo, and Sao.

PISAF provided training to CHWs in these zones on the following topics: 1) community integrated management of childhood illness including management of malaria, diarrhea, and pneumonia; 2) essential obstetric and newborn care (EONC) at the community level, including danger signs for pregnant women, women in labor, and newborns; 3) IEC/BCC approaches and tools to promote positive family health behaviors; and 4) data collection and management.

PISAF also equipped CHWs with kits consisting of long-lasting insecticide-treated mosquito nets (LLIN), Coartem, Orasel/Zinc,

condoms, paracetamol, aspirin, and oral contraceptive pills. CHWs participated in awareness campaigns and provided one-on-one counseling, as well as group counseling with mothers and youth. A success story describing the impact of PISAF's work on one CHW can be found in Annex 5.

PISAF's work in defining a package of services for CHWs, as well as in CHW supervision, contributed to the 2010 development of National Guidelines for Community Health Promotion, which for the first time clearly laid out a package of health services to be provided by CHWs and guidelines for CHW supervision and motivation.

PISAF supported heads of health posts and the focal persons of each health zone for conducting supervisory visits to each CHW at least once each quarter. PISAF staff often accompanied supervisors or conducted their own visits to CHWs to assist with any difficulties with tools and registers, and to review the activities conducted. These supervisory visits provided CHWs with feedback necessary to improve their work. For example in 2010, health workers conducted 204 CHW supervisory visits; the key results of these visits are highlighted in Table 1.



CHW demonstrates how to hang and use a bed net

In 2010 PISAF, in collaboration with the USAID-funded Health Care Improvement project, pilot-tested a community health worker assessment and improvement matrix (CHW AIM) in three health zones of Zou/Collines. This tool examines the CHW system as a whole and involves actors from community, health facility, and health zone levels. The tool assesses community participation, motivation, drugs and supplies, supervision, referrals, reporting, and sustainability, to enable improved functionality of the CHW system. PISAF and the Zou/Collines DDS discussed the results of the assessment, set priorities based on the findings, and developed targeted action plans.

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Head of Aklampa health facility responding to community concerns

Increased community awareness of fistula prevention and treatment

Obstetric fistula (an abnormal passageway between the birth canal and an internal organ such as the bladder or rectum), a serious but treatable medical condition that can occur as a result of prolonged labor, is underreported and undertreated in central Benin. PISAF partnered with two local NGOs – ALDIPE and BACAR – to work towards preventing fistula and improving the outcomes of fistula cases in Zou/Collines. The activities related to obstetric fistula, which were implemented from 2011 through 2012, had two major objectives: 1) to educate health workers and the public on fistula and its prevention and treatment; and 2) to provide comprehensive treatment and support to women with the condition, enabling their reintegration into society.

Through ALDIPE and BACAR, PISAF funded and monitored CHW training on fistula screening and prevention, public education, case identification, and social support for women and their families before and after treatment.

ALDIPE and BACAR worked with the MOH Regional Medical Coordinator to determine which communities in Zou/Collines would receive targeted education on fistula, and coordinated

PISAF Fistula Activities

1. Established a partnership with two local NGOs to support community-level activities
2. Trained healthcare providers and community health workers to identify women with fistula and inform them about treatment options
3. Published a brochure to increase understanding of fistula and how to prevent it
4. Educated the public on fistula, its prevention, and its treatment
5. Identified existing fistula cases and coordinated treatment
6. Supported social and economic integration of women who underwent successful treatment.

their efforts with those of CHWs and healthcare providers already trained on fistula to organize the events. Through 858 community meetings, the NGOs educated the general public on fistula, its treatment, and its prevention. An essential component of these meetings was discussion of fistula as a treatable condition and how women suffering from the condition need significant support from their families and communities both before and after treatment. During the meetings, community members were requested to notify a CHW or health facility about any known fistula cases, so PISAF could facilitate treatment for the women.

Targeted education sessions were held with religious and opinion leaders, traditional midwives, women's group leaders, directors of local theater troupes, and radio announcers to advocate for prevention and treatment of the condition. ALDIPE worked with radio stations to produce eight radio spots on fistula; these were translated into four local languages to support effective dissemination.

ALDIPE and BACAR also worked with health facilities and CHWs to ensure that they were notified of all positively identified fistula cases, which were then reported to PISAF. When PISAF began its work on fistula, only a few high-level referral hospitals in Benin were equipped to perform fistula repair surgery. PISAF worked with the United Nations Population Fund (UNFPA) to determine which additional hospitals were able to perform the procedure. Women were initially referred to three referral hospitals in northern Benin, which had the necessary technical expertise and equipment to provide the repairs. In 2012, the departure of staff skilled in fistula repair and a lack of resources at these hospitals resulted in a large backlog of cases. After consultation with UNFPA, it was determined that the remaining women awaiting repair could obtain treatment at the National University Hospital in Cotonou. As of December 2012, National University Hospital in Cotonou was the only hospital in Benin providing fistula repair surgery.

In total, PISAF's efforts in coordination with NGOs have ensured that 103 women with fistula were identified, 85 were treated, and 66 had successful operations. The 19 women for whom the initial surgery was unsuccessful were referred for specialized surgery and treatment procedures. For more on PISAF's fistula work, see Annex 5.

Supported gender equity

Support for gender equity cuts across all of PISAF's approaches. Particularly when identifying and recruiting CHWs and COGEC members, special care was taken to work with local communities to identify qualified female candidates who may initially have been overlooked. COGEC executive committees have three members: a president, a secretary, and a treasurer. PISAF has worked to ensure that at least one of these members was a female. Even with the educational requirements for executive committee members, the project has had success. In 2007, 42% of COGECs in the PISAF geographic area had at least one female member; by 2011, it had reached 47%.



Members of a local women's group watch a theater piece on family planning, Women's Day 2011.

In preparation for the implementation of community IMCI and EONC, PISAF worked closely with communities to communicate the roles and responsibilities of a CHW. Through community meetings, and advocacy with community leaders, PISAF advocated for inclusion of an equal number of female and male CHWs. Despite these efforts, only 16% of the identified CHWs were female, though this was a considerable improvement from earlier cohorts which included no female CHWs.

PISAF participated in the annual celebration of International Women's day on March 8th of each year with a variety of events and education sessions promoting women's health and welfare in Benin. In 2011, over 500 people attended a daylong celebration with keynote speeches from the MOH and the Ministry of Family addressing the status of women, including gender-based violence and the importance of women's participation in decisions around family health, particularly family planning. Other activities included a play put on by a local theater group and subsequent audience discussion drove these themes home, showing how poverty and hunger relate to health and family planning, and a health fair with free private family planning counseling.

In 2011, the USAID office of gender equality and women's empowerment released draft performance indicators. To support the introduction of these indicators in Benin, and to obtain a baseline value, the PISAF team pilot-tested one of these indicators: "Proportion of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities." The questionnaire was field-tested in French and in Fon, and the validated questionnaire was administered to a convenience sample of clients, health center staff, and staff in training. More information and results from the pilot survey are found in Annex 5.

Increased malaria awareness and bed net use

Malaria is a leading cause of death in children under 5 in Benin. According to 2006 DHS data, only 33% of children under 5 and 32% of pregnant women had slept under an insecticide-treated bed net (ITN) the previous night. In October 2007, PISAF played a major role in supporting a national malaria bed net distribution campaign implemented under the Ministry of Health, with a coverage target of 80% of children under 5 sleeping under a long-lasting insecticide-treated mosquito net (LLIN). To prepare for a nationwide distribution, PISAF organized a pilot distribution in Zou/Collines health zones. The pilot demonstrated that there was significant demand for bed nets and that a larger campaign would address the issue of lack of access which may have, in part, explained the underutilization.

PISAF fostered strong collaboration between the national and local stakeholders including the Ministry of Social Affairs, Ministry of Defense, village chiefs, and traditional leaders, and mobilized community resources and actors to distribute 211,210 LLINs across six health zones in Zou/Collines through 720 distribution points. At each distribution point, trained health workers showed women how to properly use and hang up a bed net and explained the benefits of bed net use. To



PISAF organized a pilot bed net distribution in Zou/Collines.

raise community awareness on malaria, PISAF simultaneously carried out BCC activities: Community theater troupes, trained to develop appropriate health messages through role playing, presented plays across the region in public venues and squares. The plays were followed by an interactive educational discussion during which participants were asked to share the lessons they learned from the performances and how they could incorporate those lessons into their daily lives.

PISAF also worked with local radio stations, and with public figures such as town criers, to advertise the bed net campaign. In a small survey (a sample of 28 mothers) carried out during supervisory visits, 68% cited town criers as their primary source of information about the campaign and an additional 39% cited radio messages. Mothers were also asked to explain their understanding of the purpose of using bed nets. Among the 20 mothers who responded, all understood that the nets were intended for children under 5 to protect them against mosquito bites. PISAF's Second Management Assessment, conducted in 2010, showed that the percentage of children under 5 sleeping under bed nets was 98% (Zou) and 96% (Collines)—a significant increase from 2006 DHS data showing only 25% (Zou) and 24% (Collines).

Implementation Research

Does the use of job aids improve the quality of healthcare worker counseling?

With a view to strengthening the competencies of skilled and unskilled workers, PISAF conducted a study on how the introduction of counseling cards affected the care of mothers and newborn babies in 14 maternity care centers in Zou/Collines. The study assessed the maternal and newborn care messages and interpersonal communication competencies of midwives/head maternity center nurses and nursing assistants at seven intervention sites. All midwives/nurses from the intervention sites were trained in the use of counseling cards, interpersonal communication, and quality improvement. The training included role playing and didactic instruction with available written materials, such as a reference guide. Midwives and nurses at the seven control sites received no training. Pre- and post-training assessments were conducted, and methods included direct observation of antenatal counseling sessions, patient exit interviews, and provider interviews.

The study showed that the mean percentage of recommended messages provided to pregnant women—on the topics of birth preparedness, danger sign recognition, clean delivery, and newborn care—significantly improved in the intervention arm compared to the control arm.

The proportion of women who exited their antenatal care visit with correct knowledge about birth preparedness, danger sign recognition, and clean delivery significantly improved following the job aid training. Job aids were positively perceived by providers and pregnant women, although time constraints remained for health workers with other clinical responsibilities. Based on these findings, PISAF recommitted to developing high-quality job aids and incorporating them into activities of the PISAF project.



Female *mutuelle* member receives health care for her sick child.

What factors contribute to the retention of *mutuelle* members?

While promoting policies that favor *mutuelles* professionalization at the central level, PISAF worked at the community level to improve membership in *mutuelles*. PISAF carried out a study of 12 *mutuelles* to understand factors that contribute to retention or departure of members. Using those results, the technical staff developed communication strategies and activities to promote and educate communities on the economic and health benefits of *mutuelles*. A brochure was developed to strengthen awareness of the 42 *mutuelles* in Borgou/Alibori, to retain current members, and to win new ones.

Que gagne t-on en adhérant à une mutuelle de santé?

Nous bénéficions de nombreux avantages en adhérant à une mutuelle de santé. Elle permet de :

- garantir la santé à tous les membres de la famille ; lorsque les enfants ont malade ou lorsqu'une femme vient accoucher, la famille va profiter au centre de santé pour s'y rendre ;
- aider les frères et sœurs (membres de la mutuelle) à aller aux soins en cas de maladie avec l'argent que tous les membres ont cotisé au nom de la solidarité ;
- se rendre vite et sans souci : sans attendre que la maladie se complique ;
- grâce à la mutuelle, la famille ne va plus passer trop à la recherche de l'argent en cas de maladie. La famille ne va plus s'endormir en voulant les sommes agréables ou son change de nuit en cas de maladie ;
- le garantisme est vite et plus rapide parce que l'argent de santé permet faire un traitement complet et correct ;

Quelles sont les prestations offertes par une mutuelle de santé ?

Tous les soins que le centre de santé peut offrir sont pris en charge par la mutuelle (soins enfants, adultes, consultations pré-natale et post-natale, vaccination, médicaments, etc.)

Les septuaginta, maladies graves ou compliquées qui sont énumérées à l'annexe de cette brochure et dont le coût est plus élevé que celui des autres, sont pris en charge par la mutuelle d'un montant de 100 000 FCFA par an et par membre de la famille.

Pour toute information, veuillez contacter le personnel du centre de santé de votre localité

Quelques témoignages positifs des adhérents de mutuelles de santé

« Les difficultés d'accès aux soins de santé et le coût des médicaments sont les raisons qui nous ont poussés à créer cette mutuelle »

« Je suis membre de la mutuelle par manque de moyens financiers surtout pendant les périodes de soudure, pour mieux gérer mes deux de santé et celle de ma famille »

Ma prière de mutualiste

Je formule le vœu :

- De continuer existant ; la mutuelle crée la sève de la mutuelle.
- De n'avoir jamais besoin de solliciter la couverture de la mutuelle ni pour moi ni pour les membres de ma famille
- De participer par ma contribution au financement de la santé des autres mutualistes qui en ont besoin.

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Mutuelle de santé au Bénin

Pourquoi? Pour qui? Comment?

Faciliter l'accès de tous aux soins de santé de qualité à moindre coût

Projet Intégré de Santé Familiale au Bénin

Mutuelle Brochure developed by PISAF

Factors linked to member retention

1. Benefits from receiving timely care
2. Health impact of a qualified health care worker caring for them when they are ill
3. Satisfaction of expectations from *mutuelle* participation
4. Less money spent in case of illness
5. Membership in a supportive group.

Factors linked to member loss

1. Lack of financial means/poverty
2. Poor understanding of the principles of mutual assistance and solidarity – the foundations of *mutuelles*
3. Lack of a culture of planning ahead
4. Low quality of a limited package of care available at health facilities
5. Trust issues between leaders and members
6. Low motivation of *mutuelle* managers due to lack of salary
7. Weak involvement of elected officials and local leaders.

Lessons Learned and Recommendations

Over the course of six years, PISAF has achieved significant breakthroughs and results. Challenges arose, solutions were developed and implemented, lessons were learned, and new opportunities were identified.

| Challenges | PISAF's Solutions |
|---|---|
| Frequent staff turnover, at the level of Regional Director as well as health facility staff | <ul style="list-style-type: none"> • Paid continuous attention to establishing relations with new Regional Health Director and involving him in all aspects of the project • Held periodic clinical update trainings for new staff • Used coaching as a way to foster teamwork within health facilities and to ensure that newly posted staff were learning the improved procedures and protocols • Used software for human resource management at the health district level to enable better tracking of staff's training and skills • Ensured that each post has a clear job description and each health facility has a clear list of personnel positions, in order to facilitate rapid replacement (when needed) by qualified personnel |
| Need for more leadership and teamwork at all levels | <ul style="list-style-type: none"> • Promoted ascendant planning as a way to foster working across different levels of the health system • Ensured that project activities are integrated into regular workplans for Regional and District levels • Promoted and supported quarterly meetings at health district and regional directorate levels to review quarterly results and to plan ahead • Scaled up lessons learned, for improvement of additional sites and regions • Engaged MOH—central level—in planning for and beginning institutionalization of improvement and teamwork • Strengthened health facility Quality Improvement Teams |
| Need for strengthened financial management capacity in health districts | <ul style="list-style-type: none"> • Promoted assignment of a trained financial manager to each health zone • Helped ensure timely distribution of allocated funds to health districts, to enable them to implement planned activities • Reinforced management through supportive supervision and promoting adherence to financial management norms |
| Imbalance between available qualified staff and workload in many health facilities | <ul style="list-style-type: none"> • Integrated offer of family health interventions by health care workers has contributed to a reduced workload • Explored task shifting of an appropriate activity to specific lower-level staff to provide high quality services and to decrease workload • Clarified and redefined job descriptions as part of Human Resource Management Improvement, which has led to better understanding of roles and responsibilities by health facility staff |
| Lack of institutionalized capacity to manage computerized information and databases | <ul style="list-style-type: none"> • Engaged central level MOH to build staff capacity and bring information technology maintenance staff to regions to provide regular supervision and support |

Lessons Learned and Recommendations continued

| Challenges | PISAF's Solutions |
|--|--|
| <p>Inconsistent availability of family health products at all levels</p> | <ul style="list-style-type: none"> • Promoted integration at the national level for ordering and supply chain management of all health products, including essential medicines, drugs and supplies, and commodities • Ensured CHWs' supply of family health products through health facilities • Developed zone-level warehouses and computerized commodities management • Ensured ongoing supervision |
| <p>Lack of financial support to existing and new mutuelles</p> | <ul style="list-style-type: none"> • Incorporated community initiatives activities into workplans and allocated funds for implementation • Encouraged integration of indigent funds into mutuelles in order to provide services to those who cannot pay • Promoted financial support of mutuelles by local authorities |
| <p>Need to strengthen awareness of gender and gender-focused programming</p> | <ul style="list-style-type: none"> • Placed stronger emphasis on couples-based decision making, particularly on family planning and fistula • Ensured that COGECs, CHWs, and mutuelles include women members |



Final observations and recommendations

PISAF's mandate was to work at the regional and district levels and to bring to scale a package of evidence-based interventions to improve the use and quality of primary level health services. Involvement of the central level of the Ministry remained limited until the onset of the national level work to improve management of malaria, within the National Malaria Control Program and hospitals. With support from USAID, PISAF established stronger relations with the central level staff working across the areas of PISAF technical support.

Under the strong leadership of the Ministry, major headway was made in scaling up the integrated package of family health services to other health regions in the country, beyond Zou/Collines. Certain practices proved to be important in the initial implementation and in the scale-up of the integrated package: Routine supervision of hospital and health center staff played a key role in maintaining their knowledge and skills, and an appropriate budget allocation is necessary to ensure that this practice continues. The practice of coaching complemented routine supervision, through improving the skills and problem-solving abilities of QIT members.

The process of institutionalization, while not yet complete, was well underway by the end of the PISAF program. The presence of champions within the Ministry greatly facilitated the scale-up of successful practices and applications nationwide – notably

Medistock and LogiGRH. The National Quality Assurance Policy Framework has been developed, and PISAF set the tone for successful implementation of the eventual policy in Zou/Collines and in Atlantique/Littoral.

Receptivity of communities and community leaders enabled a quick update of community mobilization strategies and also led to the very successful fistula program. Finally, good synergy with other donors and implementing partners fostered a stronger presence and impact across a number of program interventions.

The Government of Benin also acknowledges the importance of community-based health insurance schemes. Mutuelles are recognized as playing an important role in improving access to health services and, as shown by PISAF, in improving the quality of care offered. Continued support for the professionalization of mutuelles will be required if they are to play the role envisioned under the development of the National Health Insurance Scheme. The Department of Community Health is currently charged with developing mutuelles and their professionalization. Continued capacity building, as well as human and financial resources, will be necessary to advance the mutuelle agenda.

Annex 1. Performance Monitoring Plan

PISAF 2006–2011 Performance Monitoring Plan Indicators

| Indicator | Indicator Definition | 2007 | 2008 | 2009 | 2010 | 2011 | Data Sources | Comments |
|--|---|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|---|
| Strategic Objective 5: Expanded use of family health services, products and preventive measures within a supportive environment | | | | | | | | |
| 1. Use of family health service package | % of population who accessed (have received at least one element of) family health services by service in the target area | (318,209/ 1,345,008) 24% | (460,275/ 1,380,783) 33% | (506,158/ 1,416,716) 36% | (529,701/ 1,472,909) 36% | (569,575/ 1,521,302) 37% | SNIGS | |
| 2. Couples Years of Protection | Number of couples (of reproductive age) with protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. | NA | 14,860 | 11,648 | 12,961 | 14,860 | SNIGS | |
| IR1: Create a supportive implementation environment | | | | | | | | |
| <i>IR 1.1 Implementation of select health policies and approaches</i> | | | | | | | | |
| 1.1.1 Policy review and dissemination | Number of new policies developed and disseminated during the life of the project | 2 | 1 | 0 | 1 | 1 | PISAF Reports | <i>These are documents related to human resources management, development of zonal pharmacy depots in Zou/Collines, and the communication plan for decentralization policy.</i> |
| <i>IR 1.2 Management capacity of health system increased</i> | | | | | | | | |
| 1.2.1 Reinforcing regional and zonal management | % of regional and zonal health system managers trained on basic management (Human Resources Management, Financial Management and Quality Improvement) | 0% | 99% | 99% | 100% | NA | Training Database | <i>The target of this indicator was achieved in 2010. The project did not provide trainings in 2011.</i> |
| 1.2.2 Reinforcing the supervision system | % of health centers that received at least 4 formative supervision visits during the year | (61/112) 54% | (95/110) 87% | (95/110) 87% | (90/110) 82% | (89/110) 81% | Health Center Supervision logs | |

Values may vary from previously submitted indicators due to late submission of reports from health facilities and an extensive data validation exercise which took place in preparation for the final report. Figures reported here have been deemed accurate and valid to the best of our ability.

NA = Not Available

PISAF 2006–2011 Performance Monitoring Plan Indicators continued

| Indicator | Indicator Definition | 2007 | 2008 | 2009 | 2010 | 2011 | Data Sources | Comments |
|--|---|------------------|-----------------|------------------|------------------|-----------------|---|--|
| 1.2.3 Family Health Product Inventory | % of COGEC which took part in the inventory of family health products received | (100/107) 94% | (98/107) 92% | (102/107) 95% | (100/107) 93% | (97/107) 90% | COGEC records | |
| 1.2.4 Effective implementation of the ascendant planning process | % of EEZS using ascendent planning to develop their action plan | PD | (6/6) 100% | (6/6) 100% | (6/6) 100% | (6/6) 100% | Health Zone activity reports | |
| 1.2.5 EEZS annual action plans implemented | % of EEZS executing at least 75% of their annual plan | (5/6) 83% | (5/6) 83% | (6/6) 100% | (6/6) 100% | (6/6) 100% | Health Zone activity reports | |
| 1.2.6 Implementation of data use for decision making by the EEZS | % of EEZS which organized at least 4 meetings to review data and make decisions based on that data | PD | (6/6) 100% | (6/6) 100% | (5/6) 83% | (6/6) 100% | Health Zone activity reports | |
| IR 1.3 Civil society participation increased | | | | | | | | |
| 1.3.1 Participation of women in civil society structures | % of COGEC with at least one women on the executive board | 45/108 (42%) | (40/107) 37% | (40/107) 37% | (40/107) 37% | (50/107) 47% | Zonal Supervision team and COGEC reports | <i>Data here are from annual COGEC reports.</i> |
| 1.3.2 Regular COGEC meetings | % of health centers with a COGEC which held at least one monthly meeting (with a report) in the period | (51/107) 47% | (46/107) 43% | (55/107) 52% | (56/107) 52% | (61/107) 57% | Zonal Supervision team and COGEC reports | |
| 1.3.3 Integration of health activities in community based organizations | % of community based organizations which held at least one health activity during the year | 45% | 100% | 100% | 100% | NA | Community based organization reports and PISAF report | <i>There were no activities with community based organizations in FY2011</i> |
| 1.3.4 Integration of community health activities in the public health system | % of health zones which included community health activities in the job description of health personnel positions | (2/6) 33% | (3/6) 50% | (6/6) 100% | (6/6) 100% | NA | Zonal Supervision team reports | <i>The target of this indicator was achieved in 2010.</i> |

PISAF 2006–2011 Performance Monitoring Plan Indicators continued

| Indicator | Indicator Definition | 2007 | 2008 | 2009 | 2010 | 2011 | Data Sources | Comments |
|--|---|----------------------------|----------------------------|------------------------------|----------------------------|-------------------|--|---|
| IR2: Increased access to quality services and products | | | | | | | | |
| <i>IR 2.1 Availability of essential family health products in public health facilities</i> | | | | | | | | |
| 2.1.1 Availability of family health products | Index of inventory management for family health products | (82/112) 78% | (98/112) 87% | (102/112) 91% | (95/112) 84% | (93.2/112) 85% | Stock and ordering reports | |
| 2.1.2 Availability of family health products at the community level | % of villages where family health products are available at community level | 17% | NA | 85% | 100% | 100% | CHW supervision reports | |
| <i>IR 2.2 Availability of selected family health products at private vendors</i> | | | | | | | | |
| 2.2.1 Availability of ITNs through civil society groups | Number of ITNs sold through community based organizations and health mutuelles | NA | NA | 1500 | 45 | 7 | PISAF Reports | <i>ITN activities with community based organization were limited after FY2011 based on new MOH policy to distribute ITNs through national campaigns. No CBO activities were held in relation to this indicator in 2011.</i> |
| <i>IR 2.3 Availability of family health package in select public health facilities</i> | | | | | | | | |
| 2.3.1 Score of the offer of family health services by trained health personnel | Average performance score of health personnel trained in the offer of at least one or more elements of the family health package (There are 11 total elements of the family health package, and certain are appropriate for certain demographic groups) | 64% | NA | NA | 91% | N/A | Management assessment (completed in 2007 and 2010) | |
| <i>IR 2.4 Improved financial access to health services</i> | | | | | | | | |
| 2.4.1 Mutuelle membership | Proportion of the target population belonging to a health mutuelle in the target area | (12,452/ 894,728) 2% | (57,265/ 924,352) 6% | (101,977/ 954,015) 11% | (50,788/ 984,112) 5% | NA | Mutuelle membership registers | <i>Mutuelle work ended in 2011.</i> |

PISAF 2006–2011 Performance Monitoring Plan Indicators continued

| Indicator | Indicator Definition | 2007 | 2008 | 2009 | 2010 | 2011 | Data Sources | Comments |
|--|--|-----------|----------------|----------------|-----------------|---------|-----------------------|-------------------------------------|
| 2.4.2 Sustainability and membership retention of mutuelles | Number of mutuelles retaining at least 2/3 of members in the preceding year | NA | (14/58) 24% | (14/58) 24% | (58/58) 100% | NA | PISAF reports | <i>Mutuelle work ended in 2011.</i> |
| 2.4.3 Coverage of mutuelles in the target areas | % of communes/districts with functional mutuelles in the target area | (2/9) 22% | (2/9) 22% | (9/9) 100% | (6/9) 67% | NA | PISAF Reports | <i>Mutuelle work ended in 2011.</i> |
| IR 3 Increased demand for health services, products, and preventive measures | | | | | | | | |
| 3.1 Distribution of contraceptive products | Number of contraceptive products distributed/handed out in public health structures | NA | 49,547 | 52,432 | 39,550 | 49,547 | Health Center Reports | |
| 3.2 Access to family health package | Number of individuals with access to family health services in the target area. | 318,209 | 460,275 | 506,158 | 529,701 | 569,575 | Health Center Reports | |
| <i>IR 3.1 Improved knowledge and preventive behavior</i> | | | | | | | | |
| <i>IR 3.2 Introduction of appropriate interventions and services based on research</i> | | | | | | | | |
| 3.2.1 Research studies conducted | Number of formative, operations and evaluation research studies conducted and results shared with all actors | 3 | 3 | 0 | 1 | 1 | PISAF Reports | |

PISAF Performance Monitoring Plan Indicators Zou/Collines 2011–2012

| # | Indicator | Definition | Baseline (2010 data)** | FY2012 Indicator Value* | Data Source | Comments |
|---|---|--|------------------------|-------------------------|---|--|
| S05: Expanded use of family health services, products and preventive measures within a supportive policy environment | | | | | | |
| 1 | Use of Family Health services package | Total number of women delivering at participating health facilities by a qualified health worker | 30,528 | 29,439 | Health center M&E reports | <i>Baseline data from Q1-3 of FY2010. FY2012 data from Q1-3 of FY2012.</i> |
| | | 1a. % of all women delivering at participating health facilities receiving all three steps of AMTSL | 79% | (25,612/29,439) 87% | Health center M&E reports | <i>Baseline data from Q1-3 of FY2010. FY2012 data from Q1-3 of FY2012.</i> |
| | | 1b. % of children 0-11 months who have completed immunization calendar, disaggregated by gender | 64%*** | (37,039/60,364) 61% | Household survey, mothers of children 12 to 23 months of age | <i>Household survey not completed. Baseline data from Q1-3 of FY2010. FY2012 data from Q1-3 of FY2012.</i> |
| | | 1c. Number of pregnant women who have received two doses of SP (IPTp) | 15,844 | 17,754 | Health center M&E reports | <i>Baseline data from Q1-3 of FY2010. FY2012 data from Q1-3 of FY2012.</i> |
| 2 | Couple Years of Protection | Number of couples (of reproductive age) with protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period | 12,961 | 9,108 | National Health Management Information System reports and Hospital operating procedures reports | |
| IR1: Create a supportive implementation environment | | | | | | |
| 3 | Policy review and dissemination | Number of policies developed and disseminated during the life of the project.** | 5 | 8 | PISAF Reports | |
| 4 | Capacity building of decentralized institutions | % of Mayor's offices participating in last performance review verification in communes with performance contracting | (0/18) 0% | (6/18) 33% | Performance validation reports | |
| 5 | Reinforcing the supervisory system | % of health centers receiving at least 4 supportive supervision visits during the year | (90/110) 82% | (108/110) 98% | Supervision visit logs/ reports from health centers | |
| 6 | Management of family health products | % of distribution centers with updated logistic data in the Medistock-web each month | 60% | NA | Medistock software and Medistock-web platform | <i>Medistock web was undergoing changes in 2012 which did not allow for collection of this indicator</i> |

NA = Not available

* Data for FY2012 represents Quarter 1 (September-December 2011), Quarter 2 (January-March 2012), and Quarter 3 (April-June 2012)

** 2010 values from Q1-3 to be comparable with FY2012

*** The Zou/Collines 0-11 month vaccination rate, according to national monitoring data, was 93% in 2010. The differences in reported coverage in SNIGS and in randomized surveys justifies the need for a survey focused on vaccination.

2010 data used as baseline for Zou/Collines based on its use in the cost-extension application

PISAF Performance Monitoring Plan Indicators Zou/Collines 2011–2012 continued

| # | Indicator | Definition | Baseline (2010 data)** | FY2012 Indicator Value* | Data Source | Comments |
|---|--|--|------------------------|-------------------------|---|--|
| 7 | Timely submission of routine malaria data by health facilities | % of all health centers (public and registered private) who submit complete malaria data to the Routine Malaria Information System (RMIS) by the 5th of the month | (26/112) 23% | (67/112) 59% | National routine Malaria Information System database, health Zone statistics office | |
| 8 | Promotion of a gender approach for community based activities | Number of gender promotion activities carried out. | 0 | 2 | CHW supervision reports | |
| | | Proportion of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities (disaggregated by sex) | NA | NA | Survey (to be piloted) | See Final Report annex on pilot of gender indicator |
| 9 | Community based activities integrated into public health system services | % of CHWs who have received a quarterly supervision from the EEZS | 40% | 100% | CHW Systems Assessment survey instrument | |
| IR2: Increased access to quality services and products | | | | | | |
| 10 | Application of TETU norms in hospitals for children ages 0-59 months | 11a. % of children 0-59 months triaged upon admission to hospital, disaggregated by sex | 44% | 68% | Hospital QIT monthly report based on hospital records and triage forms | Data collection tools were not capable of collecting sex disaggregated data. Baseline is 2010 average. 2012 data is from Q1. |
| | | 11b. Child mortality rate in the first 24 hours in emergency ward of six participating TETU hospitals, disaggregated by sex | 17.5% | 9.7% | Hospital QIT monthly report based on hospital records | Data collection tools were not capable of collecting sex disaggregated data. Baseline is 2010 average. 2012 data is from Q1. |
| 11 | Adherence to health product management norms | % of public health clinics that respect health product management norms as measured through: storage assessment, stock logs, forecasting, timely orders, and appropriate decision making | 79% | 74% | Assessment tool reviewing stock logs from clinics, order forms, minutes from deliveries | |
| 12 | Professionalization of community based health insurance groups in the targeted areas | Number of commune based health insurance networks in Zou/Collines which have a documented professionalization plan | 0 | 2 | Verified professionalization plans | |

PISAF Performance Monitoring Plan Indicators Zou/Collines 2011–2012 continued

| # | Indicator | Definition | Baseline (2010 data)** | FY2012 Indicator Value* | Data Source | Comments |
|---|--------------------------------|---|------------------------|-------------------------|----------------------------|----------|
| IR 3 Increased demand for health services, products, and preventive measures | | | | | | |
| 13 | Referral of women with fistula | Number of cases of women with fistula who are referred for an operation to repair the fistula | NA | 103 | Fistula referrals database | |

PISAF Performance Monitoring Plan Indicators Atlantique/Littoral 2011–2012

| # | Indicator | Definition | Baseline (2011) | 2012 Indicator Value* | Data Source | Comments |
|---|---|--|-----------------|-----------------------|---|--|
| S05: Expanded use of family health services, products and preventive measures within a supportive policy environment | | | | | | |
| 1 | Use of Family Health services package | Total number of women delivering at participating health facilities by a qualified health worker | 2273** | 5646 | Health center M&E reports | |
| | | 1a. % of all women delivering at participating health facilities receiving all three steps of AMSTL | 39%** | (938/5646) 70% | Health center M&E reports | |
| | | 1c. Number of pregnant women who have received two doses of SP (IPTp) | 1863** | 2468 | Health center M&E reports | |
| IR1: Create a supportive implementation environment | | | | | | |
| 2 | Capacity building of decentralized institutions | % of Mayor's offices participating in last performance review verification in communes with performance contracting | 0/2 (0%) | (2/2) 100% | Performance validation reports | |
| 3 | Reinforcing the supervisory system | % of health centers receiving at least 4 supportive supervision visits during the year | N/A | (31/35) 85% | Supervision visit logs/ reports from health centers | |
| 4 | Management of family health products | % of distribution centers with updated logistic data in the Medistock-web each month | 0% | NA | Medistock software and Medistock-web platform | <i>Medistock web was undergoing changes in 2012 which did not allow for collection of this indicator</i> |
| IR2: Increased access to quality services and products | | | | | | |
| 5 | Adherence to management norms for health products | % of public health clinics that respect health product management norms as measured through: storage assessment, stock logs, forecasting, timely orders, and appropriate decision making | NA | (7/35) 20% | Assessment tool reviewing stock logs from clinics, order forms, minutes from deliveries | |

* Data for 2012 represents Quarter 1 (September-December 2011) and Quarter 2 (January 2012-March 2012)

** From Rapid Baseline Assessment 2011

Annex 2. Comparison of Actual Activities and Results with Life of Project Plan

PISAF Implementation Plan

| Results | Achieved | Comments |
|---|----------|--|
| Project Management | | |
| Set up project offices in Bohicon, Parakou, and Cotonou | x | |
| Develop annual workplans | x | |
| Develop performance monitoring plan | x | |
| Submit Quarterly and Annual Reports, and Final Report | x | |
| IR1. A Supportive Implementation Environment Created | | |
| <i>IR1.1 Selected health policies and approaches implemented</i> | | |
| Develop consensus on key strategies and approaches with MOH and partners and scale-up plans | x | |
| Finalize and assist in implementation of mutuelle strategic plan | x | |
| Develop a national QA plan | | <i>Framework for the national QA plan was developed, the plan itself was not completed</i> |
| Update policies on community provision of services | x | |
| Develop consensus on decentralized medicines warehousing implementation | x | |
| Communication plan for decentralization policy | x | |
| Regular fora for discussion of decentralization issues with health staff and civil society | | <i>This activity was not a priority of the MOH.</i> |
| Conduct feedback sessions between health zones and MOH on decentralization issues | x | |
| Implement ascendant planning at all levels of the health system (Central, regional and peripheral levels) | x | |
| Regular meetings between MOH and donors for coordination and collaboration on policy issues | x | |
| Assist in updating of minimum family health package with PMTCT, VCT, IPT, ITN, etc | x | |
| Develop mechanism for reviewing and updating standards | x | |
| Conduct cost-analyses related to treatment policies | | <i>Not achieved.</i> |
| Assist in regular standards review/updates | x | |

PISAF Implementation Plan continued

| Results | Achieved | Comments |
|--|----------|---|
| Develop mechanisms for communication of standards | x | |
| Assist in implementing communication of standards mechanisms (including preservice training) | x | |
| Assistance in design and implementation of national commodity security strategic plan | | <i>CAME (Centrale d'Achat des Médicaments) is still in the process of restructuring, and was not able to spearhead this work.</i> |
| Assist MOH in acquiring other financial support (GFATM, etc) | x | |
| Assist PNLN to use effective practices and M&E data in programming activities on Malaria/IMCI including community IMCI | x | |
| Assist NACP to decentralize HIV/AIDS and STIs programming and use effective M&E data | | <i>Functional collaboration with the NACP not achieved.</i> |
| Assist the DSF to finalize national strategy on maternal and neonatal mortality and support its implementation | | <i>Not achieved.</i> |
| Epidemic preparedness for avian flu | | <i>Not achieved.</i> |
| <i>IR 1.2 Increased Health System management capacity created</i> | | |
| Implement management assessment in Z/C | x | |
| Assist in development of regional strategic plans based on management assessment | x | |
| Develop and review institutionalization/sustainability plans in Z/C and B/A | x | |
| Support development and revision of capacity building plans for Z/C and B/A | x | |
| Introduce scoreboards in Z/C and update scoreboards to reflect expanded minimum package of FH services | x | |
| Support use of scoreboards in Z/C and B/A | x | |
| Support quarterly review of performance vis-à-vis annual action plans | x | |
| Support study tours for key health officials | x | <i>Study tour for DSME staff on supply chain management to Burkina Faso completed. Study tour on RAMU was planned, but due to competing priorities of MOH, was not completed.</i> |

PISAF Implementation Plan continued

| Results | Achieved | Comments |
|---|----------|---|
| Install LAN at the DDSP, DH, and all Health Zone offices in Z/C | | <i>Not achieved.</i> |
| Provide training in human resources/quality assurance in Z/C and reinforce in B/A | x | |
| Provide training and reinforcement for financial management in Z/C and B/A | x | |
| Provide the Z/C DDSP, HZMT and DH with computer equipment to strengthen their management capacity | x | |
| IR1.3 More effective civil society participation created | | |
| Conduct assessment of community mobilization in Z/C | x | |
| Develop consensus model for community mobilization, including engagement of women's groups, etc | x | |
| Train COGEA and COGEC (including sessions in conjunction with health center staff) including mutuelles | x | |
| Provide support to COGEA and COGEC in ascendant planning and other activities | x | |
| Provide technical support to HZ community mobilization agents | x | |
| Introduce and support Commune Mutuelle Support Committees in areas of new mutuelles | x | |
| Develop mechanisms to engage NGOs and CBOs and private sector in malaria prevention and treatment | x | <i>Private sector providers trained in malaria treatment.</i> |
| Award grants to NGOs and CBOs | x | |
| Provide training to NGO and CBO grantees in improved management | | <i>Not achieved.</i> |
| Mobilize local community groups to promote good practices vis-à-vis malaria and ARI (O/P, Z/C, B/A) | x | |
| Develop and pilot links between mutuelles and micro-finance initiatives | x | |
| Investigate how to link mutuelles and community-based distribution (ASBCs), pilot and rollout if successful | | <i>Not achieved.</i> |
| IR2. Access to Quality Services and Products Increased | | |
| IR2.1 Selected products available at public health facilities | | |
| Document PROSAF experience of reinforcing essential medicines warehousing at regional and HZ levels | x | |
| Facilitate creation of departmental and zonal warehouses in Z/C | x | |
| Build capacity for logistics management (Z/C and reinforce as needed in B/A) | x | |

PISAF Implementation Plan continued

| Results | Achieved | Comments |
|--|----------|--|
| Assure that new products for expanded minimum package are incorporated into logistics system | x | |
| Update training materials for ASBC to include new FH products | x | |
| Support expansion of FH products with ASBC and NGOs | x | |
| Insert indicators for ASBC into scoreboards and other monitoring tools of HZ | x | |
| IR 2.2 Selected products available at private sector outlets | | |
| Introduce sale of ITNs through womens groups and mutuelles | x | <i>National ITN guidelines for ITN distribution have changed, but pre-change, womens groups and mutuelles were selling ITNs.</i> |
| Test strategy for training private drug sellers | | <i>Not achieved.</i> |
| Promote links between communities and health centers, private outlets for FH products (including condoms and bednets) | x | |
| IR2.3 Quality family health package available at target public health sector facilities | | |
| Ensure that expanded minimum package norms and standards are available at DDS (Z/C and B/A) | x | |
| Incorporate expanded items into training materials, supervision guides and performance monitoring tools | x | |
| Introduce notion of integration of service delivery to Z/C through training on family health protocols (with focus on EONC, FP, HIV/AIDS & STIs, including VCT & PMTCT, etc) | x | |
| Support capacity building for health facility staff in updated guidelines (Z/C and B/A) | x | |
| Support capacity development in QA and supervision and supervision planning (Z/C and B/A) | x | |
| Support IMCI training and post-training follow-up in Z/C and for transfer-in staff in B/A and O/P | x | |
| Support HZ in the development/strengthening of collaboratives in Z/C and B/A | x | |
| Support regional and cross-zonal collaboratives | | <i>Not achieved.</i> |
| Develop and provide effective job aids | x | |
| Provide selected health facilities with medical equipment to improve quality service delivery | x | |

PISAF Implementation Plan continued

| Results | Achieved | Comments |
|--|----------|----------------------|
| IR 2.4 Financial access to health services increased | | |
| Document B/A experience with mutuelles | x | |
| Support existing mutuelles by strengthening their organizational and managerial capacity | x | |
| Create additional mutuelles in B/A in the five communes not covered by mutuelles | x | |
| Create gradually mutuelles in selected communes of Z/C based on B/A experiences | x | |
| Support creation of regional federations of mutuelles (B/A and Z/C) | x | |
| Introduce mechanisms for on-going technical support to mutuelles in B/A and in Z/C | x | |
| Create local mechanisms for on-going technical support to mutuelles in B/A and in Z/C | x | |
| Analyze barriers to use of services by the disadvantaged, including costs | x | |
| Design and test mechanisms for reducing barriers to access for the disadvantaged | | <i>Not achieved.</i> |
| IR 3. Demand for Health Services, Products, and Preventive Measures Increased | | |
| IR 3.1 Knowledge of appropriate behaviors and preventive measures improved | | |
| Elaborate BCC strategy | x | |
| Engage the national level in discussion of key messages and media | x | |
| Update inventory of IEC materials, assess community tools, adapt and translate training and IEC materials | x | |
| Print and disseminate IEC/BCC materials and job aids | x | |
| Identify key BCC priorities on an annual basis, including ITN, IPT, PMTCT, VCT, etc | x | |
| Identify groups and partners to collaborate on BCC | x | |
| Strengthen health workers and other partners capacity in BCC/IEC including IPC | x | |
| Develop annual BCC workplans | x | |
| Implement multi-media campaigns (radios, MPT, etc) on family health topics including IMCI, EONC, FP, Malaria and HIV/AIDS & STD prevention and care) | x | |
| Support development and implementation of innovative BCC strategies | x | |
| Support community IMCI and EONC | x | |
| Issue grants to NGOs and CBOs and build their capacity to deliver community based services | x | |



PISAF Implementation Plan continued

| Results | Achieved | Comments |
|--|----------|----------|
| Support Malaria Mobilization Days and Social Mobilization weeks | x | |
| <i>IR 3.2 Appropriate research-based interventions and services introduced</i> | | |
| Determine BCC topics requiring formative research | x | |
| Determine service delivery innovations needing testing | x | |
| Implement pilots and evaluation results | x | |
| Develop strategies for scale-up of pilot strategies | x | |

Annex 3. Strategy Documents and Study Reports

1. Koto-Yerima, A., Barnes, J. & Soglohoun, P. 2010. *Study on the Professionalization Experiences of Health Mutuelles in Benin*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC (URC).
2. Ouendo, EM. & Ba, A. 2010. *Study on the factors linked to the retention of mutuelle health members in Benin*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
3. USAID Integrated Family Health Project. 2007. *Behavior Change Communication Strategy*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
4. USAID Integrated Family Health Project. 2007. *Community Mobilization Strategy*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
5. USAID Integrated Family Health Project. 2007. *Midterm Evaluation of Mutuelles in Sinendé and Banikoara*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
6. USAID Integrated Family Health Project. 2012. *Policies and Strategies for Professionalization of Mutuelles and Mutuelle Health Networks in Benin: 2013-2017*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
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8. USAID Integrated Family Health Project. 2006. *Quality Management Assessment of the Zou/Collines Department Health System*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
9. USAID Integrated Family Health Project. 2010. *Second Quality Management Assessment of the Zou/Collines Department Health System*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
10. USAID Integrated Family Health Project. 2009. *Study on Indigent Health Funds and Health Mutuelles*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
11. USAID Integrated Family Health Project. 2008. *Study on Networking Health Mutuelles within Zou/Collines*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
12. USAID Integrated Family Health Project. *Study on the Implementation Context of Health Mutuelles*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
13. USAID Integrated Family Health Project. 2011. *Synthesis of Recommendations from Round Table Event on PISAF's Achievements*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC.
14. Yacoubou, I. & Otis, C. 2010. *Contribution of Health Mutuelles in the Promotion of Community Health in Benin*. Published by the USAID Integrated Family Health Project for the United States Agency for International Development. Cotonou, Benin: University Research Co., LLC (URC).

Annex 4. Tools and Job Aids Developed by PISAF

Stratégie de la Communication pour le Changement de Comportement

Behavior Change Communication Strategy Document

Year Produced: 2007

HIV/AIDS

Relative risks of Infant Feeding in the context of HIV

Year Produced: 2007

How to safely use store bought milk

Year Produced: 2007

If you have the AIDS virus, what is the best option for feeding your baby?

Year Produced: 2007

How to breastfeed your baby?

Year Produced: 2007

How to breastfeed your baby with store bought milk?

Year Produced: 2007

Feeding your baby after the age of 6 months

Year Produced: 2008

« Young people, take charge : Put your future first »

Year Produced: 2007

« Pregnant women, don't forget your midwife »

Year Produced: 2007

Family Planning

It's easy to have children when you want

Year Produced: 2007

Counseling Process (Family Planning Counseling)

Year Produced: 2008

Modern contraceptive methods flipbook

Year Produced: 2008

Family planning binder

Year Produced: 2008

Happy household

Year Produced: 2009

Malaria

Popular songs on the prevention and treatment of uncomplicated malaria in communities

Year Produced: 2007

For the wellbeing of your children

Year Produced: 2007

Donated blood saves life

Year Produced: 2008

How to administer COARTEM

Year Produced: 2008

How to assess a coma according to Glasgow and Blantyre

Year Produced: 2009

How to conduct a rapid diagnostic test for malaria

Year Produced: 2008

Management of severe malaria in children less than 5 years

Year Produced: 2008

Maternal and Newborn Health

Essential Maternal and Newborn Care

Year Produced: 2008

Protective garments for operating and delivery rooms

Year Produced: 2009

Not everything is lost

Year Produced: 2010

Inform yourself and save your life

Year Produced: 2010

Understand and Prevent Obstetric Fistula: We can overcome it together

Year Produced: 2011

Job Aids for Coaches

Year Produced: 2011

Coaching as a Tool to Support Quality Improvement Teams

Year Produced: 2011

Family Health

Family health flipbook

Year Produced: 2008

Think of your future: use your moral compass

Year Produced: 2009

Community Health

Health Mutuelles in Benin: Why? For whom? How?

Year Produced: 2008

Referral and Counter Referral Sheets

Year Produced: 2009

Popular songs on promotion of family planning, prevention of STI/HIV/AIDS and management of simple malaria at home

Year Produced: 2009



USAID | **BENIN**
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COMMUNITY HEALTH WORKERS IN BENIN SAVE LIVES BY DIAGNOSING MALARIA

Eleven-month old Basile might have died without timely intervention from Cossi Dansou, a Community Health Worker (CHW) who diagnosed severe malaria and quickly referred him to a local health center. Basile's story illustrates the potential life-saving contributions that CHWs trained by USAID's Integrated Family Health Program (*Projet Intégré de Santé Familial* or *PISAF*) make in remote areas of Benin. PISAF is implemented by University Research Co., LLC (URC).

Realizing that Basile was likely to die without immediate medical care, Cossi located the boy's father, who was working in the family's field, and helped arrange transport to the nearest health center at Agoue.

Infant Referred Just in Time

Basile had been sick for almost a week and was getting worse when his mother took him to Cossi, the PISAF-trained community health worker serving her village. Cossi recognized several signs of severe malaria including white palms, convulsions and exhaustion. Realizing that Basile was likely to die without immediate medical care, Cossi located the boy's father, who was working in the family's field, and helped arrange transport to the nearest health center at Agoue. Noting the severity of the illness, the nurse at Agoue immediately referred the family on to the Savalou-Bantè district hospital.



Basile was diagnosed with severe malaria at 11 months old by PISAF-trained community health worker Cossi Dansou (center). Basile's mother (right) and older brother (left) look on. Cossi's rapid intervention probably saved Basile's life.

Severe Malaria: A Deadly Disease

Severe malaria in young children can lead to death within hours if left untreated. Treatment differs depending on symptoms which can include convulsions, coma, shock, severe anemia, and acidosis. Treatment usually requires hospitalization, and incorrect treatment can do more harm than good. Thus a CHW's responsibility, according to Benin's national standards, is not to treat severe malaria but to recognize symptoms suggestive of it and transfer the patient to a health

facility immediately. Since severe malaria is an emergency, PISAF has worked with the Ministry of Health to introduce emergency triage and treatment (TETU or *Tri, Evaluation, Traitement, et Urgence* in French). TETU ensures that very sick children receive highest priority for immediate care rather than waiting hours in pediatric outpatient lines. Since severe malaria treatment is complex, PISAF has developed a job aid that helps clinicians select interventions appropriate to each child's symptoms.

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PISAF

As a CHW, I know that even if I don't gain anything from this work, it will give me a name. Maybe someday I can even work at a health facility. It is important to seek out honor.

Cossi Dansou, CHW

Health workers at the Savalou-Bantè hospital confirmed Basile's diagnosis and diagnosed severe anemia, a complication that occurs in over 50% of cases. As indicated in Beninese and WHO guidelines, Basile received a blood transfusion to treat the anemia. He recovered completely. Had the family waited any longer to seek care, Basile might not have survived.

PISAF Trains Community Health Workers (CHWs) in Malaria Diagnosis and Treatment

PISAF works to increase access to and improve the quality of family health services. In remote areas where formal health workers are scarce, the project trains volunteer community health workers (CHWs) to provide basic services. Known locally as *relais communautaires*, the CHWs receive kits with long-lasting insecticide-treated bednets (LLINs), oral rehydration salts (ORS) and zinc for diarrhea, condoms, paracetamol, aspirin, oral contraceptives and behavior change communication (BCC) materials. Though unpaid, CHWs are allowed to earn a small profit from selling health supplies. In 2009, when Benin began allowing CHWs to treat uncomplicated malaria in children under five, PISAF trained 150 CHWs from the departments of Zou and Collines in

community case management of malaria and community-integrated management of childhood illnesses (c-IMCI). CHWs in the area now treat over 2,000 presumptive cases of malaria per month in children under five.

CHWs Value Training

CHWs report increased demand for services, possibly due to growing community confidence in their work. Beyond case management training, they learn to recognize and manage illness in children from 6 months to 5 years old and to counsel mothers on infant feeding, birth planning, family planning, and healthy practices during pregnancy, such as sleeping under a bed net, helping to alleviate the health workforce crisis, which is more acute in Benin than the sub-Saharan average. Antoine Togni, a PISAF-trained CHW, said the knowledge he gained has helped him care for his own

community. He said, "people can come look for you anytime, even when you're sleeping. You can be in the field and people will call for you because a child is sick." Cossi's primary hardship is finding transport: even when a child is severely ill, he may lack the means to transport the child to a health center. This undermines his ability to save lives. Several CHWs have mentioned that a motorcycle to transport patients and thermometers to verify fever would equip them better. Some communities have developed innovative ways to assist CHWs: one created a village fund to pay for health center visits and transport. Financial incentives are also an issue: CHWs make only a small profit from selling medicines and mosquito nets. To assist them, village residents often agree to work in their fields, but this help can be slow to materialize.

Other CHW programs in developing countries face similar challenges. PISAF

[The CHW] training has boosted my standing in my village. It has also helped in my own household on numerous occasions. Since the trainings, I don't need to bring my children to the hospital—instead I treat them myself at home. If referral to a health facility is not necessary, I don't bring them.

Antoine Togni, CHW

family as well as his neighbors. He plans to continue serving the community even after the project ends.

Highly Motivated CHWs Face Challenges

Cossi Dansou, the CHW who worked with Basile, cited many difficulties with his position, including being on call 24 hours a day and having to repeat messages many times to effectively educate the

and initiatives like it continue to look for sustainable incentives to keep CHWs motivated. Nonetheless, many CHWs find the work immensely satisfying and remain committed to helping their communities despite the challenges. In Cossi's words, "At the beginning of this work there are difficulties. If you do not love your village, you cannot do this work; it is the love you have for your village that makes you able to do this job."

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SAVING WOMEN’S LIVES: IMPROVED OBSTETRIC CARE IN BENIN

For many women in Benin, West Africa, giving birth continues to be a life-threatening event. National figures indicate that as many as 400 women die per 100,000 live births, and this figure may underestimate the true burden of maternal mortality in Benin¹. The 2008 Human Development Report ranked Benin 163 out of 177 for maternal mortality. Regional data indicate that most maternal deaths -- more than a third -- are due to post-partum hemorrhage (PPH), excessive uterine bleeding that sometimes occurs after childbirth². URC’s PISAF (Integrated Family Health Program) is working with the

government of Benin to reverse this alarming trend.

In the departments of Zou and Collines in south-central Benin, which comprise nearly 20 percent of the country, URC is working to reduce PPH through a proven approach called Active Management of the Third Stage of Labor (AMTSL). Although the Ministry of Health adopted AMTSL as a national strategy in 2004, many facilities are struggling to put it into practice.

PISAF is implementing a quality improvement approach called the improvement collaborative, which is

designed to improve the functioning of the health system so that policies can be translated into effective practice.

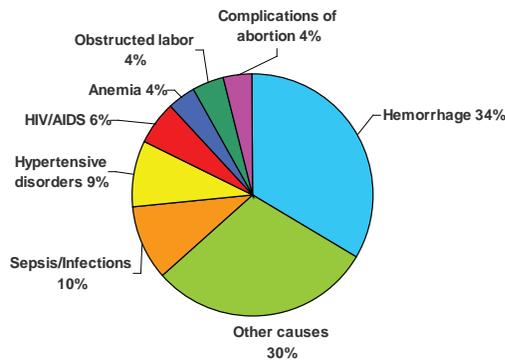
In collaboratives, practitioners from different levels of the health system work together to determine ways to rapidly improve quality in a specific health care area. Teams develop indicators and a proposed set of practices; they test these new practices; and then apply successful changes on a larger scale.

In Benin, PISAF launched a collaborative in 2008 to improve maternal and newborn care, with a focus on AMSTL. The collaborative also includes essential newborn care and infection prevention.

The initial phase of the collaborative includes 17 health facility sites (1 district hospital, 4 zonal hospitals and 12 health centers). The sites are implementing changes to ensure that all facilities provide the three components of AMTSL: 1) administering Oxytocin immediately after the birth of the baby; 2) careful traction of the umbilical cord, and 3) uterine massage.

PISAF has made rapid progress in applying the three elements of AMTSL. As performance of all three elements

Hemorrhage is the leading cause of death for mothers in Africa



1. UNICEF, 2005. UNICEF notes that when adjusted for underreporting and misclassification, this rate could be as high as 840/100,000.
2. UNICEF Causes of maternal death (1997-2002) in Africa. Source: Progress for children 7 (UNICEF, September 2008)

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PISAF

rose from 73% to 98% in less than a year (May 2008 to March 2009), post-partum hemorrhage dropped significantly (a 53% decrease), as shown in the chart to the right.³

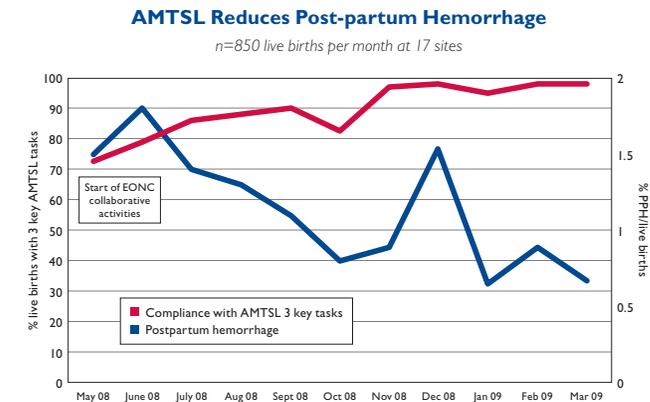
Due to the success of the collaborative in reducing PPH in its initial demonstration phase, PISAF will expand it to 22 new sites in June 2009. PISAF also plans to add interventions to prevent eclampsia—a significant cause of maternal mortality—at all 39 sites.

One woman in the Zou department gave this moving account of her experience giving birth before and after the launch of PISAF's collaborative:

“For my previous delivery in the Bohicon maternity, I went into labor at about 7:45 am, and already by 8:30am I had lost consciousness due to a major hemorrhage. The care given at this facility was not able to stop the hemorrhage, so the midwife referred me to the departmental hospital in Abomey. I was in crisis despite the intensive care provided (blood transfusion IV) at the departmental hospital. I didn't regain consciousness until about 6pm. Thank God, I managed to survive.

For my recent delivery, I went to the maternity in Zogbodomey [department of Zou], where my husband and I expected the worst, because of our previous experience. But to our immense relief, everything went well and I hardly bled at all...”

Ms. Ganse, a new mother who received AMTSL at the Zogbodomey Maternity Center



Her husband expressed a similar sentiment:

“This recent delivery went much better than the previous. This time, there were no complications. I was expecting a referral [to a hospital], since the last delivery resulted in a serious hemorrhage and a referral...But to my great surprise, everything went well. Moreover, it only cost 10,000 francs this time, compared to the 150,000 francs it cost last time, not to mention the psychological stress from the fear of losing my wife!”

Mr. Ganse



Improved obstetric care is helping families in Benin including the Ganse family pictured here.

This story highlights not only the powerful life-saving effect of these interventions, but also the cost-effectiveness of improving care quality.

Integrated Family Health Program/Projet Intégré de Santé Familiale (PISAF)

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3. It should be noted that no baseline data were collected prior to implementation of the collaborative activities.



TREATING AND PREVENTING FISTULA IN BENIN THROUGH THE USAID PISAF PROJECT

At least two million women in Africa, Asia, and the Middle East are living with obstetric fistula, and about 50,000 to 100,000 new cases occur each year. Obstetric fistula is a hole in the birth canal that is caused by prolonged labor without medical care. The condition leaves a woman with chronic incontinence and, in most cases, a stillborn baby, and if fistula is not treated, it can lead to other chronic medical problems. The constant and humiliating smell of leaking urine and feces often causes women with fistula to be shunned by their families and communities.

Fistula is almost entirely preventable. The underlying causes of the condition include early pregnancy, lack of appropriate antenatal care, home delivery in the hands of untrained persons, delay in seeking medical care during prolonged labor, and excision (female genital mutilation). Poverty is closely linked with fistula, as many of these circumstances exist more frequently for impoverished girls and women. Surgery can typically repair fistula, but the average cost of the procedure and post-operative care is US \$300. Most affected women cannot afford treatment, and many are not even aware that a treatment is available. Connecting these women with the appropriate treatment, and assisting to finance the surgical repair is key to their successful recovery.

In the Zou and Collines Regions of Benin, the United States Agency for International Development (USAID)-funded Integrated Family Health Project (Projet Intégré de Santé Familiale, or PISAF) partnered with local non-governmental organizations (NGOs) to address fistula. The fistula program, which operated from 2011 through 2012, had two major objectives: 1) to educate health workers and the public



The brochure, entitled "Understanding and fighting obstetric fistula: Together, we will overcome", includes a description of the condition, its names in local language, information on its causes and preventive measures, and guidance on families and communities can do if a woman has an obstetric fistula.



on fistula and its prevention and treatment; and 2) to provide comprehensive treatment and support to women with the condition and enable their reintegration into society. PISAF was a six-year (2006-2012) project implemented by University Research Co., LLC (URC) to improve management systems and mobilize communities for health systems focused on maternal and neonatal health, child health, malaria, family planning, and HIV/AIDS.

Methods and Results

PISAF implemented its fistula interventions through six primary activities:

1. Establishing a partnership with two local NGOs to support community-level activities;
2. Training healthcare providers and community health workers (CHWs) to identify women with fistula and on treatment options;

3. Educating the public on fistula, its prevention, and treatment availability;
4. Identifying existing fistula cases and coordinating treatment; and
5. Supporting the social and economic reintegration of women who underwent successful treatment.

Partnership with Local NGOs

To ensure that the fistula program effectively reached local communities, PISAF partnered with two NGOs: ALDIPE (Association de Lutte pour un Développement Intégré et pour la Protection de l'Environnement), which worked primarily in the Zou Region, and BACAR (Le Bureau d'Appui-Conseils d'Afrique pour les Réalisations), which worked primarily in the Collines Region. PISAF funded and provided technical support as well as supervision and monitoring for the NGO activities, which included CHW training, public education, case

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PISAF



Fistula case admitted to the National University Hospital in Cotonou waiting to receive care.



Successfully treated obstetric fistula case (right side) is socially reintegrated into her community.

identification, and support for the women and their families before and after treatment. PISAF selected the NGOs in collaboration with representatives from two Benin Ministry of Health (MOH) departments: the Regional Director in Charge of Institutional and Civil Society Relations (French acronym DDCRI) and the Regional Health Department (French acronym DDS) of Zou and Collines. These NGOs were selected based on their extensive previous community work in the local area.

Healthcare Provider and CHW Training

PISAF met with healthcare providers and the NGOs met with CHWs to train them on fistula. The trainers explained what fistula is and taught both groups about associated signs and symptoms, so that they can recognize a case of fistula, and about how to refer a woman with fistula for treatment. These trainings addressed a previously-held misconception among participants that fistula only existed in the northern part of the country (a belief that developed because the first hospitals that were equipped to treat fistula were located only in northern Benin). Participants also learned about the underlying causes of fistula and how to prevent the condition. PISAF trains Community Health Workers (CHWs) in Malaria Diagnosis and Treatment.

Community Education

ALDIPE and BACAR worked with the MOH Regional Medical Coordinator to determine which communities in Zou and Collines would receive targeted education on fistula and coordinated with the CHWs

and healthcare providers already trained on fistula to organize the events. Through a total of 858 community meetings, the NGOs educated the general public on fistula, its treatment, and its prevention. An essential component of these meetings was explaining that fistula is a treatable condition and that women suffering from the condition need support from their families and communities both before and after treatment. During the meetings, NGO representatives also requested that people notify a CHW or a health facility about any known fistula cases, so that the women could be sent for treatment.

Connecting women with the appropriate treatment, and assisting to finance the surgical repair is key to their successful recovery.

In addition to community meetings, the NGOs raised public awareness of fistula by organizing targeted education sessions with religious and opinion leaders, traditional midwives, women's group leaders, directors of local theater troupes, and radio announcers. ALDIPE also worked with radio stations to produce eight radio spots on fistula, which were translated into four local languages to support effective dissemination.

In partnership with the Benin MOH, PISAF produced a pamphlet in French intended to educate the public on fistula. Key messages from the pamphlet remind readers 1) to ensure that pregnant women go for regular antenatal care and receive

immediate care in cases of prolonged labor; and 2) to support rather than reject women with fistula, a curable condition. PISAF field tested the pamphlet to ensure that it was easy to understand and effectively conveyed all the key messages for the local context. PISAF and the NGOs used these pamphlets in education sessions and provided copies to health facilities and CHWs.

Treatment for Existing Cases

ALDIPE and BACAR worked with health facilities and CHWs to ensure that the NGOs were notified of all identified fistula cases, which they reported to PISAF. As only a few high-level referral hospitals in Benin were equipped to perform fistula repair surgery, PISAF worked with the United Nations Population Fund (UNFPA) to determine which hospitals were available to perform the procedure. Initially three referral hospitals in the north of Benin had the necessary technical expertise and equipment to provide the repairs. In 2012, departure of the staff skilled in fistula repair and lack of resources at these hospitals resulted in a backlog of cases waiting for repair. PISAF consulted with UNFPA and the National University Hospital in Cotonou (CNHU) to ensure that these women could get the necessary treatment there. As of December 2012, CNHU was the only hospital in Benin providing fistula repair surgery.

The NGOs prepared and coordinated arrangements with the women, who came to the hospitals in groups and were each accompanied by one companion. PISAF made travel arrangements and ensured

housing and a food stipend for the women and their accompanying partners during their recovery. In total, PISAF's efforts in coordination with the NGOs ensured that 103 women with fistula were identified, 85 were treated, and 66 had successful operations. Women whose initial surgery was not successful were referred for specialized surgery and treatment procedures.

Social and Economic Reintegration of Affected Women

The NGOs provided specialized support to the families of affected women to counsel them on how to provide moral support and assistance during post-operative recovery and clinical follow-up. Once the women returned home after their operations, NGO representatives regularly visited them to check on their health status and the status of their reintegration into their families and communities. During these visits, women discussed their needs and received recovery counseling. In some cases, the NGOs were able to link the women to income-generating activities, such as microfinance opportunities.

Recommendations

Although the PISAF fistula program was relatively brief, it revealed a number of valuable lessons learned and best practices for implementing fistula interventions in similar low-income settings.

- **Strengthen Health Systems and Hospital Capacity:** Community-level fistula interventions like those implemented by PISAF are only effective when they are accompanied by efforts to strengthen the health system to provide relevant care, and greater investments should be made toward this effort. Health centers must have the necessary human and financial resources, capacity, and equipment to properly treat fistula. In addition, health workers must be educated on fistula and must be able to inform their clients on its prevention and treatment. Also, hospitals must have the capacity to provide reparative treatment. By the end of 2012, there were still some women in Zou and Collines waiting for their surgeries, due to lack of hospital staff trained in fistula repair. Specialized

One Woman's Story

"I developed fistula in 2009 after a difficult and prolonged childbirth. I was 34 years old. Because of the smell, all of my friends and family abandoned me. It was difficult for me to go out into public because I could wet myself at any moment and I would need to change my clothes. My life didn't make any sense. I was desperate, crying all the time."

"By the grace of God, I heard information about fistula repair on the radio. I went to the NGO ALDIPE who spared no effort to take care of me and treat my fistula. The ALDIPE team answered all of my questions about my condition and accompanied me to the health center where I was examined and officially diagnosed with fistula. I was then included on the next trip to the Tanguiéta Hospital for my repair."

"ALDIPE paid for my transportation and gave me pocket money. At Tanguiéta we were well taken care of as soon as we arrived for our month-long stay. My operation was successful. I have completely recovered and I thank PISAF and ALDIPE for giving me back my life."

– Martine Daagbinde

centers for repairing fistula must be opened, equipped, and staffed with qualified, trained providers throughout the country.

- **Institute a Nationwide Awareness Campaign:** Efforts must be made to raise awareness about fistula both at the community and facility levels nationwide to reduce its incidence. Eradication of fistula is not the responsibility of the health sector alone. Rather, it is necessary to understand, address, and overcome social and cultural barriers to getting women treated for fistula, which include beliefs that women should be blamed and shamed for the condition and that fistula only exists in one region of the country. Awareness-raising efforts must help overcome myths and misconceptions surrounding fistula and educate the public that fistula is a disease like any other and that it is both preventable and treatable.
- **Emphasize Prevention Communication:** Educating healthcare providers and the public on the underlying causes of fistula and on fistula prevention practices is essential to combat the condition before it starts.
- **Provide Social Reintegration Opportunities after Treatment:** Frequently, women with fistula are shunned and sent away by their families due to their condition. Although PISAF's work found that in Benin, some women with fistula are not totally ostracized from their families but rather maintain a support system that can be built upon during recovery, social reintegration efforts were still an essential component of the project's work. These efforts should tap into pre-existing community-support mechanisms, such as women's groups and religious groups, to ensure their success.
- **Provide Income Generation Opportunities after Treatment:** In addition to social reintegration, economic reintegration of women is essential to enabling them to fully rejoin their communities. Income-generating opportunities should be provided for women after successful surgery and should be accompanied by skills-building activities to ensure effectiveness.
- **Adopt a Comprehensive Approach:** An approach that includes health systems strengthening, healthcare provider and community education, fistula treatment, and socioeconomic reintegration support is essential to effectively care for women with fistula and prevent future cases from developing.

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PILOTING THE USAID GENDER INDICATOR ON EQUALITY OF ACCESS TO SOCIAL, ECONOMIC AND POLITICAL OPPORTUNITIES IN BENIN

Background

Gender equality and female empowerment are now universally recognized as core development objectives, fundamental for the realization of human rights, and key to effective and sustainable development outcomes, including health outcomes. In Benin, a 2009 National Policy for Gender Promotion paper showed that gender disparities associated with social and economic traditional roles has hampered the attainment of development goals.¹ Though these traditional practices are progressing over time, men and women's status and treatment is still unequal, with the burden of poverty weighing heavily on women.

The last general population census in 2002 measured overall participation rate in the economy at 63.8%, with men's participation (68.3%) 9% higher than women's (59.7%).² The 2006 Demographic and Health Survey showed only 53.3% of women between the ages of 15 and 49 reported working for money.³ Politically, gender disparities are prevalent as well. The first local elections were organized in 2002, and women's representation on local councils was only 3.75% (45 elected women/1,200 town councilors). After the second local elections, there was a 0.43% increase in women representation (60/1,435).⁴

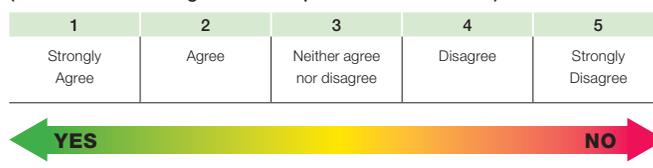
¹ Ministry of Family and National Solidarity, National Policy for Gender Promotion in Benin, 2009.

² National Statistics Office (INSAE), General Report of the Third General Population and Housing Census, 2004

³ Macro Intl/INSAE, 2006 Benin Demographic and Health Survey Report, 2007.

⁴ JICA, Country Gender Profile Benin, December 2009.

Figure 1: Visual Scale for Responses
(Tool Used for Piloting Was Developed in French and Fon)



Methods

Recognizing the critical role that this type of gender inequity plays in health outcomes, USAID is spearheading strategic planning around best practice approaches for addressing inequities at the community, health system, and health sector levels. A first step in this strategic planning is collecting baseline data to assess the current situation on the ground. The USAID-funded Integrated Family Health Project (PISAF), implemented by University Research Co., LLC, pilot-tested the USAID Gender Indicator **“Proportion of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities”** with respondents in Benin's Zou/Collines, Atlantique/Littoral and Borgou/Alibori Departments.

Data for this indicator was collected by asking respondents to rate their agreement or disagreement with the following statements:

- Women should have equal rights with men and receive the same treatment as men do.

Gender equality and female empowerment are now universally recognized as core development objectives, fundamental for the realization of human rights, and key to effective and sustainable development outcomes, including health outcomes.

- On the whole, men make better political leaders than women and should be elected rather than women.
- When jobs are scarce, men should have more right to a job than women.

Responses were scored on a 5-point Likert scale from Strongly Agree to Strongly Disagree. These questions have been previously validated in the World Value Survey and the AfroBarometer in Africa. Two additional questions were added by the PISAF team, which covered previous exposure to the concept of gender and the source of that information.

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Table 1: Descriptive Statistics of Respondents from Pilot-test

| Descriptive Statistics | | N | % |
|------------------------|---------------------|----|-----|
| Region | Atlantique/Littoral | 7 | 29% |
| | Zou/Collines | 8 | 33% |
| | Bourgou/Alibori | 9 | 38% |
| Gender | Male | 13 | 54% |
| | Female | 10 | 42% |
| | No Response | 1 | 4% |
| Education Level | None | 2 | 8% |
| | Primary | 4 | 17% |
| | Secondary | 12 | 50% |
| | University | 2 | 8% |
| | No Response | 4 | 17% |
| Marital Status | Married | 20 | 83% |
| | Single | 3 | 13% |
| | No Response | 1 | 4% |
| Religion | Catholic | 8 | 33% |
| | Protestant | 1 | 4% |
| | Christian | 2 | 8% |
| | Animist | 3 | 13% |
| | Muslim | 8 | 33% |
| | Other | 1 | 4% |
| | Unknown | 1 | 4% |

After the questions were initially translated into French, they were field-tested with a convenience sample of people around the health center in Bohicon, Benin. The clarity of concepts and understanding of the questions with respondents was good. The main issues arose around distinguishing between the concept of "rights" within a couple and then in the larger family and with the 2-part statement on political leadership. The statement "On the whole, men make better political leaders than women and should be elected rather than women" was thus reformulated to read "It is better to elect men rather than women, because they are better political leaders." For the employment statement, a common example on equal opportunity in hiring emerged from the field-testing, which was then incorporated into the statement "If both a man and a woman with equal qualifications applied for a post and only one position was available, should the position go to a man?" A visual scale was found to be useful to affirm the responses by cross-checking the degree of agreement or disagreement.

Table 2: Results of Questionnaire Pilot-test

| Results | N | % (n=24) | |
|--|--|----------|-----|
| Women should have equal rights with men and receive the same treatment as men do. | Strongly Agree | 17 | 71% |
| | Agree | 1 | 4% |
| | Neither agree nor disagree | 1 | 4% |
| | Disagree | 4 | 17% |
| | Strongly Disagree | 1 | 4% |
| It is better to elect men rather than women, because they are better political leaders | Strongly Agree | 4 | 17% |
| | Agree | 6 | 25% |
| | Neither agree nor disagree | 4 | 17% |
| | Disagree | 9 | 38% |
| When jobs are scarce, men should have more right to a job than women | Strongly Agree | 7 | 29% |
| | Agree | 3 | 13% |
| | Neither agree nor disagree | 0 | 0% |
| | Disagree | 13 | 54% |
| Have you ever heard of the concept of gender? | Strongly Disagree | 1 | 4% |
| | Yes | 15 | 63% |
| | No | 9 | 37% |
| | If so, what was your source of information (n=15)* | Radio | 11 |
| TV | | 4 | 27% |
| Training | | 3 | 20% |
| Personal Conversation | | 2 | 13% |
| Work | | 1 | 6% |
| Home | | 1 | 6% |

* % are greater than 100% since some respondents mentioned multiple sources of information

Three focus groups were held to ensure that the translated French and Fon terminology was appropriate and easy to understand for the population of interest.

After these modifications were made, the updated questionnaire was translated into Fon, the most common local language in Benin. Three focus groups were held to ensure that the translated French and Fon terminology in the updated questionnaire was appropriate and easy to understand for the population of interest. There was one focus group of all women, one of all men and one with both female and male participants. Respondents had primary and/or some secondary education level. Individual interviews with 3 women and 1 man in Fon and 2 women and 2 men

in French allowed a more detailed conversation about each of the questions.

This validation did not result in any additional changes to the core questions, though basic demographic data as well as an introduction and consent section were added to the questionnaire. An additional question was added about any past exposure to the concept of gender.

The resulting final questionnaire was distributed to PISAF staff to pilot with a convenience sample of the population of interest who they would encounter during their normal activities in the Zou/Collines, Atlantique/Littoral and Bourgou/Alibori Departments. Staff received a one-day orientation, including review of the questionnaire and the visual scale and opportunities to practice delivery of the questionnaire. During this orientation the staff developed the standardized explanation of the concept of "gender," which would be given if the respondent was not familiar with it.

Table 3: Results of Pilot-test by Gender

| Results | | number (men) | % (n=13) | number (women) | % (n=10) |
|--|----------------------------|--------------|----------|----------------|----------|
| Women should have equal rights with men and receive the same treatment as men do. | Strongly Agree | 8 | 62% | 8 | 80% |
| | Agree | 0 | 0% | 1 | 10% |
| | Neither agree nor disagree | 1 | 8% | 0 | 0% |
| | Disagree | 3 | 23% | 1 | 10% |
| | Strongly Disagree | 1 | 8% | 0 | 0% |
| It is better to elect men rather than women, because they are better political leaders | Strongly Agree | 1 | 8% | 2 | 20% |
| | Agree | 4 | 31% | 2 | 20% |
| | Neither agree nor disagree | 3 | 23% | 1 | 10% |
| | Disagree | 4 | 31% | 5 | 50% |
| | Strongly Disagree | 1 | 8% | 0 | 0% |
| When jobs are scarce, men should have more right to a job than women | Strongly Agree | 6 | 46% | 1 | 10% |
| | Agree | 3 | 23% | 0 | 0% |
| | Neither agree nor disagree | 0 | 0% | 0 | 0% |
| | Disagree | 4 | 31% | 8 | 80% |
| | Strongly Disagree | 0 | 0% | 1 | 10% |
| Have you ever heard of the concept of gender? | Yes | 8 | 62% | 6 | 60% |
| | No | 5 | 38% | 4 | 40% |

Results

A total of 24 questionnaires were completed in three Departments of Benin with patients who were visiting health centers, health center staff, and staff in training. PISAF staff who administered the questionnaires noted that while the questions were translated correctly into French and Fon, there is often not a word for gender in other local languages in Benin, and therefore they used the standard definition for clarification. In general, the questionnaire was well received.

Respondents were 54% male and 42% female, and half had at least some secondary level of education. The majority were married. Most respondents were Christian (identifying themselves as Catholic, Protestant or Christian) and a third of respondents were Muslim. There was a relatively even split between the three departments of the country. Table 1 gives the descriptive statistics of the respondents.

Because of the small sample size, statistical significance of these results could not be

Because of the small sample size, statistical significance of these results could not be tested, the majority of respondents strongly agreed that women should have equal rights with men and receive the same treatment as men do.

tested, but the majority of respondents strongly agreed that women should have equal rights with men and receive the same treatment as men do. Responses to the statement on political leadership were more evenly split, with 42% percent affirmative responses, 17% neutral and 42% negative responses. The statement about gender equity in hiring had some variation, with 42% affirmative and 58% negative responses. It was notable that for the majority of respondents who had heard of gender, the radio was one of their sources of information on the topic, with TV a distant second. Table 2 shows the complete results of the questionnaire pilot-test.

Table 4: Source of gender information by gender

| | Men | Women |
|-----------------------|-----|-------|
| Radio | 5 | 6 |
| TV | 2 | 2 |
| Personal Conversation | 1 | 1 |
| Training | 3 | 0 |
| Work | 1 | 0 |
| Home | 0 | 1 |

Interesting patterns emerged when the responses were disaggregated by sex of the respondent. For the statements on equal rights and treatment and men being better political leaders, the patterns were similar. But, for the statement on employment rights, more men agreed that men should have more right to a job than women when jobs are scarce; ninety percent (90%) of women disagreed with the statement. Tables 3 and 4 show the pilot-test results by gender. For those respondents who had heard of gender, the most sources of information were equally distributed across genders. It is interesting to note, though, that trainings were a source of gender information for 37.5% of the men who had heard of gender, while trainings were a source of gender information for no women who had previously heard of gender.

Conclusion

The adapted questionnaire was successfully piloted in three different departments in Benin. Creating standardized questions and explanations of the gender concept in local language in which the questionnaire is to be administered is an important step in a successful adaptation process. The questionnaire should be scaled-up and administered more widely throughout Benin.

Data collected from the broader implementation of this questionnaire will be useful to integrate targeted approaches to improving gender equity and women's empowerment in Benin for the improvement of health outcomes for women, children and families.

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PERFORMANCE-BASED INCENTIVES GENERATE RESULTS FOR HEALTH CENTERS IN BENIN

At the Djibgé Health Center in Benin's Atlantique/Littoral Department (A/L), health services in the maternity are led by a health aide, one of the lowest cadres of health personnel. Despite this fact, the Djibgé Health Center came in first out of 34 centers in assessments conducted through the performance-based incentives (PBI) strategy implemented in A/L and Zou/Collines (Z/C) through the United States Agency for International Development (USAID)-funded Benin Integrated Family Health Project (French acronym PISAF), managed by University Research Co., LLC (URC). Similar strategies, often called management for results or results-based financing, are underway across the world, with promising outcomes. Through PBI, incentives are awarded based on an individual's or facility's performance on an agreed set of indicators. Given the human resource challenges in Benin, PISAF developed and implemented on a limited basis a PBI strategy that does not depend on the presence of highly-skilled personnel, but that measures the quality of the performance of a health team made up of low- and mid-level personnel.

Indicator Development and Calculation

In Benin, a number of development and donor organizations have piloted different PBI strategies to improve health indicators. In 2011, PISAF met with these organizations to hear lessons learned and assess how PBI could be implemented successfully.



The zonal statistician and the health aide of the Djigbe Health Center review the maternity register during routine data collection. Djigbe Health Center would rank first out of all Health Centers in the AZT Health Zone in the Performance Based Motivation Strategy.

After these meetings, the project refined a PBI strategy in collaboration with the departmental and zonal teams.

PISAF developed a set of performance indicators that reflected the different aspects of performance at each level of the health system. At the departmental level, the indicators focused on human resources management, supply chain management, the level of execution of

action plans, and quality improvement activities. At the zonal level, indicators focused on the level of execution of action plans, completion and timeliness of data submission, and supply chain management. Individual health facilities were assessed on clinical indicators as well as human resources management, supply chain management, and supervision of the community health workers in the facility catchment area.

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Table I. Example formula for calculating points on an indicator

| Domain | Indicator | Maximum Points Possible | Excellent (100% of maximum points) | Very Good (85% of maximum points) | Good (60% of maximum points) | Adequate (40% of maximum points) | Weak (0% of maximum points) |
|----------|---|-------------------------|------------------------------------|-----------------------------------|------------------------------|----------------------------------|-----------------------------|
| Clinical | Proportion of children under 5 years confirmed to have malaria who were correctly treated with ACTs | 10 points | >95% | 90-95% | 80-90% | 60-80% | >60% |

Under PISAF's strategy, data for each indicator are collected through routine data collection systems and then validated. Based on the achievement of each indicator, the department or zone is awarded a certain number of points according to an agreed-upon formula. Indicators for health facilities are used to calculate their rankings and are included in the health zone scores. Departments, zones, and health facilities can then trade in these points to receive their choice of three types of incentives: non-financial support such as additional coaching visits, material and equipment grants for specific items, and career development and continuing education opportunities. PBI committees, made up of a variety of personnel, exist at the department and zonal level to facilitate the choice of the incentives.

PBI Implementation and Results

The first round of incentives was awarded in July 2012 to Z/C and A/L based on performance during the first two quarters of 2012. In Z/C, 6 health zones and 132 health facilities participated, and in A/L, participation included 2 health zones and 33 health facilities. Results from the performance assessment were presented in each zone during the quarterly data review meetings, with some surprising results. As previously mentioned, in A/L the highest performing facility was led by a health aide. Contradicting a common belief that staff must be highly trained in order to perform well, the performance of this health aide and her staff demonstrates that with a minimal amount of training, motivation plays a key role in improving performance.

The PBI strategy was very well received by the departmental and zonal Ministry of Health (MOH) staff. Although the process of identifying and communicating incentive

Figure 1. Overall PBI scores for A/L and its health zones

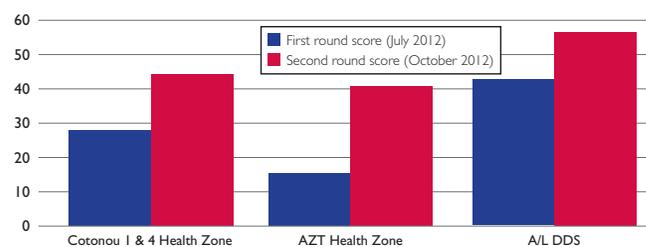


Figure 2. Proportion of newborns for whom at least 80% of monitoring norms were met in the first 6 hours of birth in A/L health zones

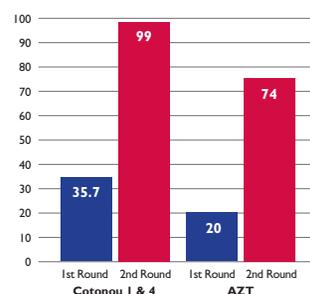
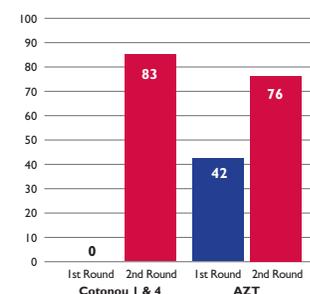


Figure 3. Proportion of pregnant women who received an HIV test at their first antenatal visit in A/L health zones



choices to PISAF was prolonged, resulting in delays, PISAF conducted delivery ceremonies in early November 2012 in both departments.

PISAF's second round of incentives, based on performance during the third quarter of 2012, focused only on A/L. Presentation of this round of performance assessments took place in October. The results were positive,

with both health zones and the department increasing their performance scores between the first and second round (Figure 1) and seeing dramatic increases on certain key clinical indicators (Figures 2 and 3). PISAF staff members validated performance data during on-site supervisions. In order to facilitate the identification of incentives and avoid the delays incurred in the first round,

PISAF staff visited the departments and zones to discuss their choice of incentive in person. The project delivered all incentives by the end of November 2012.

Health staff responded favorably to the PBI strategy. One MOH staff member explained, "Yes the PBI strategy provided a performance boost to my health structure, but it is too soon to tell if it will be sustained. However, based on the level of interest and engagement of the personnel in their performance scores, it seems that this is a springboard to improved performance." Additionally, the A/L Departmental Health Director indicated that the PBI strategy was effective because it acknowledges the importance of functioning as a team, and the incentives are based on group rather than individual performance.

Recommendations

1. Ensure an adequate implementation period that allows for PBI to be tested.

PISAF was only able to implement two rounds of PBI assessment. A long period of implementation would allow for a more in-depth evaluation of this approach's sustained effects.

2. Ensure a clear understanding of PBI among all involved parties. Proper training and explanation of PBI is needed before implementation. This training ensures that staff at all involved levels of the health system clearly understand and agree with how their performance will be assessed and how that performance will translate to incentives.

A Midwife of the Sekou Health Center Reflects on Her Experience with the PBI Strategy

This is a good initiative that boosts our morale. During the indicator review, it was an honor for me and my health center to come in second out of 34 centers. Even though I would have liked to be first, I was comforted by the fact that it was the Djigbé Health Center which was first, since the work there is lead by the maternity in-charge, a health aide. She is very engaged, and I was one of her mentors. PISAF was very transparent and objective in their results and rankings. The conclusion I can draw is that for better health of our people at the community level, we need good performance at our health facilities that reflects the commitment and resolve of all staff at various levels.

3. Involve government from the beginning. In order to ensure PBI strategies are sustained and integrated with existing and future strategies, it is imperative that initial discussions and implementation of PBI include government representation.

4. Coordinate among partners. There are currently many pilots of different PBI approaches underway across the developing world. Sharing indicators and best practices, especially around costs and sustainability, would enrich the dialogue and evidence base for both governments and development organizations.

5. Provide useful non-financial incentives. PISAF was contractually limited to providing non-financial incentives to the departments and zones. This limitation provided the project the opportunity to introduce the concept of non-financial incentives and to encourage managers from the health facilities to think more broadly about the definition of an incentive and how it can encourage health staff to improve performance.

Although PISAF ended in 2012, its experience in implementing a PBI strategy was successful and should be considered a promising practice for improving health system performance in the country.

Integrated Family Health Program/Projet Intégré de Santé Familiale (PISAF)

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MINISTRY OF HEALTH
BENIN

SAVING THE LIVES OF CHILDREN WITH INNOVATIVE STRATEGIES: EVALUATION, TRIAGE, AND TREATMENT

A high impact strategy to reduce mortality of children under 5 at referral hospitals in Benin

In Benin in 2011, malaria was the cause of approximately 1.2 million health care consultations and resulted in over 1,700 deaths in health facilities. More than 40% of malaria cases seen at health facilities are in children under 5 years of age. Similarly, the large majority of malaria deaths (approximately 75%) are among this same age group, and of the children that die of malaria, more than 1 in 4 die in the first 24 hours after admission to the hospital.

Worldwide, many hospital deaths among children under 5 occur in the first 24 hours after admission and many of these seriously ill children spend precious minutes waiting their turn in line at the hospital to be consulted. Most of these deaths could be prevented if these seriously ill children were identified immediately upon their arrival at the facility and if appropriate treatment was started immediately. This strategy is called “**Evaluation, Triage, and Treatment**” or **ETAT**. ETAT is a systematic, efficient and integrated approach, introduced by the WHO and which includes guidance for urgent care situations for which a child under 5 would be brought to the hospital, including severe malaria. The strategy consists of systematic evaluation of all children under 5 years of age when they arrive at the hospital, quickly triage patients based on the severity of their case and provide immediate emergency care.



Oxygen therapy for a child with the emergency oxygen concentrator with a 5-way distributor, bought with PMI funds.

Before ETAT, I was afraid of pediatric emergency cases, but now, with ETAT, I feel comfortable treating urgent cases

In 2010, the Integrated Family Health Project (PISAF), with financing from PMI/USAID and implemented by University Research Co., LLC (URC), initiated an effort to improve the

quality of care for seriously ill children in the hospital setting, including children with severe malaria. Using a structured approach to improvement, PISAF collaborated with the Ministry of

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PISAF

Figure 1. Severe malaria job aid developed by PISAF

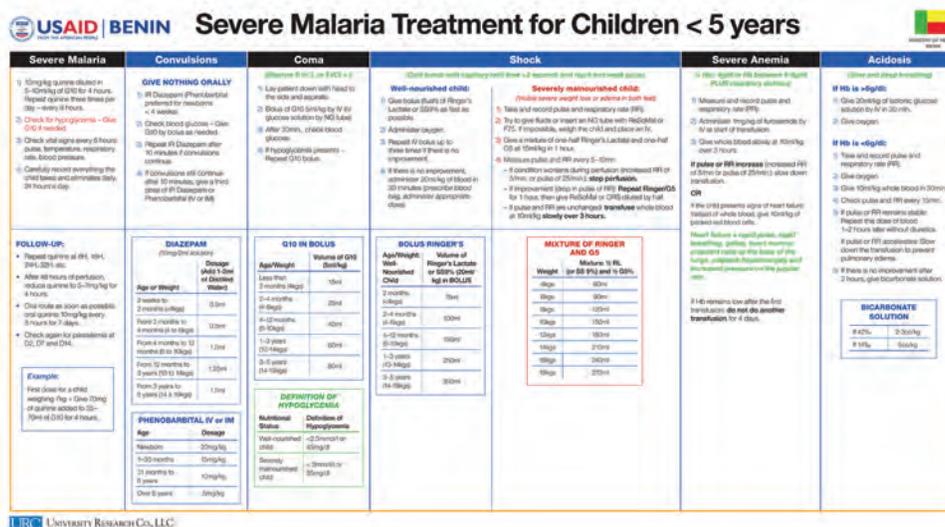


Table 1. Improvements tested by ETAT QITs

| Examples of the improvements initiated and tested by the Quality Improvement Teams | | | |
|---|---|---|---|
| Hospital organization | Skills Reinforcement | Logistics strengthening | Organization of Care |
| <ul style="list-style-type: none"> Reorganization of space to create a triage post Internal reorganization of health staff for triage, stabilization and surveillance of hospitalized cases | <ul style="list-style-type: none"> Meetings of the staff and the QIT to discuss ETAT and severe malaria norms and quality of care Positioning of job aids in the consultation and stabilization rooms | <ul style="list-style-type: none"> Implementation of a management notebook for emergency medications Provision of oxygen concentrators in the stabilization rooms | <ul style="list-style-type: none"> Implementation of a systematic triage form which is included in children's hospital files Regular utilization of technical job aids and tools for emergency care |

Health to reach consensus on clinical guidelines, develop and validate a job aid for diagnosis and treatment of severe malaria and initiate improvement work, with the following objectives:

- i) to implement systematic triage of all children under 5 when they arrive at the hospital by classification in one of the three categories: Urgent, Priority or Standard; ii) To treat, according to guidelines, all cases classified as

- “Urgent”; iii) To treat according to guidelines, all cases of severe malaria in children under 5 years in the hospitals; iv) To reduce the number of deaths in the first 24 hours after admission; v) To reduce mortality due to severe malaria in children under 5 years in the hospitals. Twelve public and private hospitals were included: the 2 national reference hospitals, 5 regional hospitals and 6 district hospitals. The process began

with a consensus workshop to define the ETAT clinical package, followed by the development and roll-out of the ETAT training by national experts, as well as on-site ETAT skills reinforcement for health workers coupled with Quality Improvement work. Trained QI coaches provided regular visits to ETAT hospitals to provide targeted skills building and improve team functioning. Each hospital was equipped with oxygen concentrators and distributors to provide oxygen to 5 children at a time, as well as ETAT job aids and monitoring tools (Figure 1).

Quarterly meetings were organized to allow hospital Quality Improvement Teams (QIT) to share experiences, results, and lessons learned. The table below outlines specific examples of improvements tested by the QITs which were found to improve compliance with the ETAT norms.

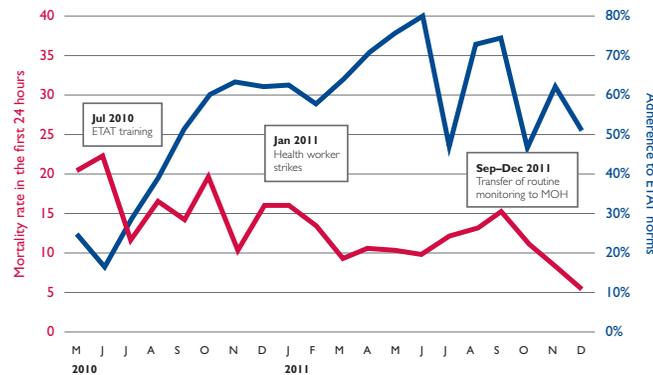
These very encouraging results were themselves a source of motivation for health staff at the hospitals. Even despite periods of health worker strikes, which prevented regular functioning

of the health centers and hospitals in the country, implementation of the ETAT approach continued to improve outcomes in the severe malaria mortality rate and the number of deaths in the first 24 hours after admission (Figure 2).

In October 2011, the ETAT approach and best practices were expanded to the Atlantique/Littoral Department as a part of a larger scale-up effort of the project. Applying the lessons learned from the initial ETAT work, six additional hospitals, four public and two religious hospitals,

received training, supervision, and coaching in ETAT from February to June 2012. In the four months of implementation, the rate of adherence to the ETAT norms increase from 0 to 80%; the 24 hour mortality rates did not immediately drop (Figure 3). PISAF continued to support the twelve original ETAT hospitals, with more reliance on routine supervision by the Ministry.

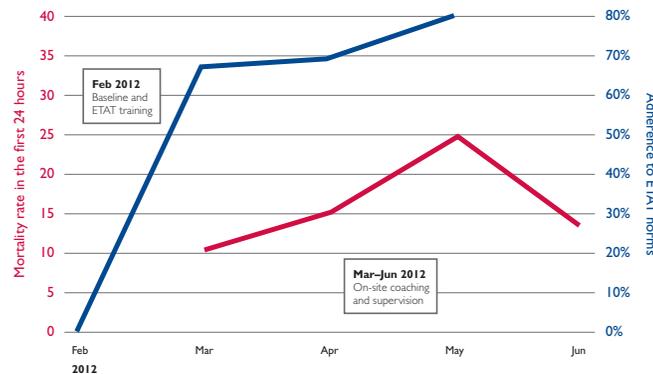
Figure 2. Twenty-four hour mortality and adherence to ETAT norms in the 12 ETAT collaborative hospitals



As the head pediatrician at one of the national reference hospitals stated a learning session of the ETAT Collaborative in Bohicon, Benin:

I am so completely convinced of the effectiveness of this approach that I will not hesitate for an instant to support to the staff of my department to maintain gains made in the implementation of ETAT.

Figure 3. Twenty-four hour mortality and adherence to ETAT norms in the 6 scale-up hospitals



As can be seen, these hospitals found it challenging to maintain the results achieved. These results point to the necessity of maintaining routine supervision and coaching to health facilities implementing ETAT and to the importance of the application of quality improvement approaches to affect the ultimate goals of ETAT. The scale up hospitals did not yet have the opportunity to consolidate their QI knowledge. In order to successfully and sustainably implement the ETAT approach, routine supervision and coaching of health facility teams, as well as the application of quality improvement methods is recommended. This valuable approach has shown its promise in reducing the large number of unnecessary child deaths from severe malaria.

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Annex 6: Posters Presented at Open Door Day Conference continued





Mutuelles de santé

Objectif
Améliorer l'accès à l'ité financière des populations du Zou/Collines et du Borgou/Alibori soins de santé de qualité

Lieu
CARACTÉRISTIQUES DES INTERVENTIONS OUSUOUF PAF DANS LE DOMAINE DES MUTUELLES DE SANTÉ



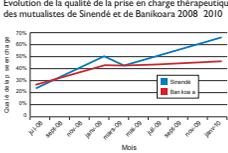
Interventions

- Étude de faisabilité de l'implantation
- Mise en place des mutuelles et réseaux de mutuelles de santé
- Formations et suivi des mutuelles
- Mise à disposition de motos aux réseaux de mutuelles;
- Collaboratif d'amélioration de la Qualité des soins dans les mutuelles
- Partenariat avec les élus locaux: les institutions de micro finances.
- Forum national des mutuelles de santé au Bénin

Résultats

- 59 mutuelles de santé dans 9 communes
- 9 réseaux de mutuelles de santé
- 0.808 adhérents et 29 180 bénéficiaires

Evolution de la qualité de la prise en charge thérapeutique des mutualistes de Sinendé et de Banikoara 2008-2010



Lieu
CARRIÈRE DES INTERVENTIONS OUSUOUF PAF DANS LE DOMAINE DES MUTUELLES DE SANTÉ

Interventions

- Étude de faisabilité de l'implantation
- Mise en place des mutuelles et réseaux de mutuelles de santé
- Formations et suivi des mutuelles
- Mise à disposition de motos aux réseaux de mutuelles;
- Collaboratif d'amélioration de la Qualité des soins dans les mutuelles
- Partenariat avec les élus locaux: les institutions de micro finances.
- Forum national des mutuelles de santé au Bénin

Résultats

- 59 mutuelles de santé dans 9 communes
- 9 réseaux de mutuelles de santé
- 0.808 adhérents et 29 180 bénéficiaires





Coaching

Objectif
Mettre en place un cadre de coaches locaux pour appuyer les Équipes d'Amélioration de la Qualité (EAQ) à devenir autonomes afin d'être capables d'utiliser seules les outils et les procédures appropriés pour adhérer aux normes du système sanitaire.

Lieu
Département du Zou et de Collines

- Toutes les six zones sanitaires
- Tous les 147 centres de santé publics
- Le CHD et tous les hôpitaux de zone

Département du Borgou et de l'Alibori

- Deux zones sanitaires:
 - Banikoara (dix centres de santé);
 - Bembéréké – Sinendé (quatre centres de santé)

Interventions

- Identification par les Équipes d'Encadrement de Zone Sanitaire (EEZS) des coaches au niveau de zone et de formations sanitaires.
- Renforcement des capacités des coaches sur la technique de coaching et d'encadrement
- Organisation des visites de coaching dans les sites: Préparation visite proprement dite synthèse avec l'EAQ et rapport de la visite
- Appui de proximité au coaching

Résultats
ETUDE DE CAS D'EFFICACITE DE COACHING

En décembre 2009 les 8 SONE/GATPA de Ouessé ont identifié comme leur performant suite à un suivi à court terme deux visites de renforcement par les coaches. Il a requis une visite inspirée en juin 2010 pour juger de l'évolution des performances après les visites de coaching.

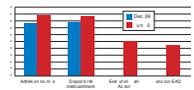
Qui sont des coaches?

Les coaches sont des prestataires performants ou des tuteurs identifiés par les médecins coordonnateurs pour encadrer les équipes d'amélioration de la qualité à l'intérieur des cadres de la DIDS chargés du suivi des activités.

Actuellement il y a 83 coaches du paquet intégré dans le Zou-Collines




Résultats
Evolution de la performance du SONE/GATPA de OUESSE Dec 2009 au Juin 2010



Résultats du coaching du site de Ouessé avec amélioration de:

- la fonctionnalité de l'équipe passant de 0 à 40%
- exécution du plan d'action passant de 0 à 60%
- adhésion aux normes 77 à 88%





Utilisation des media populaires traditionnels

Objectif
Appuyer la Direction Départementale de la Santé (DDS) à améliorer la demande des services de santé des produits et des mesures préventives à travers l'utilisation des media populaires traditionnels

Lieu
Département du Zou et de Collines

- 3 Troupes de théâtre populaire à Abomey Savalou et Savé
- 5 Groupes de Musique Populaire Traditionnelle à Abomey Savalou Dassa Glazoué et Savé

Interventions

- Renforcement des capacités des groupes de musique et de théâtre populaires à développer des thèmes de santé familiale dans les chansons et théâtre en langues locales

Résultats

- Trois troupes de théâtre populaire et 5 groupes de musique traditionnelle ont touché 313 820 personnes
- 24 chansons populaires sont produites et diffusées sur des thèmes de santé familiale
- 22 sketches théâtraux sont représentés sur le paludisme, la planification familiale, les Soins Obstétricaux et Néonataux d'Urgence (SONU) communautaires, les IST/VIH-5 DA, les Mutuelles de Santé, les grossesses en milieu scolaire
- 4 CD audio sur le paludisme, la PF, les SONU communautaires, les IST/VIH-5 DA et les Consultations prénatal (CPN)
- 1 VCD sur la Planification Familiale (PF)




Actuellement il y a 83 coaches du paquet intégré dans le Zou-Collines





Approche collaborative d'amélioration de la qualité en santé de la reproduction

Objectif
Toute parturiante ayant accouché par voie basse à la maternité bénéficiaire de la Gestion active de la troisième période de l'accouchement (GATPA) y compris les soins et la surveillance post-partum immédiat (durant les 6 premières heures) dans un environnement propre et sûr (P).

Lieu

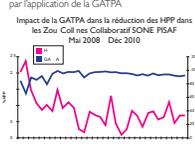
- Toutes les six zones sanitaires à savoir:
 - Djigbé-Abomey-Angangrizon (DA-A)
 - Covié-Zagnanado-Ouhé (COZO)
 - Zogbodomey-Bohicon-Zalokpa (ZOBZO)
 - Dassa-Glazoué (DAGLA)
 - Savalou-Benté (SABA)
 - Savé-Ouessé (SAC)
- Tous les centres de santé publics
- Le Centre Hospitalier Départemental (CHD) et tous les hôpitaux de zone

Interventions

- Élaboration et validation des paquets de changement Soins Obstétricaux et Néonataux Essentiels et Gestion Active de la Troisième Période de l'Accouchement (SONE/GATPA) Pré-éclampsie-Éclampsie et la Prévention Transmission de VIH Méris-Enfant (PREPTHE) Planification Familiale (PF) et Pâs simple
- Renforcement des capacités des prestataires sur les différents domaines
- Suivi post-formation et coaching
- Organisation des sessions d'apprentissage et de synthèse des meilleures pratiques
- Extension clinique et géographique
- Élaboration et mise en oeuvre du « Paquet intégré des soins et services de qualité en santé familiale »

Résultats
Réduction des hémorragies post-partum (HPP) par l'application de la GATPA

Impact de la GATPA dans la réduction des HPP dans les Zou Collines Collaboratif SONE PISAF Nov 2008- Dec 2010









Collaboratif TETU/Paludisme grave PMI 2010-2011

Objectif
Réduire la mortalité intra hospitalière chez les enfants de moins de 5 ans admis en urgence dans les hôpitaux de référence au Bénin

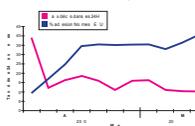
Lieu
Dans 12 hôpitaux du pays:

- 2 hôpitaux de référence nationale (CHU et HOMEL à Cotonou)
- 5 Centres Hospitalier Départemental: CHD Ouémé Plateau, CHD Mono, CHD Zou, CHD Borgou, Abomey et CHD Atacora-Dongé
- 5 Hôpitaux de Zone: l'hôpital privé Bethesda de Cotonou et les 5 HZ de Zou-Collines

Interventions

- Adaptation du curricula de formation Tri: Evaluation Urgence (TETU);
- Formation de 9 formateurs nationaux;
- Formation de 13 formateurs départementaux;
- Formation en cascade de 258 prestataires des services de pédiatrie;
- Organisation de 3 visites de coaching;
- Organisation de 2 sessions d'apprentissage;
- Achat et mise en place sur fonds PMI de 13 concentrateurs d'oxygène avec distributeurs à 5 voies

Résultats
Evolution des décès de 24 H aux urgences comparée à l'adhésion aux normes TETU dans les 12 hôp taux du collaboratif TETU au Bénin de Juin 2010 à Avril 2011



| | avant TETU avr 10 à mai 11 | après TETU juin 10 à avr 11 |
|--|-------------------------------|--------------------------------|
| % de décès de 24 H aux urgences | 3,9% | 0,2% |
| % de décès de 24 H aux urgences chez les enfants de moins de 5 ans | 24,7% | 0,4% |
| % de décès de 24 H aux urgences chez les enfants de moins de 5 ans | 20,0% | 4,0% |
| % de décès de 24 H aux urgences chez les enfants de moins de 5 ans | 53,3% | 0,0% |
| % de décès de 24 H aux urgences chez les enfants de moins de 5 ans | 9% | 0% |






Annex 7: CD that includes the following items

- PMI Final Report
- BCC Materials
- Mutuelle studies
- Journal Article on PISAF's work improving Antenatal counseling



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