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# Table of Contents

I. Abbreviations and Acronyms .................................................................................................................. 4

II. Overall performance for the year......................................................................................................... 7
   Sub-component 1: Increased access to an Integrated Package of Quality Services (IPQS)........... 7
   Sub-component 2: Improved quality of health services in health posts, health centers, and regional hospitals ........................................................................................................................................ 7
   Sub-component 3: Improved human resources management in public sector health facilities..... 7
   Sub-component 4: Development of relationships with private sector health facilities............... 8

III. Main achievements ............................................................................................................................... 9
   Sub-component 1: Increased access to an Integrated Package of Quality Services (IPQS).......... 9

III. Supervision and monitoring & evaluation ......................................................................................... 57

IV. Management and coordination ........................................................................................................... 63

III. Financial report .................................................................................................................................. 66
## I. Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Association Conseils pour l’Action</td>
</tr>
<tr>
<td>ACD</td>
<td>Reach Every District</td>
</tr>
<tr>
<td>ACT</td>
<td>Artemisinin-based Combination Therapy</td>
</tr>
<tr>
<td>ADEMAS</td>
<td>Marketing and Social Development Agency (Agence de développement du marketing social)</td>
</tr>
<tr>
<td>AEFI</td>
<td>Adverse Events Following Immunization</td>
</tr>
<tr>
<td>AHT</td>
<td>Arterial Hypertension</td>
</tr>
<tr>
<td>AMTSI</td>
<td>Active Management of the Third stage of Labor</td>
</tr>
<tr>
<td>ANSD</td>
<td>National Statistics and Demography Agency (Agence nationale de la statistique et de la démographie)</td>
</tr>
<tr>
<td>AOR</td>
<td>Agreement Officer Representative</td>
</tr>
<tr>
<td>APIX</td>
<td>Senegal’s Investment Promotion Agency (Agence pour la Promotion des Investissements Privés)</td>
</tr>
<tr>
<td>AS</td>
<td>Advanced Strategies</td>
</tr>
<tr>
<td>ASBEF</td>
<td>Senegalese Association for Family Welfare (Association sénégalaise du bien-être familial)</td>
</tr>
<tr>
<td>ASGO</td>
<td>Senegalese Association of Gynecologists and Obstetricians (Association des Gynécologues Obstétriciens du Sénégal)</td>
</tr>
<tr>
<td>AWP</td>
<td>Annual Work Plan</td>
</tr>
<tr>
<td>AYRH</td>
<td>Adolescent and Youth Reproductive Health</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>CA</td>
<td>Cooperative Agencies</td>
</tr>
<tr>
<td>c-DHS</td>
<td>Continuous Demographic and Health Survey in Senegal</td>
</tr>
<tr>
<td>CESAG</td>
<td>African Center for Higher Education in Management (Centre Africain d’études Supérieur en Gestion)</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CYP</td>
<td>Couple-Years of Protection</td>
</tr>
<tr>
<td>DOT</td>
<td>Directly Observed Treatment</td>
</tr>
<tr>
<td>DPT3</td>
<td>Diphtheria/Pertussis/Tetanus</td>
</tr>
<tr>
<td>DSISS</td>
<td>Division of the Health and Social Information System (Division du Système d’Information Sanitaire et Sociale)</td>
</tr>
<tr>
<td>DSR/SE</td>
<td>Department of Reproductive Health and Child Survival (Direction de la Santé de la Reproduction et de la Survie de l’Enfant)</td>
</tr>
<tr>
<td>ECD</td>
<td>District Medical Team (Equipe Cadre de District)</td>
</tr>
<tr>
<td>ECR</td>
<td>Regional Medical Team (Equipe Cadre de Région)</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Neonatal Care</td>
</tr>
<tr>
<td>ENC</td>
<td>Essential Newborn Care</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GNAP</td>
<td>Global Newborn Action Plan</td>
</tr>
<tr>
<td>HKI</td>
<td>Helen Keller International</td>
</tr>
<tr>
<td>HSS</td>
<td>Health Systems Strengthening</td>
</tr>
<tr>
<td>ICP</td>
<td>Head Nurse (Infirmier Chef de Poste)</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
</tr>
<tr>
<td>iHRIS</td>
<td>Health Workforce Information Software</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IP</td>
<td>Infection Prevention</td>
</tr>
<tr>
<td>IPDSR</td>
<td>Institute of Population, Development, and Reproductive Health (Institut de Population, Développement et Santé de la Reproduction)</td>
</tr>
<tr>
<td>IPQS</td>
<td>Integrated Package of Quality Services</td>
</tr>
<tr>
<td>IPS</td>
<td>Integrated Package of Services</td>
</tr>
<tr>
<td>IPT</td>
<td>Intermittent Preventive Therapy</td>
</tr>
<tr>
<td>ISBC</td>
<td>Systematic Identification of Client Needs (Intégration systématique des besoins du client)</td>
</tr>
<tr>
<td>ISM</td>
<td>Information System for Management</td>
</tr>
<tr>
<td>ISSU</td>
<td>Senegalese Urban Reproductive Health Initiative (Initiative sénégalaise de santé urbaine)</td>
</tr>
<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
</tr>
<tr>
<td>JLS</td>
<td>Local Vitamin A Supplementation Day (Journées locales de supplémentation en vitamine A)</td>
</tr>
<tr>
<td>JNV</td>
<td>National Immunization Days (Journées nationales de vaccination)</td>
</tr>
<tr>
<td>LLITN</td>
<td>Long-Lasting Insecticide-Treated Bednets</td>
</tr>
<tr>
<td>LTPM</td>
<td>Long-Term and Permanent Method</td>
</tr>
<tr>
<td>MAM</td>
<td>Management of Acute Malnutrition</td>
</tr>
<tr>
<td>MCD</td>
<td>Chief District Medical Officer (Médecin chef de district)</td>
</tr>
<tr>
<td>MI</td>
<td>Micronutrients Initiative</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Newborn, and Child Health</td>
</tr>
<tr>
<td>MR</td>
<td>Medical Region</td>
</tr>
<tr>
<td>MSAS</td>
<td>Ministry of Health and Social Action</td>
</tr>
<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
</tr>
<tr>
<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
</tr>
<tr>
<td>NA</td>
<td>Not Available</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral Rehydration Salts</td>
</tr>
<tr>
<td>PAC</td>
<td>Post-Abortion Care</td>
</tr>
<tr>
<td>PECADOM</td>
<td>Home-based care (Prise en charge à domicile)</td>
</tr>
<tr>
<td>PECMAS</td>
<td>Case Management of Severe Acute Malnutrition (Prise en charge de la malnutrition aiguë sévère)</td>
</tr>
<tr>
<td>PHF</td>
<td>Public Health Facility</td>
</tr>
<tr>
<td>PNLP</td>
<td>National Malaria Control Program (Programme National de Lutte Contre le Paludisme)</td>
</tr>
<tr>
<td>PPP</td>
<td>Public-Private Partnership</td>
</tr>
<tr>
<td>PRA</td>
<td>Regional Procurement Pharmacy (Pharmacie Régionale d’Approvisionnement)</td>
</tr>
<tr>
<td>PRONALIN</td>
<td>National Nosocomial Infections Control Program (Programme National de Lutte contre les Infections nosocomiales)</td>
</tr>
<tr>
<td>QIP</td>
<td>Quality Improvement Partnerships</td>
</tr>
<tr>
<td>RDT</td>
<td>Rapid Diagnostic Test</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RO</td>
<td>USAID Regional Coordination Bureau for the Health Program</td>
</tr>
<tr>
<td>RPM</td>
<td>Regional Program Manager</td>
</tr>
<tr>
<td>RPS</td>
<td>Health Services Improvement</td>
</tr>
<tr>
<td>RSJ</td>
<td>Réseau Siggil Jigéen</td>
</tr>
<tr>
<td>RUTF</td>
<td>Ready-to-Use Therapeutic Food</td>
</tr>
<tr>
<td>SA</td>
<td>Situational Analysis</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>SAMU</td>
<td>National Emergency Medical Service (Service d'Aide Médicale Urgente)</td>
</tr>
<tr>
<td>SDM</td>
<td>Standard Days Method</td>
</tr>
<tr>
<td>SDP</td>
<td>Service Delivery Point</td>
</tr>
<tr>
<td>SEDA</td>
<td>Automated Data Exchange System (Système d’échange des données automatique)</td>
</tr>
<tr>
<td>SFE</td>
<td>State Registered Midwife (Sage-femme d’Etat)</td>
</tr>
<tr>
<td>SLAP</td>
<td>Pest Management Section (Section de lutte antiparasitaire)</td>
</tr>
<tr>
<td>SP</td>
<td>Sulfadoxine Pyrimethamine</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SYSNIS</td>
<td>Computerized System of the National Health Information Service (Système Informatisé du Service National d’Information Sanitaire)</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UCAD</td>
<td>Cheikh Anta Diop University</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UREN</td>
<td>Ressuscitation and Nutrition Education Unit (Unité de récupération et d’éducation nutritionnelle)</td>
</tr>
</tbody>
</table>
II. Overall performance for the year

During this year, the component reported the following major outcomes, listed by sub-component:

Sub-component 1: Increased access to an Integrated Package of Quality Services (IPQS)

- Enrollment of 26 health districts, bringing the total enrolled since Year 1 to 41 districts, or 54% of the districts in Senegal
- Enrollment of 12,456 new users of FP methods
- Development of training module for providers on Emergency Obstetric and Neonatal Care (EmONC)
- Strengthening the management of eclampsia and pre-eclampsia in 350 SDPs through the training of 448 providers
- Strengthening of nutrition services through the training of:
  - 503 providers on the management of diarrhea with low-osmolarity ORS and zinc
  - 114 trained health care workers on monitoring growth and screening for acute malnutrition with the WHO Anthro software

Sub-component 2: Improved quality of health services in health posts, health centers, and regional hospitals

- Supervision of 11 Regional Procurement Pharmacies, 73 district warehouses, 70 health center warehouses, 2 level-one Public Health Facilities and 1 CHR
- Training of 89 providers on management of emergencies, including 53 men and 36 women
- 1 specialist tour in the Ziguinchor region
- 1586 integrated advanced strategies
- 1400 supervision visits conducted in health huts
- 276 QIP teams implemented within targeted SDPs
- Training of 1912 providers on infection prevention and protection of the environment
- 4 facilities identified to house the production of hydro-alcoholic solution

Sub-component 3: Improved human resources management in public sector health facilities

- Identification of training needs on the IPQS for providers in the 14 regions
- Development of 70 job description types
- Entering of 1675 health care professionals into the iHRIS software
- The use of SEDA by 100% of SDPs in the Foundiougne district
Sub-component 4: Development of relationships with private sector health facilities

- Enrollment of 89 private SDPs in TutoratPlus
- Signing of 43 Memoranda of Understanding between districts and private SDPs
- Participation of 106 members of the private and public sector in the “Mobilization of Private-Sector Leaders” Day
- Development of an information program on the IPQS for men working in companies
- Strengthening the capacities of 107 private-sector pharmacists on the IPQS
III. Main achievements

Sub-component 1: Increased access to an Integrated Package of Quality Services (IPQS)

1.1 Introduction and implementation of TutoratPlus

TutoratPlus is the technical approach through which the Component plans to improve the availability and use of an Integrated Package of Quality Services while strengthening the operations and management of service delivery points (SDPs). TutoratPlus implementation has continued this year through the following activities:

Enrollment of districts in TutoratPlus: During this second year, enrollment of new districts began in the first quarter through orientation sessions held for selected district medical teams (ECDs) on the TutoratPlus by the medical regions. These orientation sessions informed 1054 people, including 373 women and 681 men, on the TutoratPlus implementation process and the roles and responsibilities of stakeholders, such as local governments, health committees, tutors, the ECDs, and heads of SDPs.

Having followed the process during the first year of implementation, the regional medical teams (ECRs) took on the technical leadership in running the orientation workshops. Thus, these orientations were a great opportunity for the component to initiate the transfer of skills to the ECRs for the implementation and monitoring of TutoratPlus. With this new wave of enrollment, the TutoratPlus coverage rate in the regions is 54%.

The lowest coverage rates are in the regions of Dakar, Louga, Tambacounda, Kédougou, and Matam, as shown in Table 1 below. Low coverage in the regions of Tambacounda, Matam, and Kédougou is because these regions were not initially targeted by the program for TutoratPlus implementation. They were included with the selection of three districts per region to ensure equity between regions.

For Dakar, only six districts are targeted by the TutoratPlus program. By contrast, for Louga, the component could only enroll two of the four districts targeted for Year 2. Providers from the districts of Linguère and Kébêmer decided to boycott any activity taking place within the SDPs.
Table 1: TutoratPlus coverage of regions

<table>
<thead>
<tr>
<th>Medical region</th>
<th>Total number of Districts</th>
<th>Number of districts enrolled during Year 1</th>
<th>Number of districts enrolled during Year 2</th>
<th>Coverage rate of districts by TutoratPlus</th>
</tr>
</thead>
<tbody>
<tr>
<td>TutoratPlus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louga</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>38%</td>
</tr>
<tr>
<td>Dakar</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td>Diourbel</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>60%</td>
</tr>
<tr>
<td>Fatick</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>57%</td>
</tr>
<tr>
<td>Sédhiou</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>67%</td>
</tr>
<tr>
<td>Kaolack</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>75%</td>
</tr>
<tr>
<td>Tambacounda</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>29%</td>
</tr>
<tr>
<td>Kolda</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>67%</td>
</tr>
<tr>
<td>Kaffrine</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>75%</td>
</tr>
<tr>
<td>Matam</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>Saint-Louis</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>60%</td>
</tr>
<tr>
<td>Kédougou</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>67%</td>
</tr>
<tr>
<td>Thiès</td>
<td>9</td>
<td>1</td>
<td>4</td>
<td>56%</td>
</tr>
<tr>
<td>Ziguinchor</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>60%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>77</td>
<td>15</td>
<td>26</td>
<td>54%</td>
</tr>
</tbody>
</table>

Training of trainers for tutor: The component trained a second pool of tutor trainers, giving priority to members of the regional medical teams and the component’s heads of regional programs who are responsible for the joint monitoring of the implementation of TutoratPlus at the district level. Thus, 11 members of the regional medical teams (including 6 women) and 6 regional program heads (including 2 women) participated in this training.

Training of tutor trainers emphasized:

- Training methodologies and facilitation techniques
- Performance-based learning
- Use of the tutor tool kit

During this training, conducted with technical assistance provided by IntraHealth headquarters, the trainers revised the tutor booklets and manuals for each package, updated the tutor training guide, and adapted the tutor training program. This made it possible to have a package of standardized tools for tutor training and on-site supervision of providers.

Training of tutors: Tutor training began after tutors were selected by the ECDs and ECRs, based on a rigorous process involving a call for applications, screening, and then final selection with a skill assessment. Hence, with support from tutor trainers, the component organized eight tutor training sessions by area. After holding the first test session lasting 12 days, the time for the training was reduced to 9 days, with 6 days devoted to theoretical training and classroom simulations and 3 days of practical training in the SDPs. Table 2 presents tutor distribution by package.
Table 2: Tutor distribution by package

<table>
<thead>
<tr>
<th>Service packages</th>
<th>Content</th>
<th>M</th>
<th>F</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package 2: Family Planning</td>
<td>Counseling - Contraceptive technology with emphasis on LTPM - Management of FP files - ISBC - FP logistics - Infection Prevention</td>
<td>1</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>Package 4: Management and organization of services</td>
<td>Drug and product management FP Financial management Human resources management Implementation of advanced strategies</td>
<td>25</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>Package 5: Health information system</td>
<td>ISM Development and monitoring/evaluation of action plans Supervision</td>
<td>24</td>
<td>4</td>
<td>28</td>
</tr>
<tr>
<td>Package 6: Health promotion</td>
<td>Community-based participatory approaches BCC and creating demand for IPQS</td>
<td>28</td>
<td>10</td>
<td>38</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>112</td>
<td>109</td>
<td>221</td>
</tr>
</tbody>
</table>

Training prepared each tutor to conduct supervision of providers in the SDPs based on the different stages selected in the approach in order to strengthen providers’ knowledge and skills in the technical areas related to the relevant package of quality services.

Each trained tutor has a kit comprising:
- The tutor booklet
- The tutor manual
- Data collection tools for on-site supervision including the activity notebook, the on-site supervision notebook, and tutor summary report.

Following the training, each tutor developed his or her on-site supervision plan for SDPs for validation by the relevant district medical team. This allowed for quick roll-out of on-site supervision of providers.

**Situational analysis of service providers:** The situation analysis enabled data collection on the gaps in service delivery in the SDPs. Teams of surveyors trained by the ECRs and ECDs administered observation checklists and questionnaires on the content of the Integrated Package of Quality Services (IPQS) to various providers and heads of the visited SDPs.

Thus, we were able to conduct the situation analysis (SA) in 494 SDPs in 26 of the 28 planned districts. Only the districts of Linguère and Kébémer did not implement the activity due to unrest among unionist workers. In Linguère, the activity was stopped because the unionist providers
refused to allow the surveyors into the SDPs after their training to collect the SA data. In Kébémer, the district could not plan the activity because unionists threatened to disrupt it.

Presentation of results from the situational analysis for each district took place over four days in two phases:

- During the first two days, the component helped the health district identify and analyze the district’s main gaps and to write the draft of the district action plan.
- The last two days were devoted to sharing results from the SA with the heads of public and private SDPs, the health committees, the local governments, administrative officials, and other district partners and to developing SDP action plans based on the gaps identified by the situational analysis.

Providers were able to use these presentations to inform local officials on the challenges in delivering high-quality services that arise in the health system. Also, many of these officials are committed to supporting the implementation of the district action plan and monitoring them and SDPs, each at their respective level.

**On-site supervision of providers by tutors:** Once their changeover plans were validated by the district and shared with the heads of the SDPs, the tutors began on-site supervision and on-site training of providers. The on-site training took place for each package through the following steps:

- Step 1: Preparation of on-site training
- Step 2: First tutor visit in the SDP: Orientation and supervision of provider(s)
- Step 3: Individual work (Self-evaluation and Preparation for the second visit)
- Step 4: Second visit to the SDP (followed by update-orientation and supervision)
- Step 5: Handover of results to the district (Sharing results with the ECD)

These visits helped strengthen capacities in specific service delivery areas at the sites of providers who achieved the required minimal performance level of at least 80%. The table below shows the number of providers trained on site by area of service delivery and by sex.

**Table 3: Distribution of providers trained on site by area service delivery and by sex**

<table>
<thead>
<tr>
<th>Area of Service Delivery</th>
<th>Number of Providers Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Pregnancy, delivery, and post-partum</td>
<td>15</td>
</tr>
<tr>
<td>Family Planning</td>
<td>9</td>
</tr>
<tr>
<td>Disease management</td>
<td>47</td>
</tr>
<tr>
<td>Management and organization of services</td>
<td>4</td>
</tr>
<tr>
<td>Information System for Management (ISM)</td>
<td>64</td>
</tr>
<tr>
<td>Health Communication and Promotion</td>
<td>43</td>
</tr>
</tbody>
</table>

In addition to strengthening providers’ skills, the tutor visits to the SDPs allowed for the acquisition of equipment and the recruitment of trained staff in some SDPs through the health committee and site renovations.
Monitoring of TutoratPlus implementation: Through monitoring missions, particularly in the districts of Thiès, Ziguinchor, Kaolack, and Foundiougne, we noted:

- Improved environmental cleanliness with the organization of “set sétal” in some SDPs
- Providers’ commitment and buy-in to the on-site training approach
- Involvement of Bajenu Gox in the on-site supervision activities
- Acquisition of good clinical practices by providers with a change in the skill level for all providers. For example, at the health post in Diakhao (Thiès district), the four providers had an average score of 58% on the pre-test on “Help Babies Breathe” and an 82% average score on the post-test.
- The commitment of some local governments and health committees to execute plans to resolve issues in the SDPs, particularly equipment purchase.

Main challenges

It appears that the component should ensure the transfer of all skills for the monitoring of TutoratPlus implementation, including monitoring of the tutor visits in the SDPs. TutoratPlus is a new approach, and the ECRs and ECDs believe that they are not adequately equipped to perform all activities in the process. This skills transfer will lead to greater ownership of the TutoratPlus approach by the ECRs/ECDs and the central level.

Opportunities

Through the district grants, the component will be able to encourage the districts to conduct better monitoring of implementation. To do this, the component has revised the grant agreements and proposed a new list of deliverables that all districts approved. These new deliverables promote greater ownership among the districts to take on monitoring of TutoratPlus implementation through holding quarterly monitoring meetings and mid-year reviews to evaluate TutoratPlus implementation in the district.

Prospects

- Continued implementation of TutoratPlus
- Strengthening of capacities of ECRs and ECDs in monitoring the implementation of TutoratPlus
- Integration of monitoring TutoratPlus into the district grants

Improve access to high-quality Family Planning services

Achievements

Strengthening providers’ capacities in FP

The component supported the districts in training providers in contraceptive technology and management of the FP file.

Training on managing the FP file targeted providers from 101 SDPs, including 2 private SDPs, in the regions of Ziguinchor and Thiès.

In addition to providers from Kaolack and Kaffrine, training in contraceptive technology targeted
15 members from the Dakar Medical Women’s Association. However, only 30% of the annual target was trained, due in part to the Association’s difficulty in mobilizing its members for training sessions lasting over several days. On the other hand, with the target being revised following the development of the AWPs, the regions of Louga, Diourbel, and Fatick, which had planned to do this training, could not hold it due their busy schedules.

**Post-training follow-up for providers:** For this year, priority was placed on post-training follow-up. Hence, the areas of FP counselling/Management of the FP file/SDM/LTPM were monitored. In the regions of Dakar, Thiès, Louga, Saint Louis, Fatick, Diourbel, Kaolack, Kaffrine, and Ziguinchor, 290 people (including 254 women and 36 men) underwent post-training follow-up in 260 SDPs, including 2 private SDPs. The findings and main recommendations are summarized as follows:

**Strengths:** Acceptable level of theoretical knowledge; mastery among providers of the collection process as well as the source for collecting data on indicators; proper record keeping in the registers and FP forms (good filing and organizing); initiative taken to create a notebook for data collection by some counselors; displays of the costs of contraceptive products in some SDPs; organization of a counseling room in some SDPs; willingness to build staff capacities in some districts; and commitment of some health committees to provide management tools.

**Areas for improvement:** Frequent stockouts of some FP products at the SDP level; non-compliance with the frequency for writing RTSs by ICPs; inadequate number of FP files and folders in SDPs with high volume of FP activity; inadequate availability and filling-out of management tools (registers, consultation forms, and stock management forms); unavailability of “Connaissez-vous vos options en PF? (Do you know your FP options?)” posters, displays, and sterilization supplies (autoclave/Poupinel); inadequate provision of IUD/implant insertion and removal kits in some SDPs; overworked counselors who must handle several tasks at once (selling tickets, EPI, care) in some SDPs, which hinders providing counseling in compliance with standards.

**Recommendations:** Provide regular formative supervision in managing the FP file, counseling and LTPM by the ECDs; increase the availability of IEC/FP/IP supplies, FP products and management tools; build capacities of trained staff at the SDPs with high-volume FP services.

**Improvements in services for youths**

With support from the component, the DSR/SE conducted supervision of the implementation of standards for youths in the health centers and Adolescent Counseling Centers of the regions of Kolda, Sédhiou, Saint Louis, Kédougou, and Kaolack.

This supervision revealed that orientations on AYRH standards were held in all regions for providers in the districts. The supervision also found that some districts are using free vouchers for consultations for students. The main recommendations are: provide SDPs with IEC tools for AYRH; train providers in AYRH; and integrate AYRH into routine supervisions.

**Support for the medical regions to implement the National Action Plan for Family Planning**
Funding provided to the medical regions of Sédhiou and Kolda in the implementation of the National Family Planning Action Plan was used to ensure organization of free FP consultations at health fairs by the Regional Midwives Associations.

Thus, this funding enabled the medical regions to involve Health Professionals Associations, such as the Midwives Association, in the repositioning and revival of family planning by giving them the opportunity to inform people about FP and to enroll new users outside of their regular consultations.

**Integration of Family Planning into services**

The integration of FP into immunization services and advanced strategies allowed the SDPs to take advantage of two good opportunities to provide family planning services to women who wanted them.

This integration enabled the **enrollment of 12,456 new users** of FP methods, including:

- 7432 new users through 814 immunization sessions that reached 25,775 people or an enrollment rate of 29%. (See Annex 4.)
- 5024 through 1586 advanced strategy visits in 13 regions. (See Annex 5.)

The distribution of new users by method confirms a strong preference among women for injectable, chosen and used by close to half of them. By combining the number of new users from last year with that of this year, the component will have directly supported the enrollment of 16,974 new users of an FP method through the integration approach. This amounts to 12.53% achieved in 18 months of the final goal set in the National FP Action Plan, which is 135,000 new users for the public sector by 2015.

*Figure 1: Distribution of new FP users by method*
Main challenges

- The regularity of post-training follow-up and supervision integrating FP, counseling, management of FP files, LTPMs, and SDMs
- Better coordination of interventions by partners
- Effective implementation of the regional FP plans
- Structuring of DSR/SE interventions to improve RH services delivery to youths

Opportunities

- The reactivation of the Steering Committee and the thematic groups of the National FP Action Plan, which will ensure better coordination of partners and interventions at the regional level
- The appointment of a Head of the Division of Family Planning, which will facilitate monitoring of the implementation of family planning activities, particularly introduction of the post-partum IUD
- Start of the development of the AYRH strategic plan

Prospects

- Introduction of the post-partum IUD under the technical leadership of the DSR/SE
- Support for the implementation of the national FP action plan in the regions and districts
- Continuation of approaches to integrate FP into other services, particularly testing the integration of FP into services for nutrition and the monitoring-promotion of children’s growth
- Support for development, dissemination, and implementation of the AYRH strategic plan

Improving the availability of quality maternal and neonatal health services

Achievements

**Development of a training module in EmONC**

During the second year, the component supported the Department of Reproductive Health and Child Survival (DSR/SE) in the organization of a workshop to develop the training module on Emergency Obstetric and Neonatal Care (EmONC). This module is a tool to use as a guide during the training of providers, nurses, and midwives. It specifically deals with the management of obstetrical emergencies and pathologies (in particular: monitoring during pregnancy; ante-partum hemorrhage; the management of pre-eclampsia and eclampsia; the management of fistula; post-abortion care (PAC); post-partum hemorrhage; monitoring during delivery; management of difficult labor; resuscitation and obstetrical anesthesia; the management of puerperal infections; post-partum consultations; vascular-renal accidents; and kidney failure).

**1.3.2 Training for providers on EmONC**

Following the development of the EmONC module, the component supported the DSR/SE in
the organization of a training session for trainers on EmONC with a view to strengthen provider skills and reduce complications related to pregnancy, delivery, and post-partum in health posts and health centers. Participants were from the regional hospitals and the National SAMU. The DSR/SE, the National SAMU, the Gynecology and Obstetrics Clinic of the Aristide Le Dantec Hospital facilitated the training.

1.3.3 Training for providers in the management of pre-eclampsia and eclampsia

Eclampsia is one of the most deadly conditions (12% of maternal deaths) in developing countries (WHO 2008) in the period between pregnancy and immediate post-partum. During the second year, training sessions on the management of eclampsia and pre-eclampsia targeted midwives and nurses in hospitals, health centers, and health posts.

The training improved providers’ skills in order to reduce the incidence and severity of cases, particularly through the recognition and appropriate management of various types of arterial hypertension (AHT) during pregnancy and organization of early referral.

“Thanks to the training on the management of pre-eclampsia and eclampsia, 75% to 80% of women presenting eclampsia who were evacuated by the districts received pre-transfer care,” stated the gynecologist and head of maternity services at the Louga Regional Hospital.

1.3.4 Training of providers in post-abortion care (PAC)

This training targeted providers (midwives and nurses) from hospitals, health centers, and health posts. It is divided into two parts, a three-day theoretical part including exercises, illustrated lectures, group work, case studies, and simulations with mannequins in the classroom and a two-day practical workshop in the health centers.

This methodology enabled providers, during the training, to manage clients who are admitted and presenting an incomplete abortion using an approach for appropriate care. Following this training, the providers could identify the different parts of the MVA equipment and had mastered the practical aspects in abortion cases.

By contrast, the target set for the year could not be achieved (only 23%) because the regions of Thiès and Kaolack that had planned training sessions for providers on PAC in the AWPs did not conduct them.

Key results

<table>
<thead>
<tr>
<th>Availability of quality maternal and neonatal health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Availability of training module on EmONC</td>
</tr>
<tr>
<td>• 13 trainers, including 6 men and 7 women, from 10 public health facilities received orientation on EmONC</td>
</tr>
<tr>
<td>• 448 providers, including 128 men and 320 women, from 350 health facilities, of which 11 were private, were trained in the management of eclampsia and pre-eclampsia</td>
</tr>
<tr>
<td>• 48 providers, all of them women, from 13 public SDPs were trained in PAC</td>
</tr>
<tr>
<td>• 59 providers (including 44 women and 15 men) from 46 SDPs (including 1 private SDP) were trained in AMTSL, ENC, and the kangaroo method</td>
</tr>
<tr>
<td>• 69 SDPs, including 1 private SDP, visited and 92 providers, including 80 women, supervised on the MNCH package</td>
</tr>
</tbody>
</table>
1.3.5 Training in focused ANC

Prenatal care, or the care a woman receives during her pregnancy, helps ensure better health outcomes for mothers and children. The focused ANC approach emphasizes the quality of prenatal care rather than the number of visits.

One of the key strategies of focused ANC is that each consultation must be conducted by a skilled health care provider (midwife, doctor, or nurse or other trained provider).

The regions of Thiès and Ziguinchor organized training sessions aimed at strengthening providers’ skills on focused antenatal care. The evaluation of participants’ knowledge during these training sessions as well as workshops held in the field (practice on real cases) showed a significant increase in participant performance; the average for participant performance went from 43% on the pre-test to 92% on the post-test.

1.3.6 Training for providers on AMTSL, ENC, and the kangaroo method

This training aims to strengthen providers’ skills in administering care to mothers to prevent immediate post-partum hemorrhage, known as Active Management of the Third Stage of Labor (AMTSL). It also covers management of newborns at birth through the administration of essential care and management of low-birth weight using the kangaroo method.

The importance of this package not only lies in the fact that post-partum hemorrhage is the leading cause of maternal mortality in Senegal (29% according to the 2001 UNFPA survey) but also because low-birth weight exacts a heavy toll on neonatal mortality.

The training targeted trained providers (midwives, nurses, and nurse assistants) in hospitals, health centers, and health posts from the regions of Kaolack, Ziguinchor, and Thiès. The regions of Saint Louis, Kaffrine, Kolda, and Sédhiou could not train the target set in the AWPs due to the volume of ECR and ECD activities.

Learning logs were used to master the skills. Teaching methods included illustrated lectures, demonstrations on mannequins, and an on-site supervision to practice on patients and newborns. The training evaluation includes observation of skills in AMTSL, essential newborn care, and the kangaroo method. Overall, evaluation results showed a knowledge and skills acquisition level ranging from 65% to 80%. The training also addressed the new updated guidelines on the elimination of mother-to-child transmission of HIV.

1.3.7 Post-training follow-up for providers on maternal and neonatal health services

Post-training follow-up of 35% of providers trained in maternal and neonatal health in the first year made it possible to assess and evaluate the knowledge and skills acquired by providers. It also helped identify under-performance among providers and facilities and to suggest solutions based on an action plan for problem solving. An integrated MNCH supervision grid including the observation of skills for real cases has been designed for this purpose.

The post-training follow-up revealed effective application of AMTSL and immediate basic care in nearly all service delivery points and good availability of medicines (oxytocin) and
resuscitation equipment (nasogastric tube, electric or pedal-operated nasal aspirator, and suction probes).

In Dakar, supervision also showed that training effectively allowed providers to improve case reporting and to master the steps to manage eclampsia/pre-eclampsia. The supervised providers are committed to comply with the recommendations, such as:

- Avoid medicine stockouts (albumin test, oxytocin, clonidine, nicardipine, magnesium sulphate, diazepam, etc.)
- Provide oxygen to health centers to ensure resuscitation of eclampsia patients
- Make essential drugs available to treat newborns (vitamin K1, antiseptic or antibiotic collyrium, etc.)
- Comply with measures to prevent infections in healthcare settings
- Equip the health posts with respiratory equipment (ventilation bag, mask, pedal-operated nasal aspirator, no. 6 and 8 suction probes)
- Sensitize women to seek care early
- Provide emergency medicines, specifically magnesium sulfate (MgSO4) and its antidote
- Strengthen the SDPs with equipment (oxygen absorbers)
- Provide protocols for the management of cases of pre-eclampsia and eclampsia in consultation rooms and delivery rooms

Main challenges

- The lack of a quarterly work plan for districts, which has an impact on planning and compliance with planned activities.
- The lack of coordination among partners’ interventions at the operational level sometimes resulting in funding for the same activities for the same targets by two, or even three, partners simultaneously. For example, in Saint Louis, UNFPA funded the DSR/SE for a situational analysis of maternal health services when the component had already funded the medical region to conduct the situational analysis of TutoratPlus in the same SDPs.
- The lack of health data used to conduct a concrete assessment of the impact of interventions at the operational and community level, despite the lifting of the withholding of information.

Opportunities

- Availability of a training module in EONC that will allow EONC training to start and give trainers and participants a harmonized reference document with standardized practices
- Availability of an integrated MNCH/FP supervision grid giving supervisors an opportunity to monitor the training sessions with tools that can objectively assess providers’ performance and streamline resources for post-training follow-up
- Participation of health committees in equipping some health posts (heated table, newborn resuscitation equipment)
- Equipping of some SDPs through sub-grants to the districts to help improve service delivery
Prospects

- Continuing cascade training for providers on the MNCH package, ensuring regions and districts conduct quarterly planning of training
- Providing cascade training for providers on EmONC
- Continuing post-training follow-up for providers trained in the integrated MNCH package

1.4 Strengthening the management of child health and nutrition

Achievements

1.4.1 Support for routine distribution of vitamin A

Local vitamin A supplementation days definitely enabled high coverage in vitamin A supplementation for children ages 6–59 months every 6 months. However, low coverage of routine vitamin A supplementation means that a percentage of children do not receive their first dose of vitamin A until the age of 7–11 months. Given the important role of vitamin A to child survival, it is appropriate to identify strategies that ensure administration of vitamin A starting at 6 months.

Therefore, support from the component for the DAN in partnership with HKI focused this year on the implementation of a pilot study on “Improving routine vitamin A supplementation coverage starting at 6 months.” This three-month study was led by HKI in six districts, including three intervention and three control districts. The intervention areas were the districts of West Dakar, Mbacké, and Thionck Essyl, and the corresponding control areas were in the districts of Thiès, Bambey, and Diouloulou, respectively. Its overall goal was to test the effects of the introduction of a package of activities to improve routine supplementary vitamin A coverage for children age 6 months and older. A baseline study was conducted in the six districts to determine a retrospective assessment of vitamin A supplement coverage from age 6 months.

Key results

Strengthening the management of child health and nutrition

- Improved routine distribution of Vitamin A from age 6 months in the intervention districts in West Dakar (from 20.1% to 45%), Mbacké (from 5.2% to 69%), and Thionck Essyl (from 0% to 100%)
- Training of 214 providers (including 132 women and 82 men) on applied nutrition and the life cycle in the regions of Diourbel, Dakar, Saint Louis, and Ziguinchor. The number of SDPs covered is 125, including 1 private SDP
- Training of 315 providers, including 143 women, on revised clinical IMCI in the regions of Saint Louis, Kaffrine, Ziguinchor, Dakar, and Kolda. A total of 226 SDPs affected, including 11 semi-public and private SDPs
- Training of 503 providers (including 254 women) from the regions of Kaffrine, Fatick, Saint Louis, Diourbel, Dakar, and Ziguinchor on the management of diarrhea with low-osmolarity ORS and zinc
- Training of 114 skilled health care workers from the regions of Thiès, Fatick, Saint Louis, and Kolda on monitoring growth and screening for acute malnutrition with the WHO Anthro software
The intervention strategies used were: provision of inputs (vitamin A capsules, child health record) at the SDP level, social mobilization, and SMS reminders. A significant improvement in coverage was noted, as indicated in the figure below.

**Figure 2: Coverage rate of vitamin A supplements pre and post intervention in the intervention districts (West Dakar, Mbacké, and Thionck Essyl) and control districts (Thiès, Bambey, and Diouloulou)**

![Coverage rate of vitamin A supplements pre and post intervention](image)

The study results will be used for advocacy to promote the effectiveness of routine distribution of vitamin A in all SDPs.

1.4.2 *Integrated Management of Childhood Illnesses (IMCI)*

Infant and child mortality is 72 deaths per thousand live births in Senegal (2010–2011 DHS-MICS), and the goal set for 2015 is 44 per thousand live births. According to WHO, the main causes of infant and child mortality are neonatal illnesses (27%), pneumonia (17%), diarrhea (14%), and malaria (19%). One-third of these deaths occur in a malnourished area. The component has emphasized training in revised clinical IMCI, an effective and recognized strategy in the fight against infant and child mortality.

In total, the component supported training of a pool of trainers (ECRS and ECDs) in the regions of Thiès, Kafrine, Kaolack, Dakar, Saint Louis, Kolda, and Ziguinchor. These trainers, in turn, provided cascade training for 315 providers, including 143 women from 252 SDPs of which 12 were private. Training dealt with the following topics:

- Checking for general danger signs
- Assessing signs and symptoms of the disease
- Classifying the disease in the appropriate category
- Identifying treatments for the various classifications of childhood illnesses
- Deciding to transfer the child to the referral structure
• Administering pre-transfer care
• Administer treatment at the health facility
• Educating the mother by teaching her to administer a specific treatment at home
• Counseling the mother about diet and when to return to the health facility
• Monitoring and re-evaluating

1.4.3 Management of diarrhea with ORS/zinc

The MSAS and its partners have focused on plans to scale up the management of diarrhea with ORS and zinc. Thus, a select committee made up of representatives from MSAS, HKI, IntraHealth, UNICEF, MI, and IPDSR (UCAD) was set up.

In this context, the component has provided technical and financial assistance to cover, on the one hand, the training for providers in the regions of Kaolack, Kaffrine, Fatick, Diourbel, Saint Louis, Dakar, and Ziguinchor and, on the other hand, the development of job tools for the screening and management of diarrhea. These tools are currently being distributed in the 11 IPQS regions and include: a technical guide on the main treatment tools for the management of diarrhea; technical sheets for treatment (Plan A, B, and C), and brochures on the national guidelines for the management of diarrhea. In addition to these activities, the component has provided technical assistance to the MSAS to train providers in the other regions.

In total, 503 providers (including 254 women) were trained, covering 316 SDPs, of which 16 were private. The completion rate of 118% is explained by the fact that during execution, the MSAS requested that the component train distributors from the regions of Dakar and Ziguinchor.
1.4.4 Training on the WHO Anthro

Management of diarrhea without signs of dehydration

Management of diarrhea with obvious signs of dehydration

Management of diarrhea with severe dehydration
This year, the component has also emphasized strengthening providers’ capacities in using tools for assessing the nutritional status of children with the goal of improving nutritional care. Thus, the component strengthened the capacities of 114 providers from health posts and health centers that have functioning resuscitation and nutrition education units on monitoring growth and screening for acute malnutrition with the WHO Anthro software, version 3.2.2, in the regions of Thiès, Fatick, Saint Louis, and Kolda. This software can assess nutritional status and provide individualized monitoring of children’s growth.

1.4.5 Setting up district-level teams/units responsible for the management and referral and counter-referral of acute malnutrition cases in compliance with the new national protocol

Operating a unit for the management of malnutrition requires the availability of basic elements such as inputs (RUTF: F75, F100), equipment for assessing nutritional status (anthropometric equipment), and medicines for routine treatment. To do this, the component began work with the DAN to identify needs in basic resources at the district level in addition to the support provided for equipment by UNICEF.

Meanwhile, the component provided financial and technical support for the revision and validation of the national protocol for the Management of Acute Malnutrition (MAM). Today, Senegal has its national protocol (guide) on the management of malnutrition.

Similarly, the component supported the DAN to develop job aids for providers to improve nutritional care. These included a poster on “How to manage severe acute malnutrition without complications in the URENs” for providers in the Resuscitation and Nutrition Education Units (URENs) and a weight-for-height table to screen for cases of acute malnutrition.

Lastly, results from the situational analysis conducted within the framework of TutoratPlus revealed that the major gap at the SDP level resulted not only from the unavailability of anthropometric equipment but also the lack of training in the Management of Acute Malnutrition (MAM). Hence, the component ordered 48 height rods and 49 Seca electronic scales to help fill the remaining gaps in equipment in SDPs after the allocation provided by UNICEF.

Main challenges

The main challenge is better coordination of all partners by the DAN.

Opportunities

The broad range of partners increasingly focusing on improving nutrition will allow for better coverage of SDPs to strengthen nutrition services and the management of malnutrition.

Prospects

For Year 3, this involves continuing training sessions on nutrition applied to the life cycle,
IMCI, and the management of diarrhea with ORS and zinc. Priority will also be placed on post-training follow-up.

1.5 Malaria control

Achievements

1.5.1 Training/retraining of providers on the prevention, diagnosis, and treatment of malaria, including malaria during pregnancy

During this year, the component supported the districts and medical regions to organize training/retraining sessions on the prevention and management of malaria. The component also provided technical and financial assistance to develop training modules integrating the new policies for care. These tools will allow for taking into account WHO recommendations when managing malaria cases, particularly for intermittent therapy and the introduction of ACT for pregnant women.

1.5.2 Capacity building for MSAS staff in monitoring-evaluation

The component supported capacity building for staff in monitoring-evaluation through a course organized by CESAG. This course enabled participants (ECD and ECR members and central-level staff) to deepen their understanding of the concepts, principles, and methods of monitoring and evaluation of health programs, and familiarize themselves with tools for the collection, analysis, and interpretation of qualitative and quantitative data. Thus, training these staff members will facilitate using information to improve the performance of health programs.

1.5.3 Support to implement home-based care (PECADOM) for malaria

The component supported the supervision of DSDOMs by ICPs in the pilot districts for integrated PECADOM of Tivaouane, Khombole, Joal-Fadiouth, Diourbel, and Bambey. This supervision made it possible to assess the quality of case management for malaria, diarrhea, and ARI within the community by the DSDOMs and to identify problems related to the implementation of integrated PECADOM. It also enabled an assessment of the management of inputs (RDT, ACT, ORS and Zinc, and Co-trimoxazole) and to develop a plan to resolve problems that arise.

1.5.4 Support for supervision of sentinel sites

Key results

Malaria control

- 277 providers (132 men and 145 women) from 193 SDPs, including 29 private SDPs, trained in the prevention and management of malaria in Diourbel, Dakar, Matam, Kédougou, Kolda, and Ziguinchor
- 200 community actors trained in Dakar and Diourbel within the context of strategies to increase IPT2 coverage
- 11 persons (including 8 men and 3 women) trained in the course on monitoring-evaluation of health programs
- 18 sentinel sites supervised
- End-use verification of antimalarial products conducted in 30 facilities, including 20 health posts, 6 health huts, and 4 district warehouses
With support from the component, the PNLP organized formative supervision in partnership with the UCAD Department of Parasitology and the Thiès SLAP at the malaria sentinel surveillance sites. This supervision enabled the PNLP to identify training needs for nurses at these sentinel sites in addition to setting up laboratory equipment and providing retraining for CHWs from laboratories.

1.5.5 Approaches to improve IPT for pregnant women

Following an initial review of the data on the prevention and management of malaria among pregnant women, the component together with the PNLP selected the districts of Touba and Mbao to implement strategies to increase IPT2 coverage. Hence, the districts implemented the following activities:

- A situational analysis based on reproductive health and malaria data for pregnant women and a survey of the communities (health committees, local governments, “Bajenu Gox” and relais community networks, pregnant women coming for consultations, and men), providers from the ECD and ECR
- Development of recovery plans following the SA, mainly based on:
  - Training/retraining for providers in the prevention and management of malaria
  - Training for community actors on malaria among pregnant women
  - Renewed discussions with providers and local governments to review the memo from the Minister of Health on universal access to SP

In total, 200 community actors (“Bajenu Gox,” relais) were trained in the two districts on malaria and its prevention among pregnant women. The districts are also committed to complying with guidelines on universal access to SP at all levels.

1.5.6 End-Use Verification of antimalarial inputs

The End-Use Verification of antimalarial inputs was conducted in the central part of Senegal (Kaolack, Fatick, Kaffrine, and Diourbel) for the first round.

This activity made it possible to establish a baseline of the situation at the visited warehouses, particularly in terms of antimalarial commodity availability and to plan corrective measures before the rainy season to decrease mortality and morbidity due to malaria. It also helped to correct some gaps on site in managing commodities, for example at the health post warehouse in Medina Baye where the distributor, due to technical and supervision-team support, succeeded in meeting the standards for product and medicine storage.
1.5.7 **Strengthening malaria case management in the private sector**

The component supported the MSAS Division of Private Health Establishments to conduct a situational analysis (SA) to assess the functional capacity of health facilities that deliver the integrated package of quality services, especially as regards to the management of malaria. The survey aimed to assess the availability and quality of service delivery for malaria in semi-public and private facilities and to identify the areas and mechanisms for partnership between semi-public and private health facilities and the MSAS with a view to create a dynamic public-private partnership. The SA was launched in the Thiès region where 62 private facilities located in the 9 health districts were surveyed. Then it was extended to the 13 other regions.

In total, 186 private SDPs were visited, including private clinics (28%), private dispensaries (26.9%), doctors’ offices (17.2%), paramedical offices (16.1%), company medical services (10.8%), and private hospitals (1.1%).

The preliminary report is undergoing validation before being disseminated to stakeholders.

**Main challenges**

The main challenge in the implementation of malaria control interventions is the coordination of all activities supported by the project’s various partners, particularly the coordination and synergy between the activities under the Fixed Amount Reimbursement Agreement signed with USAID and those of the component.

**Opportunities**

Reactivation of the Monitoring/Evaluation Task Force envisaged by the PNLP and Coordination Committee for Malaria Control could support better coordination between partners.

**Prospects**

The component will focus on supervision and strengthening the capacities of staff, particularly on the prevention, diagnosis, and treatment of malaria, including malaria among pregnant women. For the latter target, the component intends to continue and expand support for the implementation of approaches that improve IPT adherence. In addition to the regular supervision activities, implementation of the End-Use Verification for antimalarial inputs will also be pursued.

1.6 **HIV and tuberculosis control**

**Achievements**

No activity was carried out due to scheduling. These activities will be conducted during Year 3 in partnership with the HIV/AIDS Component, the DLSI, and the DSR/SE.

**Main challenges**

The main challenge continues to be the effective creation of synergy with the HIV/AIDS Component to implement this intervention.
Opportunities

The creation of an inter-agency synergetic group on the integration of services to allow for restarting this activity.

1.7 Improve immunization services

Achievements

1.7.1 Training for providers on the new EPI guide

This training targeted providers from the medical regions of Dakar, Louga, and Kolda. It enabled them to upgrade the management of vaccines and the cold chain, the safety of injections, waste management, integrated surveillance of diseases, and response to epidemics, as well as to learn about new vaccines that will be introduced in October 2013 for pneumococcus and for rubella in 2014. Since revision of training modules by the central level took time, training for providers began late and not all targeted providers could be trained. Hence, 22% of the set annual goal was achieved.

1.7.2 Support to set up equipment to monitor the cold chain

Setting up data loggers and training for their users could not be conducted during Year 2 for programmatic reasons. It has been scheduled for Year 3.

1.7.3 Reach Every District (RED) Strategy

Within the framework of the RED strategy, 10 health districts were identified as low performing based on the results of the immunization coverage survey. These districts all have a Penta-3 coverage rate below 50%.

The RED strategy aims to improve the organization of immunization services, optimize the use of available resources, and ensure high immunization coverage is reached (at least 90% nationally and 80% at the health district level).

The districts of Koki and Koungueul received support through the strategy. This support consisted of sharing the recovery plan with all stakeholders: the community networks (Bajenu Gox and CHWs relais), mutual health organizations, local and administrative officials (prefects, Rural Council presidents, and mayors), the ECD, the ECR, and heads of SDPs.

1.7.4 Support for the introduction of new vaccines

As part of introducing the pneumococcus and rubella vaccines, the component supported holding a preparatory workshop for technical,
logistics, communications, and surveillance commissions. This meeting enabled the finalization of tools and plans for activities. The various tools that were developed are:

- Management tools: supervision grid for all levels, scorecard, and data-entry templates
- Communication plan
- Plan for pharmacovigilance and management of adverse events following immunization
- Procurement and waste management plan
- Campaign implementation guide
- Training guide
- Micro-planning outline

Since the introduction of pneumo-23 and the measles rubella campaign has been planned for November, the final preparatory activities will be supported in Year 3.

**Main challenges**

To improve immunization services, we should involve UNICEF, a key partner of the Department of Medical Prevention to better coordinate support provided to the MSAS and streamline technical and financial resources.

**Opportunities**

The diversity of technical and financial partners makes it possible to cover EPI needs, which remain significant.

**Prospects**

- Continuation of training on the new EPI guide
- Implementation of the RED strategy in the health districts of the Thiès region
- Preparatory activities for the implementation of the measles-rubella campaign in November 2013
- Preparations for the introduction of the pneumococcus vaccine in November 2013
- Setting up data loggers accompanied by training for users

**1.8 Institutional support for partners**

**Achievements**

Institutional support for partners targeted the Senegalese Association of Gynecologists and Obstetricians (ASGO) for free consultations in the district of Diamniadio and the establishment of sub-agreements with districts to implement TutoratPlus.

The component’s support of ASGO demonstrates its commitment to providing increased accessibility to quality services and trained staff to the community. Services that are often inaccessible—such as gynecology, cervical cancer screening, and ultrasound—could be available and delivered to women during these free consultations.

This funding is part of the support for partners’ events. It is limited and is particularly intended to encourage the ASGO to develop activities that increase peoples’ access to services. See Annex 7.
As part of the district grant, grant agreements for 15 first-generation TutoratPlus districts were signed, and their implementation has now started. The procedure manual for sub-grant management was developed and distributed to all districts. The medical teams of these districts have received orientation on procedures for sub-grant management and are now well equipped to manage them and comply with the procedures and conditions related to them. The total amount disbursed for the payment of milestones is 74,694,206 FCFA.

Also, it should be highlighted that through the sub-grants, IntraHealth guided the beneficiary districts through signing Memoranda of Understanding with private health facilities so that they could be fully included in TutoratPlus and in delivering the Integrated Package of Quality Services. Overall, 43 private facilities signed the Memoranda of Understanding with 15 districts that are receiving sub-grants. Close monitoring to ensure that milestones are achieved within the required time will be the main challenge with these sub-agreements.

For the direct joint financing for the regions, the Implementation Letters have been signed between the Implementing Agencies of the USAID Health Program and the medical regions of Thiès, Kaolack, and Kolda. This year, the component contributed to the payment of deliverables for an amount of 24,867,529 FCFA.

Thus, the component will have allocated a total amount of 99,561,735 FCFA to the regions and health districts through a direct funding mechanism.

The component also provided support in IT equipment to the DRH to ensure the entry and electronic archiving of information on the health workforce. This equipment is for the Division of Staff Management (DGP) of the DRH and for the medical regions and health districts of Kolda and Kaolack. It includes:

- 8 desktop computers for the medical regions of Kolda and Kaolack and their districts
- 6 laptop computers with docking stations and flat screen displays for the central level
- 1 multifunction network printer
- 3 digital cameras (including 2 for the regions)
- 3 scanners (including 2 for the regions)

### Key results

**Institutional support for partners**

- Through support for ASGO, 934 people received free RH/FP services
- Support for the DRH for IT equipment
- 142 members of the ECRs and ECDs received orientation on combining the JLS and JNV (including 40 women and 102 men)
- Through the combined JLS and JNV:
  - 2,746,104 children vaccinated orally for polio
  - 2,542,026 children received vitamin A supplements
  - 2,273,124 children dewormed with mebendazole
- 74,694,206 FCFA awarded to 15 districts through sub-grants
• 1 video projector
• 3 desktop printers
• 1 external hard drive for back-up
• 14 antivirus software licenses

The financial support awarded to the Division of Child Survival was used for training for all ECRs and ECDs on organizing the vitamin A Supplementation Days combined with deworming on the National Immunization Days. This orientation brought the ECRs and ECDs up to date on the combining of days and the data collection tools.

Main challenges
• For special events such as the JLS combined with the JNV, inadequate coordination between the central and regional levels had a negative impact, particularly in Ziguinchor, on the event’s success.
• The regions’ actual contribution in the monitoring of sub-contract implementation remains low. Monitoring is mainly done by the RPMs with support from the RO and the sub-contract service.

Opportunities
• The diversity of partners within the DAN (MI, UNICEF, and WHO) ensured easy implementation of the JLS/JNV.
• Training for the ECRs and ECDs in management already conducted by the HSS Component in 10 regions enabled us to begin discussions with ACA about training the ECRs and ECDs in the remaining four regions.

Prospects
• Monitor the implementation of sub-grants with the districts
• Sign sub-grant agreements with the districts enrolled in Year 2
• Support direct financing for the regions of Kaolack, Kolda, and Thiès
• Strengthen the capacities of ECRs and ECDs in the management of sub-grants
Sub-component 2: Improved quality of health services in health posts, health centers, and regional hospitals

2.1 Support for equipment and supplies for SDPs

Achievements

The component supported the regions to identify the SDPs’ equipment needs to provide IPQS services. This helped highlight the gaps that primarily concern equipment for newborn corners, Jadelle and intra uterine device (IUD) insertion and removal kits, pedal bins, gynecological examination tables, Poupinel and autoclaves, stools, metal cabinets, etc. All 14 regions expressed significant supply needs in FP kits. In addition, we noted that in most of the regions, the newborn corners exist but do not have all the equipment needed to make them functional.

In addition, the component supported implementation of the plan to procure the equipment needed to gradually close these gaps. Hence, the component ordered IUD and implant insertion kits, height rods, scales, and newborn resuscitation equipment. The international order for equipment is expected to arrive in October 2013. Acquisition of this equipment was accompanied by advocacy with partners (local governments, health committees, local NGOs, and other district financial partners) to contribute to the implementation of the health district plans to obtain equipment.

Main challenges

Misunderstandings about support expected from other partners complicate equipment selection. We realized that in addition to the component’s contribution, during the year the medical regions and health districts received equipment through partners that was not included in the district AWPs.

Opportunities

District grants helped to meet urgent needs in equipment such as suction probes, pedal bins, and additional equipment for newborn corners. Funding from other partners such as UNFPA and UNICEF for equipment is a good opportunity for the component to streamline its resources for equipment.

Prospects

- Organize an official ceremony to present this equipment with the DSR/SE
- Strengthen coordination with UNICEF and UNFPA

2.2 Securing products for contraception, RH, child survival, and malaria

Achievements

Key results
Support for equipment and supplies

- 23,989,107 FCFA allocated to 15 districts to purchase equipment and supplies
- Acquisition of 200 implant insertion/removal kits, 200 IUD insertion/removal kits, and 60 newborn resuscitation kits
During Year 2, the HSI Component, through its logistics sub-component, supported the MSAS through the DSR/SE on seven interventions.

2.2.1 Training in Reality Check

With USAID support and in partnership with EngenderHealth, the HSI Component organized training sessions to introduce a new approach to quantify and plan for contraceptive needs with the Reality Check tool. Training on Reality Check began in Year 1 through the capacity building of logistics specialists at the central level followed by training in specific areas for the ECRs and ECDs. These activities made it possible to quantify contraceptive needs at the central level until 2015 with partners. This also enabled determining how many additional new FP users each region must contribute in order to reach 27% coverage in CPR by 2015.

This year, emphasis has been placed on the training of ECDs in Reality Check with ECR members and trainers between January and February 2013. This training, comprising 13 sessions, concerned all members of the targeted ECDs and helped strengthen the skills of 218 providers, including 125 women. This training also supported the development of FP action plans for each district.

2.2.2 Support for training on and supervision of CHANNEL

The component supported the DSR/SE in the training of hospital pharmacists on the CHANNEL management software in partnership with UNFPA. This training allowed the pharmacists to share experiences on the latest updates on stock management of contraceptive products and to provide them with computers to facilitate completing reports used to produce and send logistics data.

The HSI Component has also supported the DSR/SE in the CHANNEL formative supervision of the PRAs and district warehouses of the MRs of Kaolack and Fatick. This CHANNEL formative supervision made it possible to collect distribution data used during the mid-year reviews of the Contraceptive Procurement Tables.

2.2.3 Support to train distributors on stock and drug management

In May 2013, the component supported the Department of Pharmacy and Medicine (DPM) in partnership with WHO to train distributors from the SDPs of Kaolack MR on stock

Key results

Securing products

- 227 members of ECDs from 14 regions (including 125 women) trained in Reality Check
- 8 hospital pharmacists, 4 PRA pharmacists, and 8 warehouse distributors trained in CHANNEL
- Development of a procurement plan for contraceptives for 2013, 2014, and 2015
- Support to train 41 warehouse distributors in Kaolack
- 11 Regional Procurement Pharmacies, 73 district warehouses, 70 health center warehouses, 2 level-1 Public Health Facilities, and 1 CHR were supervised
- Support for CHANNEL formative supervision of 2 PRAs and 10 district warehouses (4 MRs in Kaolack and 6 MRs in Fatick)
- Gaps assessment of the stock management of 26 SDPs conducted in the Nioro health district
management of essential medicines. This training strengthened their skills in complying with storage guidelines, filling out management tools, estimating needs, receiving a drug order, and dispensing drugs. It was also an opportunity to share the latest updates on contraceptives management in terms of stock levels and the adjusted average monthly consumption.

2.2.4 Supervision of PRA and district warehouses

The HSI Component supported the medical regions in partnership with the DSR/SE, the National Procurement Pharmacy, the Division for AIDS Control, and USAID for the integrated logistics supervision of the PRAs and district and health-center warehouses of Senegal’s 14 medical regions. This supervision took place between March and June 2013 and has helped to assess the availability and accessibility of tracer drugs for programs (antimalarial commodities, contraceptive commodities, antiretroviral drugs, drugs for opportunistic infections, and reagents for HIV testing). The IMAT tool was used to measure indicators for record keeping and availability.

This supervision made it possible to:

- Collect data on the distribution of contraceptives in the 11 PRAs (Dakar, Diourbel, Fatick, Kaolack, Kolda, Louga, Matam, Saint Louis, Tambacounda, Thiès, and Ziguinchor), 73 district warehouses, 70 health center warehouses, 2 PHFs, and 1 CHR.
- Follow up on recommendations from previous supervisions to improve availability of essential medicines and products in the PRAs and district and health center warehouses.

Although the PRAs have made efforts with an availability percentage over 90% in contraceptive products, stockouts persist at some district and health center warehouses (an average of 26% availability) despite a significant improvement compared to last year (an average availability of 3%).

2.2.5 Planning for procurement of contraceptives

The HSI Component supported the DSR/SE in conducting two mid-year reviews for the Contraceptive Procurement Tables with funding from USAID and UNFPA in May and September 2013.

These reviews involved three programs (DSR/SE, DLSI, and ADEMAS) and used the data on contraceptive distribution collected by VALDAFRIQUE for ADEMAS and in the PRAs and health districts for the DSR/SE and DLSI. The distribution data collected by each program will be analyzed compared to projections.

The exercise to quantify needs in contraceptive products and procurement planning uses a software for contraceptive product planning called Pipeline 5. These reviews allow each program to send its requests for contraceptive products through 2015 to its partners: USAID and UNFPA.

2.2.6 Supporting districts in developing initiatives to secure products and essential
medicines for the IPQS

Following the persistent stockouts reported during the CHANNEL integrated logistics and formative supervisors at the district and health center warehouses, the component launched a plan to improve stock management of tracers for essential medicines at service delivery points.

A pilot intervention was launched in September 2013 with an analysis of gaps in stock management in 26 SDPs in Nioro. This gaps analysis uses an interview and observation grid focused on:

- Training for staff in stock management
- Supervision of district warehouses
- Conditions in the drug storage location
- Compliance with procedures for organizing drug storage
- Drug orders
- Availability and filling-out of management tools
- Drug inventory
- Compliance with price margins for essential medicines and products
- Data management

Results from this evaluation should be shared with district stakeholders who should then develop a plan to resolve gaps.

Main challenges

The main challenge is to ensure the ECDs provide regular quarterly supervision at the health center and health post warehouses by systematically including them in the integrated supervision of SDPs.

Opportunities

The ECRs and ECDs are adequately reinforced in management of medicine stocks and have participated in several supervision missions so they can take ownership of the logistics supervision activity.

Prospects

The component will support the districts in setting up systems aimed at reducing stockouts, for example by implementing a process to analyze gaps and to develop and implement a plan to resolve problems.

2.3 Strengthening the referral and counter-referral system

Achievements

The main achievements reported for Year 2 are as follows:

- The development and validation of the national SAMU strategic plan enabled advocacy to promote SAMU among partners and MSAS officials.
- Reproduction of the SAMU strategic plan. This document is a job aid that can be used as a
guide and reference document for the implementation of any emergency management project or program in Senegal.

- **Strengthening of the regulation center for SAMU calls** was done through the acquisition of four additional receptionist positions to increase the capacity of emergency calls reception and regulation.
- Reproduction of 300 copies of the Emergency Care Protocols Guide for providers in order to standardize the management of emergencies.
- **The launch of the decentralization of SAMU in Thiès** consisted of advocacy among stakeholders and the recruitment of two midwives for the decentralized mobile units in Thiès.
- **The component supported the SAMU to train providers in the regions of Thiès and Ziguinchor on the management of emergencies.** Thus, 89 providers (including 53 men and 36 women) were able to improve their skills. The content focused on prerequisites for medical evacuation, gyneco-obstetric emergencies, medical emergencies, psychiatric emergencies, surgical emergencies, and pediatric emergencies. During these sessions, a list of drugs and products for an emergency kit available in each SDP was established.
- **In Ziguinchor, the component supported the SAMU to lead a specialists tour.** This tour of the CHR highlighted organization issues related to referred patients and the management of emergencies. It was a factor in making decisions aimed at solving the identified problems.

**Main challenges**
The lack of resources (medicines, equipment) from the MSAS is a challenge to effectively launching SAMU activities in Thiès.

**Opportunities**
The strong commitment of medical regions and the SAMU to strengthen the capacities of SDPs to manage emergencies will facilitate the implementation of activities to improve the referral and counter-referral system.

**Prospects**
The component will continue to implement activities such as the training of providers on managing emergencies, support to decentralize SAMU, and specialists tours.

### 2.4 Implementation of integrated advanced strategies

**Key results**

**Strengthening the referral and counter-referral system**

- Writing and validation of the SAMU strategic plan
- A workshop to share experiences on the initiative to decentralize obstetrical SAMU to Thiès
- Training of 89 providers, including 36 women, on the management of emergencies
- 1 specialists tour in Ziguinchor
- 300 copies of protocols for the management of emergencies disseminated
Achievements

In the context of improving the accessibility and availability of quality services at the community level, the component supported advanced strategies on a national scale. This involved provision of a minimum package of services by the head nurse/State registered midwife (ICP/SFE) or a qualified staff member appointed by the health district at the health hut level in the area covered by the Community Health Component. It is organized every two months by the health post or health center. The option selected from the advanced strategies implementation guide is to conduct supervision of health hut services during the strategy using a supervision grid developed jointly by the MSAS and the Community Health and HSI Components.

The figure below shows a slight discrepancy between the number of advanced strategies and the number of hut supervisions. This means that the ICPs are not regularly supervising the huts, with most of them citing the extra work required during the advanced strategy. This discrepancy is especially noticeable in the regions of Louga and Kolda.

Figure 4: Comparative table of advanced strategies conducted and supervision visits made to health huts

<table>
<thead>
<tr>
<th></th>
<th>Nombre de sorties en SA</th>
<th>Nombre de cases supervisées</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louga</td>
<td>100</td>
<td>60</td>
</tr>
<tr>
<td>Senegou</td>
<td>150</td>
<td>80</td>
</tr>
<tr>
<td>Seboom</td>
<td>200</td>
<td>120</td>
</tr>
<tr>
<td>Kolda</td>
<td>300</td>
<td>180</td>
</tr>
<tr>
<td>Tamba</td>
<td>400</td>
<td>240</td>
</tr>
<tr>
<td>Yooka</td>
<td>500</td>
<td>300</td>
</tr>
<tr>
<td>Dikoumbi</td>
<td>600</td>
<td>400</td>
</tr>
<tr>
<td>Siaoundjo</td>
<td>700</td>
<td>500</td>
</tr>
<tr>
<td>Saint-Louis</td>
<td>800</td>
<td>600</td>
</tr>
<tr>
<td>Matam</td>
<td>900</td>
<td>700</td>
</tr>
<tr>
<td>Fatick</td>
<td>1000</td>
<td>800</td>
</tr>
<tr>
<td>Diourbel</td>
<td>1100</td>
<td>900</td>
</tr>
<tr>
<td>Podor</td>
<td>1200</td>
<td>1000</td>
</tr>
</tbody>
</table>

Main challenges

- Increase the effective participation of midwives in activities involving integrated advanced strategies along with the ICPs to reduce the ICPs’ workload
- Comply with the ICP visit frequency (every 2 months)

Key results

Advanced Strategies

- 1586 ASs were conducted for a goal of 2000, or an execution rate of 79.3%
- 1400 supervision visits conducted in health huts
- 46,486 children immunized, 5571 children received vitamin A supplements, 16,130 women received ANC, and 2075 LLITNs distributed to pregnant women
- 5024 new users of FP enrolled
Opportunities

- The effective participation of the Community Health Component at the district level enables better monitoring and good organization of activities.
- The integration of advanced strategies into the milestones of the Implementation Letter for the regions with direct financing (Thiès and Kolda) will enable the medical region to monitor their implementation.

Prospects

- Continue the implementation of advanced strategies from the health posts to the health huts in regions not covered by direct financing.
- Support the participation of midwives in strengthening integrated advanced strategy activities.
- Conduct joint supervision of advanced strategies by the regions and districts in partnership with the Community Health Component.

2.5 Quality improvement partnership for SDP services, including client flow

Achievements

2.5.1 Training tutors on the QIP approach

The Réseau Siggil Jigéen (RSJ) organized three training sessions for tutors on the QIP approach in Kaolack, Thiès, and Saint Louis. Following this training, plans were developed for tutor visits to launch the activities at the district level.

2.5.2 Implementation of the QIP in SDPs

After the training, tutors began to implement the approach in the SDPs that were enrolled in Year 2 and, thus, could set up the QIP teams within the SDPs and help develop action plans to improve the service quality.

The QIP approach is implemented through the following steps:

**Step 1: Seeking support** - This step involves presenting the process and obtaining a commitment from members to participate in it. The QIP process is a partnership mechanism that requires commitments from community and the health system leaders to join.

**Step 2: Quality survey** - This step provides an opportunity to understand the various perceptions of quality as seen through the community, the health system, and local authorities.

**Step 3: Harmonizing definitions of quality** - This step launches the partnership because it helps to reconcile the

**Key results**

**QIP**

- 36 QIP tutors trained in the QIP approach in Kaolack, Thiès, and Saint Louis
- 276 QIP teams established around targeted SDPs
- 254 action plans developed and implemented at the SDP level by the QIP teams
- 1 supervision mission conducted by RSJ
community’s, providers’, and authorities’ ideas. Having the different parties sit down together to find a solution to their problems spurs the development of a common vision for the desired quality of services. This harmonization results in setting up the QIP team.

Step 4: Development and implementation of a QIP action plan - Using the analyses, the group identifies problems, determines the causes, and finds solutions in order to achieve the desired quality. The group also establishes indicators to monitor progress and determine when a given problem had actually been detected.

2.5.3 Monitoring of the implementation of the QIP approach in SDPs

A supervision mission was conducted in 11 regions to assess progress of the implementation of the approach. This supervision mission revealed that communities, providers, and local elected officials are receptive to the project and are involved and committed. This promotes the implementation of the action plans and achieving some successes. The implementation of these action plans will improve the quality of operations and services in the visited SDPs through, among other things: repair of the ambulance, recruitment of midwives, purchase of a generator, community clean-up of the SDPs and their surroundings, the availability of equipment for solar energy in some SDPs, investments from sports and cultural associations in the cleanliness of SDPs, and the construction of waiting rooms to improve client reception.

Main challenges

Maintaining and strengthening community involvement, particularly locally-elected officials, are the main challenges for QIP implementation.

Opportunities

- Existing supportive community networks can provide significant leverage in ensuring actors’ support of the QIP approach.
- The presence of partners at the community level (emigrant associations, NGOs, good intentions) facilitates mobilization of resources for the implementation of QIP action plans.

Prospects

- Continuing to introduce the QIP into SDPs
- Conducting joint quarterly monitoring of QIP implementation by RSJ
- Holding an annual meeting to share experiences on QIP implementation
- Supporting the program quality in the consolidation of quality approaches
2.6 Infection prevention and the protection of the environment in SDPs

Achievements

Support from the HSI Component for the National Nosocomial Infections Control Program (PRONALIN) falls within the scope of strengthening the security and quality of care through infection prevention and protection of the environment, as outlined in this program’s 2005–2015 strategic plans. The main achievements this year are summarized as follows:

- Identification of four facilities (Heinrich Lübke Hospital in Diourbel, Matlaboul Fawzaini Hospital in Touba, Amadou Sakhir Mbaye Hospital in Louga and Aristide Le Dantec Hospital) for setting up hydro-alcoholic solution production units. The Fann and Principal Hospitals will receive technical support to set up and monitor activities in the hydro-alcoholic solution production units.
- Improving compliance with standards for the management of biomedical waste through the training of trained and untrained providers on infection prevention and protection of the environment.
- Integrated supervision of SDP staff demonstrating compliance with rules for infection prevention and protection of the environment by 100% of SDPs that were supervised in the health district of Medina Yero Fula.
- The production and standardization of training modules for providers on infection prevention and protection of the environment in health services in the form of one guide for providers and another for trainers. These tools will enable the ECDs and ECRs to provide high-quality training wherever the need is expressed at the peripheral level.

Main challenges

The main challenge is to ensure the ECRs and ECDs provide post-training follow-up for providers so that they put the knowledge gained during the training into practice.

Opportunities

The institutional frameworks set up by the PRONALIN at the regional and district hospital level, particularly the committees for nosocomial infection control along with various managers, offers a real opportunity to ensure monitoring of activities and supervision of actors and that providers in the SDPs gain the necessary practical knowledge.

Key results

Infection prevention and the protection of the environment

- 1912 providers, including 1166 women, trained on infection prevention and the protection of the environment
- Integrated supervision of staff from 10 SDPs in Medina Yoro Fula, including infection prevention and the protection of the environment in health care services.
- Identification of 4 facilities to accommodate the production of hydro-alcoholic solution.
Prospects

The component will emphasize the implementation of operational activities to improve the quality and safety of care. This will involve capacity building, supervision of providers, providing hydro-alcoholic solution to providers for hand hygiene when administering any care, evaluation of procedures for processing reusable supplies, and surveillance of nosocomial infections in SDPs.

2.7 Communication and promotion of health services

Achievements

2.7.1 Production and diffusion of job aids

To support the implementation of IPQS in the SDPs, the HSI Component has created a series of job aids for health care providers.

- The bags given to trained tutors serve as supports for the tools and documents that they use, making it easier to move around during on-site supervision.
- The aide-memoire, in addition to work guidelines for FP counselors, contains information on the full range of FP methods available in health facilities. It serves as a reminder for counselors on how to conduct FP counseling. This document should help improve the quality of PF counseling delivered in SDPs.
- The checklists for the initial visit and follow-up visit for the Standard Days Method will be distributed to providers, especially those in faith-based SDPs where this natural method is offered.
- The distributors guide for drug management complements the supervisions conducted in the district warehouses. It is a reminder tool with information on how to properly organize drugs and fill out management tools for a drug warehouse.
- The printing of the new EPI guide that will be provided to health workers, including those from the private sector, for better understanding of immunization practices for children.
- Daily collation tables for collecting data on immunization each day
- The trainer and provider guides on the prevention of health care associated infections are currently being printed. They should be available to trainers and providers to help reduce the risk of infections related to care.

2.7.2 Support for the celebration of World Malaria Day

Support for the National Malaria Control Program for the celebration of World Malaria
Day helped provide clothing to school children and communities and to expose them to messages on malaria prevention. The official launch took place in Tambacounda and was attended by the Honorable Minister of Health and Social Action, various services within the Ministry, technical and financial partners, state and local officials, and the community.

2.7.3 Support for the national family planning campaign

The DSR/SE received funding for fabric and T-shirts for the organization of the National Day to Launch the FP Campaign, celebrated in November 2012. For the National Campaign, the component participated in the various meetings to validate tools and the campaign program.

Main challenges

- The effective use by SDPs of job aids that have already been produced and distributed
- Restarting communication activities within the SDPs to promote the use of IPQS and offered services.

Opportunities

Having tutors for health promotion could help to identify needs for job aids and lead to greater use of those already produced. In addition, plans to promote health that were developed by the SDPs visited by these same tutors provide a working basis for effectively restarting communication activities within the SDPs.

Prospects

In Year 3, while continuing to support the celebration of special events and the production of job aids, the component will place priority on strengthening communication efforts in the SDPs and within communities on the IPQS and the promotion of available services in SDPs. Therefore, specific attention will be given to the promotion of services such as ANC, IPT, ARIs, and PNC, which are not covered by the Health Communication and Promotion Component. Efforts will be made to involve local religious leaders in the promotion of IPQS.
3.1 *Strengthened capacities of ECRs and ECDs in human resources management*

**Achievements**

In Year 2, the component supported the medical regions to identify needs in SDP staff training on the IPQS. This exercise highlighted the significant gaps in training needs in areas such as infection prevention and protection of the environment, management of the Expanded Program on Immunization, applied nutrition and the life cycle, adolescent and youth reproductive health, and the management of diarrhea with ORS and zinc. Some of these gaps were dealt with in the conventional training on the IPQS conducted by the component.

**Main challenges**

The availability of regional training plans and their implementation is a challenge for the heads of health services at the operational level.

**Opportunities**

The commitment made by the Division of Training, within the DRH of the MSAS, to support the medical regions in making regional training plans available will enable their implementation.

**Prospects**

This involves updating training needs in the medical regions and the development and diffusion of regional training plans.

3.2 *Support granted to districts to implement a performance improvement system targeting SDPs and providers*

**Achievements**

- Since this intervention is pegged to TutoratPlus, a booklet on organizing services, including human resources management, was introduced in the tutor training tools. Hence, the trained tutors could use this session to help heads of SDPs implement job descriptions and a performance improvement system.
- In addition, the component supported the Division of Training within the MSAS Department of Human Resources to develop a guide for managing human resources performance. The draft of the guide deals with the following topics: An introduction to the management of health programs, leadership, human resources management, and...
monitoring and evaluation of performance.

- Capacity building for 83 ECD and ECR members on the development of job descriptions for all staff in the center they head. This activity gives each provider a job description and helps modernize the human resources management system. This would foster creating a foundation for objective worker assessment while also serving as a data source for needs and requirements for workers and their work stations.
- Provision of 70 models for job description types for ECRs and ECDs.
- Establishment of the standardized list of socio-professional categories for the MSAS.

These activities allowed the DRH to prepare for the implementation of modern tools for managing performance.

**Main challenges**

After the various training sessions, the actual implementation of job descriptions in the SDPs was a challenge for the ECRs and ECDs, which could be drawn upon for doing integrated supervisions of SDPs.

**Opportunities**

The main opportunity is the commitment of MSAS officials to implement a performance management guide.

**Prospects**

- For the performance guide, testing will occur at the medical region level, with the goal of collecting observations at the operational level.
- Concerning the availability of job description sheets, the component will support the medical regions to conduct supervisions on the implementation of job descriptions. In addition, tutors for package 4 (Management and Organization of Services) will be relied on for supervising the implementation of job description sheets.

### 3.3 Support for increased number of staff in SDPs

**Achievements**

The main achievements are summarized as follows:

- **The component introduced the iHRIS software** (Health Workforce Information Software) in two test areas (Kolda and Kaolack) and the central level. This software created a mapping of health care staff in the MSAS at the central level and in the regions of Kolda and Kaolack.
personnel and will help various MSAS officials to have a tool for analysis and decision making about health care personnel management.

The box below provides an overview of the iHRIS.

<table>
<thead>
<tr>
<th>iHRIS</th>
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<tbody>
<tr>
<td>• The iHRIS is a human resources management tool that can provide the health system with updated information on data. The software has developed an innovative approach to workforce management and can write reports based on managers’ specifications. It can:</td>
</tr>
<tr>
<td>• <strong>Managing individuals:</strong> Add a new employee or applicant, record him or her into the system, and search or update records entered into the system. Also, it can complete applications for job vacancies, review those that are complete, and assign a job to the best candidate.</td>
</tr>
<tr>
<td>• <strong>Search records:</strong> Retrieve any employee or position in the system for review, printing, or updating.</td>
</tr>
<tr>
<td>• <strong>Display reports:</strong> Customize, view, and print combined lists, statistical graphs, and other standard reports. The reports help analyze human resources data in several departments.</td>
</tr>
</tbody>
</table>

To date, 1675 profiles of health professionals have been entered into the database and validated by the MSAS. For example, the figure below presents an extract from the software showing the distribution of retirements.

**Figure 6: Retirement planning for employees entered into the iHRIS**
• **The situational analysis of SDPs in TutoratPlus districts** helped determine the gaps in human resources. In the developed action plans, the SDPs and the district suggested solutions for greater staff availability (recruitment of midwives by the health committee or local governments).

• **With the Department of Human Resources of the MSAS, the component began the recruitment process of 20 State registered midwives and nurses** for the health services of Kolda and Ziguinchor on the recommendation of the Minister of Health and Social Action. These positions will fill the SDPs that were closed in these regions due to a lack of skilled personnel.

**Main challenges**

The main challenge will be to mobilize all MSAS partners around the issue of human resources at the decentralized level.

**Opportunities**

The commitment from MSAS officials to ensure the successful extension of this software’s implementation throughout the entire country is a real opportunity for the sustainability of the iHRIS.

**Prospects**

- Concerning the iHRIS software, conducting an evaluation of the pilot phase before sharing results with MSAS officials, other ministries, local governments, and MSAS partners
- Finalization of the recruitment process of 20 State registered midwives and nurses for the health services of Kolda and Ziguinchor

3.4 Using technologies to monitor training and performance

**Achievements**

3.4.1 Implementation of the Automated Data Exchange System (SEDA)

Building on the lessons learned from the first version of the SEDA, the MSAS, with the support of the USAID Health Services Improvement Component for 2011–2016, has reintroduced an enhanced version. It consists of simple tools for working with and using collected health data at all levels.

The SEDA was introduced through a process structured into several steps, as shown in the figure below.

**Key results**

**Use of technologies**

- 18 persons trained, including 9 women, on using the SEDA
- Nearly 600 reports sent by mobile phone, corresponding to six months of data
- Establishment of a steering committee for the learning platform on IPQS
This year, involving project stakeholders helped roll out important steps before scale-up.

- First of all, the component worked with the DSISS to identify a set of health indicators designated as “critical.” These indicators were then organized by category and grouped into collection forms: **50 indicators divided into 6 forms.** These forms take into account indicators for: FP; Maternal, Newborn, and Child Health (MNCH); disease control (malaria and HIV); immunization; supervision, referral/counter-referral, and the advanced strategy.

- Then, with support from Medic Mobile, the component developed an innovative platform based on web and mobile technologies, taking into account lessons learned from the first version of SEDA and integrating new features. It consists of a broad range of tools for collecting and using health data at all levels of the system. To avoid duplicating data and to foster compatibility between tools, the component plans to provide the MSAS with mechanisms for integrating SEDA data in the DHIS2 system that the DSISS plans to use to replace the SYSNIS in the short term. To facilitate this, we have used open-source technologies.

- Next, to test the first version once it is improved before its extension, the medical region of Fatick, and specifically the health district of Foundiougne, was selected as a pilot site. Foundiougne was chosen as the pilot site due to its geographic characteristics: 80% of service delivery points are located on islands, and therefore isolated, replicating most of the constraints to overcome before scale-up. This pilot phase allowed us to test the technical platform and gradually integrate the various expected features. We organized a working meeting with the DSISS on the necessary conditions for launching this pilot phase in the Foundiougne district.

Following this work session, the DSISS and the component organized an information-sharing meeting with all partners and MSAS programs affected by the SEDA. The meeting allowed for:

- Involving all actors affected by the SEDA in the implementation of the pilot phase
- Explaining and confirming the relevance of the selected indicators
- Listing the major steps of the pilot phase

The following partners attended this meeting:

- Department of Reproductive Health and Child Survival
- Department of Health Facilities
- Department of Medical Prevention
- Division of the Health and Social Information System
- National Malaria Control Program
- Division of AIDS/STI Control
- MSAS IT Unit
- USAID
- PATH

- The component purchased the equipment necessary for launching the pilot phase, namely: the server that will host the platform and mobile phones equipped with the
technology for data collection.

- The component then organized a two-day orientation session for providers from the pilot district of Foundiougne on the SEDA and the tools they should use.

Each provider worked on the data from his or her area’s reports for a six-month period from January 2013 to June 2013, averaging out to 585 reports sent for 11 of the district’s SDPs. The supervisor was trained to conduct real-time monitoring of the completeness and quality of the data sent by providers. Following data collection and verification of data consistency, a session was organized on using and analyzing data. Data analysis enabled the district and providers to measure their performance for the first half year. Since this training, providers from Foundiougne regularly send monthly reports.

- The component worked on the dashboards for decision-making that we will propose to the DSISS and various programs and partners of the MSAS. These dashboards involve both the national and peripheral levels and provide each level with a tool for data analysis.

- The coordination meeting organized by the Foundiougne district gave the component an opportunity to connect with the new MCD of Foundiougne and present the SEDA to him. Our participation in the district coordination meeting also allowed us to:
  - Share the performance level for the district and providers for the first half of the year using the dashboards that we defined; and
  - Collect feedback from providers and the issues they faced during the first months using the SEDA.

At this stage of implementation, the component has begun the development of SEDA dashboards as well as the development of evaluation tools for the pilot phase. We will scale up at the start of Year 3.

### 3.4.2 Implementing an early warning system for stockouts

The early warning system for stockouts is an integral part of the SEDA insofar as tracer products for stock monitoring were validated at the same time as the SEDA forms, and the system is integrated into the technological platform used for the SEDA. This offers the advantages of having a single platform to facilitate working with and using the data.

The information reported for each tracer product (contraceptive products and essential medicines) were selected based on indicators used in the system to calculate stock forecasts.

The system is undergoing configuration and will be integrated into the SEDA platform during the pilot phase.

### 3.4.3 Learning portal

The meeting to launch the project to implement the learning portal on the IPQS, organized by IntraHealth, brought all the project’s stakeholders together around one table. This meeting was attended by representatives from the Division of Training, the IT Unit, and various programs and enabled:
• Validating the institutional bearer, namely the Division of Training supported by the IT Unit, responsible for setting up the technical infrastructure
• Establishing the select steering committee
• Listing the project’s major steps following a detailed execution plan

We have shared the terms of reference for the project, which outline the framework, resources, and methodology to adopt to achieve the learning portal's objectives. Based on these elements, a draft of the specifications was written and shared with the Steering Committee for validation.

Main challenges

Implementation of the SEDA is a long process consisting of several critical steps necessary to meet the challenge of creating a system to aid in quick and effective decision making.

• It is important to involve all actors working to improve community health, including health committees, to ensure the project’s sustainability. This involvement is particularly important for issues such as purchasing SMS credit, which requires collective consideration to find viable solutions.
• Submission of data by mobile phones can be perceived as extra work and may limit the use of the SEDA. Health care providers are quite overburdened with producing and reporting health data. They are expected to fill out several tools, including the ISM (Information System for Management) and forms for various programs. Therefore, several incentives must be found to help encourage transmitting reports via mobile phones.
• In addition, the adoption and deployment by the DSIISS of a new health data management tool, namely the DHIS2, at the same time as the SEDA scale-up could diminish the MSAS commitment.

Concerning the learning portal, the major challenge is to mobilize the institutional and technical capacities of the MSAS to ensure project coordination, define the teaching strategy, and set up the technological and equipment infrastructure to give every provider access to the portal. Since the production of content is the responsibility of various programs, it is important that the Ministry’s Division of Training oversees its coordination.

Opportunities

• Lifting of the withholding of data
• Marked interest from the Ministry and its partners to turn to new technologies. The various meetings held with the Ministry of Health and Social Action and attended by its partners brought to light the enthusiasm and strong interest in the use of technology to strengthen the health system.

Prospects

• Continuing extension of the automated data exchange system to the TutoratPlus districts of the medical regions of Kaolack, Fatick, Ziguinchor, Kolda, and Sédhiou, which amounts to an average of over 500 SDPs that would use the SEDA by the end of Year 3.
- Equipping the SDPs that do not have electricity with solar chargers to recharge their mobile phones. The area in the south will be given priority because it faces greater challenges in accessing electricity.
- Organizing supervision missions in the relevant districts to ensure monitoring of implementation and support for staff trained on SEDA.
- Supporting the MSAS to implement an online learning portal on IPQS to strengthen health care staff’s knowledge. The portal will first involve a package of content on priority programs and will then be gradually expanded. It will also define a mechanism to support learners and assess a particular tool’s impact on providers’ performance. Once it is launched, the portal will be accessible to all health care providers with a computer and Internet connection.
- Diffusing the learning portal to health care staff: once the learning portal is accessible online, an effective communication strategy will be defined to promote the portal among all providers to encourage continuing education.
- Testing the early warning system for stockouts of contraceptive products and essential medicines in the regions of Sédiou and Kaffrine: while the early warning system for stockouts is being developed, a test phase will be implemented in a few districts and particularly those using the mobile storage system. This will help us establish a link between the delivery points with a stockout and the mobile storage units covering the area.

**Sub-component 4: Development of relationships with private sector health facilities**

**4.1 Including the private sector in the TutoratPlus approach**

**Achievements**

In order to increase delivery of the IPQS, the component integrated the private sector into the implementation of the TutoratPlus approach. Thus, 88 private SDPs were enrolled in TutoratPlus.

Involving the private sector in this process is a good opportunity to update their providers’ knowledge on current standards and protocols.

Therefore, 36 providers from the private sector were informed about the TutoratPlus approach, and 28 of them were trained in the various TutoratPlus packages.

To ensure continuity of TutoratPlus activities, the districts enrolled in Year 1 had to sign Memoranda of Understanding with the private sector. Thus, 43 Memoranda were signed between the districts and private SDPs.
Commitments made through these memoranda by the private sector, if met, will strengthen their links with the health districts.

Supervision to verify compliance with these Memoranda of Understanding was conducted after signing. This supervision made it possible to check for compliance with clauses in Memoranda of Understanding and to fix problems noted in the cooperation between districts and private delivery points.

- Effectively involving private SDPs in the various district activities (training, participation in coordination meetings, participation in planning activities, and supervision of private health facilities by the district)
- Sharing data from the private sector with the district
- Developing and implementing a plan to improve the quality of services in private health facilities

The problems primarily concerned the lack of integration of private SDPs into the coordination meetings. Private-sector health workers were primarily invited by the districts to the training sessions on malaria and reproductive health. Data sharing with the districts was not effective for most districts. Only the private Catholic dispensaries had plans for improving service quality. Only 30% of the facilities visited underwent district supervision.

In some districts such as Foundiougne, the existence of a Memorandum of Understanding helped create links between the private SDPs and the health district.

A nun from the Foundiougne private Catholic dispensary stated, “Signing the Memorandum of Understanding with the district allowed us to get involved in all the district’s activities. We now feel like we are fully part of the district.”

The signing of the Memoranda of Understanding allowed these districts to invite private SDPs to their coordination meetings. Thus, providers from private SDPs took part in 21 district-level coordination meetings and 4 meetings at the medical region level.

Additionally, in an effort to expand IPQS delivery, contact meetings were held with the ASBEF and helped establish a solid partnership. A draft of the action plan was submitted by the ASBEF to the component. Once it is finalized, this plan will be implemented for Year 3.

Key results

Including the private sector in TutoratPlus

- Enrollment of 88 private SDPs in TutoratPlus
- Signing of 43 Memoranda of Understanding between districts and private SDPs
- 36 persons from the private sector informed about the TutoratPlus approach (17 men and 19 women)
- 28 private sector staff trained in the TutoratPlus approach
- Participation of private-sector managers in 4 regional coordination meetings
- Participation of private-sector providers in 21 coordination meetings at the district level.
Main challenges

The major challenge is the signing of the Memoranda of Understanding between the maximum number private SDPs and districts. In some areas, it is essential for the districts to maintain a solid partnership with the private SDPs. This is the case for the districts of Kaolack and Rufisque, where 50% of the SDPs are private. Another challenge involves compliance with clauses in the signed memoranda.

Opportunities

Resolving gaps highlighted in the situational analysis is an opportunity to involve private health structures in district activities but also to involve them in training through the TutoratPlus approach.

Prospects

The component will monitor the Memoranda of Understanding signed between the district and the private health facilities in its intervention area by obtaining signatures with the maximum number of private SDPs.

4.2 Strengthening the IPQS as part of the medical services provided by companies

Achievements

The component contacted the Senegalese Association of Company Physicians through its president, and an action plan was developed.

Identified training needs for the IPQS are, among others, training on malaria case management, family planning, and the Expanded Program on Immunization, particularly on managing the cold chain.

Main challenges

The main challenge was mobilizing this association, which recently underwent a renewal of its governing bodies.

Opportunities

The main opportunity is the existence of direct contact, the Senegalese Association of Company Physicians, which is a unified and highly organized association that recently appointed a training manager.

Prospects

The primary prospect is the organization of training sessions on the IPQS for health care workers employed in private companies.

4.3 Informing and involving individuals working in large companies in the IPQS with emphasis on RH/FP

Achievements

The component has trained 27 company paramedical staff, including 8 women, in
interpersonal communication techniques applied to the IPQS.

The goal of this training was to strengthen the capacities of company paramedical staff in interpersonal communication so that they can implement the plan to inform men in companies about the IPQS with a view to changing behaviors within companies. Together with the company paramedical staff, we have named the program "Liggey te Djeumeul njaboot."

This program targeting workers aims to involve men in their families’ health through providing better information on key family practices that trained providers can provide them.

**Figure 8: Program description: “Liggey te Djeumeul njaboot”**

**Main challenges**

The challenge is to implement the “Liggey te Djeumeul njaboot” action plan into all the targeted companies and to document this program’s impact on the lives of workers and their families.

**Opportunities**

The opportunity to seize is the presence of a direct and dynamic partner: the Association of Company Paramedical Staff.

**Prospects**
The implementation of the “Liggey te Djeumeul njaboot” action plan in companies will be our main prospect. Thus a series of discussions on the IPQS will be held in these companies that will aim to effectively involve men in the health and well-being of their families.

4.4 Mobilizing private-sector leaders to ensure increased availability of the IPQS

Achievements

During this year, the component organized a meeting to mobilize leaders from the private sector around the win-win public-private partnership to improve the health of Senegalese people. This workshop, which took place on June 21, 2013 in Dakar, was attended by 106 actors from the private and public sector

Participants included:

- 51 members of the private sector: APIX, employers organizations (CNP, CNES), the Physicians and Pharmacists Orders, the private physicians and private pharmacists unions, and heads of companies
- 38 members from the public sector: Mayors Association, representatives from Dakar City Hall, representatives of local officials, representatives of the Ministry of Economy and Finance, program managers, and heads of MSAS services

The goal of this meeting was to identify funding gaps for health and to discuss areas for collaboration in the public-private partnership.

This meeting was chaired by the Minister of Health and Social Action, evidence of a strong political commitment for the success of the public-private partnership to promote health.
This day culminated in obtaining many commitments from private-sector leaders with a view to strengthen the public-private partnership.

- On the one hand, for private-sector health: standardized practices for standards and protocols and a discussion on sharing health data and mechanisms to facilitate public-private partnerships.
- On the other hand, concerning private business: opportunities for investment in health and a mechanism to facilitate these public-private partnerships.

The component also supported setting up a Technical Committee for the Public-Private Partnership within the MSAS Division of Partnerships. This technical committee was able to unite technical and financial partners, APIX (as facilitator), and the Ministry of Health through the Division of Public-Private Partnership around the dynamics of public-private partnership.

**Main challenges**

- Facilitating public-private partnerships in the health sector by having them engage in the Ministry’s current practices that may resolve identified gaps.
- Supporting the MSAS in creating a direct discussion with private-sector actors by making the existing public-private coordination and collaboration frameworks operational.

**Opportunities**

- The existence of plans to accelerate interventions in child survival and securing commodities of vital importance is an opportunity insofar as activities to strengthen the public-private partnership having an impact on child survival and securing commodities of vital importance were identified by these plans.
- The existence within USAID of the Public-Private Partnership Component that serves to facilitate PPP projects is a significant opportunity.
- USAID support can be used as a catalyst for the implementation of PPP projects to promote health.
- The synergy between the implementing agencies around the public-private partnership could be an opportunity for this partnership’s success.

**Prospects**

The component will support the Ministry of Health to make the existing public-private partnership framework operational. It will also support the implementation of a public-private partnership project that can serve as a precursor to other health projects.

4.5 Involving pharmacists in the delivery of quality health services

**Achievements**

Several studies have found that 80% of the population turns first to private health structures, and 30% of these structures are private pharmacies (recent publication of the ISSU project database). Therefore, pharmacies are often the first place people turn to when a health issue
arises.

Therefore, the component is interested in private pharmacies in order to increase accessibility to health services. Empowering private pharmacies with good pharmacopeia capacities not only enables them to provide good advice but also to direct people toward providers likely to solve their problem.

In Year 2, the component strengthened the capacities of 112 private pharmacists on the Ministry’s standards for immunization services, the management of malaria, the management of diarrhea with ORS and zinc, the management of ARIs, and delivery of family planning with specific emphasis on counseling. This training helped improve service delivery in private offices.

Main challenges

The challenge continues to be collecting health data from private offices. Another challenge is generating discussion around offering family planning in pharmacies in order to broaden the range of available methods.

Opportunities

An available pool of trainers drawn from the pharmacists order and the pharmacists union will facilitate the strengthening capacities in the IPQS of pharmacists and staff working at the counters in private offices. These pioneering facilities within the profession have taken the lead in this activity, which has struck a chord with pharmacists.

Prospects

The component will extend this training to the various regions of Senegal.

Key results

Involving pharmacies

- Development of a training manual for private pharmacists on the IPQS
- Building capacities in the IPQS of 107 private pharmacists (43 women and 67 men)
III. Supervision and monitoring & evaluation

5.1 Strengthening supervision systems at the district, SDP, and community levels

Achievements

During Year 2, the component provided technical and financial support for the integrated supervision of ECDs, providers, and community staff from health huts. Integrated supervision has helped resolve some constraints experienced by providers and community staff in the implementation of activities and takes into consideration priority health programs such as reproductive health, family planning, malaria control, HIV and tuberculosis, and the Expanded Program on Immunization.

The supervision of districts by the ECRs and of health facilities by the ECDs experienced a slight resurgence during the third quarter, following the lifting of the boycott by unionist workers who were on strike. Thus only 425 facilities (of the 882 planned for Year 2, or 48%) could receive at least one supervision.

This low achievement rate is due to the fact that despite the availability of resources, the operational supervision activities suffered considerably from the boycott that was still in effect in the country during the first quarter of Year 2. In addition, as a key activity in improving provider performance, supervision often faces major challenges, notably compliance with frequency (every three months), availability of the logistical means to conduct the activity, and institutional anchoring.

The component also seized the opportunity offered by the sub-grants awarded to the first 15 districts enrolled in TutoratPlus within the framework of the District Grant to promote supervision activities. In effect, all districts receiving grants had included funding in their plans for the organization of quarterly structured supervisions as milestones, with supervision reports as required documents.

By contrast, integrated supervision of community facilities by health post and health center staff saw better implementation this year following an orientation workshop held in Year 1 for ECDs and providers (ICPs, SFEs) on the implementation of integrated advanced strategies. Specifically, 1400 supervision visits of functioning health huts by providers were reported during the advanced strategies, with an annual goal of 1176. This achievement rate of 119% shows the effective resumption of an activity that helps strengthen the performance of community staff and increase the supply of integrated basic services in maternal, newborn, and child health and family planning (in some huts).

5.2 Increased availability and use of health data for decision-making purposes

<table>
<thead>
<tr>
<th>Strengthening supervision systems</th>
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<tr>
<td>• 44 districts supervised by the ECRs</td>
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<tr>
<td>• 425 SDPs received at least one supervision visit from the ECD</td>
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<tr>
<td>• 1400 supervision visits of health huts</td>
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</tbody>
</table>
Achievements

5.2.1 Strengthen capacities in the ISM

Following completion of the user manual for the revised ISM and training of trainers during the second quarter of the year, the component supported ISM training for 682 providers, including 370 women, from the regions of Fatick, Matam, Kédougou, Tambacounda, Louga, Kaffrine, and Kolda. In addition, the component also supported updating 93 data managers from districts and medical regions in the regions of Dakar, Kaolack, Kaffrine, Fatick, Tambacounda, Kédougou, Thies, Diourbel, Kolda, Sédhiou, Ziguinchor, Louga, Saint Louis, and Matam on the SYSNIS—the software for entering and reporting routine data.

There was a real need for this capacity building following the lifting of the withholding of data, as shown by the 136% achievement rate for ISM training. This training helped participants gain a harmonized and updated understanding of the concepts and revised tools, improve methods for data analysis and recording, and be able to analyze the health situation in their intervention areas so they can make appropriate decisions to increase health care coverage.

Moreover, this need for capacity building had been identified by the DSISS during a supervision mission conducted at the start of Year 2 in a sample of districts with support from the component. This supervision, whose goal was to check the availability of reports, evaluate the functionality of the SYSNIS software, and identify training needs at the district level, highlighted:

- A declining rate of availability of SDP reports at the district level throughout the years of the strike (2010 to 2012)
- The need to retrain all district and regional operators on the SYSNIS
- The low level of SYSNIS use, mainly due to issues of functionality (occasional bugs, lack of software updating, and inadequate staff training).

Therefore, this supervision helped the DSISS to measure the major challenge it will have to face in rebuilding the health information system and updating key health indicators following the lifting of withholding of data and of active data collection. The identified operational issues also led the DSISS to plan to adopt the DHIS2 software for the collection, transmission, and processing of health data.

During the last quarter and in synergy with the HSS and HIV/TB Components, the HSI Component supported retrospective collection of data from July 2010 to March 2013 in the regions of Ziguinchor, Sédhiou, Kolda, Kaffrine, and Fatick. This data collection is part of the implementation of the MSAS roadmap for rebuilding the data system following the lifting of the union’s withholding of data. It is expected that training providers and bringing managers
up to date will help improve the quality of data that is collected and sent. The data undergoing validation in the regions should be available before the end of the first quarter of Year 3 and will lead to better visibility of the impact of our interventions on using the IPQS.

5.2.2 Support for the reproduction of ISM tools

With the goal of making the new versions of revised management tools available in the SDPs and facilitating the replacement of older versions, the component has provided the DSISS with an initial allocation of 2750 registers (for PAC, FP, Hospitalization, Death, ANC, General Consultation, Delivery, and the Overall Health Post Report). For example, the quantity of Overall Reports provided will cover the needs for the 76 districts for a duration of 2 years. In addition, to ensure that all SDPs use the same versions of the data collection tools, the component supported the DSISS in setting up, via the medical regions, an accreditation system for authorized printers to print the revised tools. These stabilized tools on PDF format and burned to a CD have been distributed to the medical regions, who make them available to the printers. Henceforth, the printers can only provide the districts with revised tools.

5.2.3 Automating management of component data

Lastly, within the framework of setting up an internal information and management system for the component, the implementation process for the computerized operations platform underwent significant progress. The platform was tested at the Thiès Regional Office (RO) using the Regional Program Managers (RPMs) of Thiès and Dakar and the RO Coordinator and RO Administrative and Financial Manager as targets. Following the evaluation of this test, adjustments were made to the platform and the beta version was presented to users (coordinators, administrative and financial managers, RPMs) at two other regional offices. The final step was to put the database online; it is hosted for free at the State Computerization Agency, which provides better Internet access and greater data security. Training for all users (RPMs, technical advisors at the central level, coordinators and administrative and financial managers from the RO) began during the fourth quarter to make the database operational by the start of Year 3.

Main challenges

Despite these achievements, the component has faced some challenges related to improving the supervision system as well as the availability and use of health data for decision-making purposes. These are primarily:

- The lack of institutional anchoring for supervision: in the context of reorganizing the directorates and services within the Ministry of Health, the former division in charge of this aspect (Division of Primary Health Care) was replaced by a Community Health Unit that does not have the power to oversee the implementation of supervision.
- The low level of private sector involvement in the district and regional activities: the private SDPs rarely undergo supervision; private-sector providers are rarely targeted during capacity building activities; and data from the private sector is insufficiently taken into account in the national health information system.
Opportunities

- The lifting of the withholding of data and resumption of regular ISM data collection: this will improve visibility of the impact of the component’s interventions and evidence-based decision making.
- Political will at the highest level of the MSAS to rebuild the health information system through the development of a roadmap that all partners are committed to supporting.
- The decision of the DPRS/DSISS to support the activity to revive supervision and monitoring until the institutional vacuum created by the reorganization of MSAS departments and services is filled.
- The signing of Memoranda of Understanding between the districts and private SDPs that emphasize capacity building and supervision of private-sector providers as well as sharing information and taking into account private-sector data.

Prospects

In Year 3, the component will support all efforts aimed at making the following effective: the supervision of workers, coordination and monitoring of activities as well as routine collection of high-quality data and using it for decision making, particularly by SDP staff to improve service delivery. In partnership with the HSS Component, the HSI Component will work with the MSAS (DPRS/DSISS, medical regions, and districts) to reposition supervision and effective resumption of the activity, notably through the development and diffusion of a circular note and orientation guide on supervision.

Support will also be provided for strengthening the health information system, namely:

- **Continuation of training for staff on health data collection** with the revised ISM tools, with particular attention on private sector staff.
- **Introduction of the DHIS2 software**: in fact, the MSAS is firmly committed to replacing the SYSNIS, which has demonstrated its limitations relative to the processing and analysis of collected data. The DHIS2 is a free software that offers an integrated platform for the collection, processing, and analysis of health data. The DSISS began configuration with support from the West African Health Organization and University of Oslo. Implementation of the pilot phase is planned for the first quarter of Year 3, with support from the HSS of the Global Fund. The component will support the mainstreaming phase, planned to start during the second quarter of Year 3, in particular, training for users at the district and regional level.
- **Resumption of monitoring of SDP activities**: monitoring is a participatory exercise for self-evaluation and review of facility performance as well as for developing plans to resolve issues. It should offer SDP actors a framework for monitoring the impact of TutoratPlus implementation, notably on-site supervision, and improvements in the quality of services and people’s use of them. The monitoring thus helps promote the effective use of data locally by SDP actors for decision making to improve the accessibility and coverage of health services.

Lastly, during Year 3, the component will pay particular attention to documenting lessons
learned for the project’s key interventions; specifically, these include the following interventions:

- District Grant
- Integration of family planning into immunization
- Use of ICT to improve provider and SDP performance
- Strategies to improve IPT2 coverage for pregnant women in the 2 test districts
- Feasibility of introducing the IUD in post-partum

5.3 Strengthening the coordination of interventions aimed at improving service delivery

Achievements

During Year 2, the component provided the technical and financial assistance needed to hold 120 coordination meetings for the districts and regions. The coordination meetings are opportunities to plan activities and monitor the implementation of interventions. They also provide an opportunity to update providers’ knowledge and provide a space for discussions among the various health actors in the area, including the districts’ and regions’ other technical and financial partners. These meetings gave regional program managers (RPMs) an opportunity to share the regional and district medical teams the progress made in TutoratPlus implementation, the results of on-site supervision, including problems that arise, and to negotiate a schedule with each district for tutor visits to the SDPs and the monitoring and supervision of their activities by the support teams.

Main challenges

The main problems concerning coordination meetings at the district and regional level continue to be their regularity and their targets. Specifically, these meetings should be held monthly for the districts and quarterly for the regions. They should also be an opportunity to discuss the implementation of activities supported by the component with all actors, including representatives from the private sector and local governments.

Opportunities

Direct financing, which will be extended to three other medical regions in addition to the first three, is an opportunity to improve the regularity of holding district and regional coordination meetings. Similarly, in the framework of the District Grant, the Memoranda of Understanding between the districts and the private SDPs places particular importance on providers’ and private-sector representatives’ participation in these forums for sharing information.
Prospects

Given their significance and the opportunities that they provide for monitoring the implementation of activities, the component will continue to provide technical and financial assistance to the districts and medical regions to hold coordination meetings.
IV. Management and coordination

Achievements

6.1 Management of component implementation

- With the goal of evaluating the implementation and effect of activities such as TutoratPlus, IPQS training, infection prevention, and compliance with legislation on family planning, three joint supervision missions (IntraHealth/USAID) were carried out in the regions of Kaolack, Kolda, Sédhiou, and Ziguinchor. The team for these missions consisted of the COP and AOR. This involved discussions between the Regional Office, the regional and district medical teams, and providers on the implementation of the component’s interventions. In addition to these joint meetings, the COP was able to discuss aspects related to support for staffing with the head physician of the Sédhiou medical region.

- With the goal of providing monitoring of the implementation of the Quality Improvement Partnerships (QIPs), monthly meetings are held with the RSJ managers. These meetings were opportunities to share and discuss the QIP achievements.

- Supervision of the implementation of the sub-grants helped provide solutions to some technical and contractual difficulties encountered in the implementation of the Quality Improvement Partnerships (QIPs) in the regions of Dakar, Fatick, Kaolack, Kaffrine, Louga, and Thiès.

- To strengthen staff at the central level, the following positions were filled:
  - Improved Performance Technical Advisor
  - Information Technologies Applied to Health Technical Advisor
  - Private-sector technical advisor
  - Infectious-diseases technical advisor
  - HSI technical advisor (posted at the DSR/SE)

- Sharing the annual action plan with the various partners of the Ministry of Health—in particular the SAMU, the Department of Reproductive Health and Child Survival (DSR/SE), the PNLP, the Division of the Health and Social Information System (DSISS), the National Nosocomial Infections Control Program (PRONALIN), and the Expanded Program on Immunization (EPI)—has been instrumental this year. This exercise helped partners to take ownership of the action plan and subsequently integrate the interventions into their AWP.

6.2 Strengthened collaboration and external communication

With the goal of increasing partnership with other agencies, we have:

- Participated in 3 coordination meetings organized by Abt concerning direct financing for the regions and building synergy between agencies.

- Participated in coordination meetings concerning the national FP action plan initiated by USAID between the implementing agencies. These meetings mainly dealt with the process for introducing intramuscular and subcutaneous administration of injectables at the community level and in service delivery points.

- Took part in the quarterly coordination meetings of the Regional Offices of Kaolack, Kolda, and Thiès through our Regional Program Managers.
• Held meetings to create synergy with the HSS and HCP Components, respectively, on the issue of capacity building for ECDs in human resources management and involving the private sector.

The coordination meetings between agencies helped ensure monitoring of the implementation of direct financing and identified new synergetic intervention domains between agencies, such as the involvement of the private sector, integration of RH/HIV/TB and malaria, and capacity building for ECRs and ECDs in management.

The quarterly RO coordination meetings enabled participants to discuss each component’s achievements during the preceding quarter and identify the main constraints to implementing activities.

To increase collaboration between partners, the technical staff participated in the development of annual work plans for regions and districts. This activity enabled the regions and districts to better integrate the component’s interventions. In addition, technical staff at the central level participated in various meetings with partners from the central level: coordination meetings between CAs, MSAS-level meetings, and the IPS Committee meeting, which is an opportunity to share approaches for integrating services.

In addition to these activities, on the request of USAID, we supported the DSR/SE in the development and validation of the Intervention Acceleration Plan for Child Survival, integrating the monitoring/evaluation plan. Thus, the component could:

• Recruit a consultant responsible for the development of the action plan and the monitoring-evaluation plan
• Support a training workshop for Chief Regional Medical Officers on the Lives Saved Tool
• Facilitate the validation workshop for high-impact interventions on maternal, newborn, and child health and each region’s objectives
• Support the preparation and organization of the launch of the National Plan by producing communications media and managing the event schedule

In addition, we participated in the first International Conference on Newborn Health for five days held in Johannesburg, as a member of the Senegalese delegation. This delegation also included representatives from USAID and UNICEF. The main recommendation from this trip was the development of a Global Newborn Action Plan (GNAP).

6.3 Compliance with regulations for family planning and environment protection

Regarding regulation for family planning, the component organized on-site orientation sessions for IntraHealth staff and its partners, as follows:

• Orientation for IntraHealth staff (11 women and 17 men)
• Orientation for 8 head midwives of MSI mobile clinics on compliance with requirements and USAID policy on family planning
• Training for the pool of 20 tutor trainers
• Orientation of 221 tutors, including 112 men and 109 women on compliance with requirements and USAID policy on family planning

These orientations were carried out using a module that we developed based on
documentation and the USAID on-line course.

This orientation made it possible to:

- Show that regulations for family planning have been clearly reflected in the standards and protocols for family planning services
- Encourage participants to check for compliance with voluntary and informed choice when offering FP services in SDPs and at their own level

For protection of the environment, the component reported the following achievements:

- 1912 providers trained, including 1166 women
- 810 SDPs covered by training, including 43 private SDPs


**Main challenges**

The main challenges are:

- Effective synergy between the various agencies
- Better appropriation of the component’s interventions by the Ministry of Health
- Better visibility of the component’s interventions through ongoing documentation

**Opportunities**

An existing cooperation framework with actors from the health system (inter-agency meeting, IPS committee meeting, etc.) should help us ensure better coordination with the various stakeholders.

**Prospects**

- Intensify improvements in external communications through sustained collaboration with partners
- Optimize program management by strengthening staff skills and performance
- Ensure greater visibility of the component’s interventions through success stories and the branding strategy
- Implement and monitor compliance with regulations for family planning and protection of the environment.
III. Financial report

ANNEXES

Annex 1: Performance monitoring plan
Annexe 1 : Plan de Monitoring de la Performance

<table>
<thead>
<tr>
<th>#</th>
<th>Enoncé des Indicateurs</th>
<th>Désagrégé par</th>
<th>An1</th>
<th>An2</th>
<th>Taux de réalisation An2</th>
<th>Commentaires et Justification pour tout dépassement ou non atteinte de l'objectif annuel &gt; 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pourcentage de points de prestations de services qui offrent le PISQ dans un programme soutenu par le gouvernement Américain</td>
<td>Ensemble</td>
<td>73%</td>
<td>33%</td>
<td>16%</td>
<td>74% 102%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cible</td>
<td>Réalisé T1</td>
<td>Réalisé T2</td>
<td>Réalisé T3</td>
</tr>
<tr>
<td>2</td>
<td>Nombre de points de prestations de services de conseils en PF appuyés par le gouvernement Américain</td>
<td>Ensemble</td>
<td>882</td>
<td>357</td>
<td>404</td>
<td>230 855 97%</td>
</tr>
<tr>
<td>3</td>
<td>Couple-années de protection (CAP) désagrégé par méthode</td>
<td>Ensemble</td>
<td>143303</td>
<td>ND</td>
<td>37899</td>
<td>ND 134740 106%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Phils</td>
<td></td>
<td>18701</td>
<td>ND 82425</td>
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<tr>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>DIU</td>
<td></td>
<td>181</td>
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<td></td>
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<td>Injectable</td>
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<td>ND 62890</td>
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<td></td>
<td></td>
<td></td>
<td>Préservatif</td>
<td></td>
<td>706</td>
<td>ND 2647</td>
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Au cours de l'an 2, 494 points de prestations de service qui offrent le PISQ dans un programme soutenu par le gouvernement Américain ont été enrôlés pour offrir le PISQ. Ceci porte à 895 le nombre de PPS qui offrent le PISQ, représentant 74% des PPS à atteindre au terme du projet (soit 102% de l'objectif pour l'an 2).

Le nombre de points de prestations de services de conseils en PF appuyés par le gouvernement Américain a progressé de 882 à 855, soit un taux de réalisation de 97%.

Malgré la levée de la réétion des données et la reprise de la collecte de routine, les informations ne sont pas encore disponibles à l'échelle des PPS. Pour apprécier l'indicateur, nous avons dû recourir aux quantités distribuées pendant la période d'octobre 2012 à juin 2013 par les dépôts de district aux PPS lesquelles données ont été collectées au cours de la supervision logistique. Les données des 76 districts sont disponibles au 25 pour les district de l'Ihogne, région de Matam et de Koki, région de Louga (pour la période octobre à décembre 2012), l'ensemble des districts des
<table>
<thead>
<tr>
<th>#</th>
<th>Enoncé des Indicateurs</th>
<th>Désagrégé par</th>
<th>An2</th>
<th>Taux de réalisation An2</th>
<th>Commentaires et Justification pour tout dépassement ou non atteinte de l’objectif annuel &gt; 10%</th>
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<tr>
<td></td>
<td></td>
<td>Cible An2</td>
<td>Réalisé T1</td>
<td>Réalisé T2</td>
<td>Réalisé T3</td>
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<tr>
<td>1</td>
<td>Contraception d’urgence</td>
<td>ND</td>
<td>13</td>
<td>ND</td>
<td>34</td>
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<tr>
<td></td>
<td>Collier</td>
<td>ND</td>
<td>79</td>
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<td></td>
<td>Ensemble</td>
<td>813,141</td>
<td>232,584</td>
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<td>Implants</td>
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<td>634</td>
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<td>4051</td>
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<td>Injectable</td>
<td>ND</td>
<td>67,017</td>
<td>ND</td>
<td>251,560</td>
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<td>Préservatifs</td>
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<td>ND</td>
<td>317,656</td>
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<td>Contraception d’urgence</td>
<td>ND</td>
<td>256</td>
<td>ND</td>
<td>675</td>
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<tr>
<td></td>
<td>Collier</td>
<td>ND</td>
<td>157</td>
<td>ND</td>
<td>993</td>
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<td>Enoncé des Indicateurs</td>
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<td>An2</td>
<td>Commentaires et Justification pour tout dépassement ou non atteinte de l'objectif annuel &gt; 10%</td>
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<tr>
<td></td>
<td></td>
<td>Cible An2</td>
<td>Réalisé T1</td>
<td>Réalisé T2</td>
<td>Réalisé T3</td>
</tr>
<tr>
<td>5</td>
<td>Pourcentage de femmes enceintes qui ont reçu le traitement préventif intermittent lors de leur dernière grossesse (TP12)</td>
<td>Ensemble</td>
<td>52.8%</td>
<td>ND</td>
<td>ND</td>
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<tr>
<td></td>
<td></td>
<td>Urbain</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
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<td></td>
<td></td>
<td>Rural</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>6</td>
<td>Pourcentage de femmes recevant le GATPA dans un programme soutenu par le gouvernement Américain</td>
<td>90%</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>#</td>
<td>Enoncé des indicateurs</td>
<td>Désagrégé par</td>
<td>An2</td>
<td>Commentaires et justification pour tout dépassement ou non atteinte de l'objectif annuel &gt; 10%</td>
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<td>---------------------------------------------------</td>
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<tr>
<td>7</td>
<td>Pourcentage de nouveau-nés ayant reçu une visite post natale dans les 3 jours suivant la naissance</td>
<td>Cible An2, Réalisé T1, Réalisé T2, Réalisé T3, Réalisé An2, Taux de réalisation An2</td>
<td>70%</td>
<td>Malgré le fait que l'information a été collectée par l'EDS-c2012-2013, elle n'a pas été compilée, analysée et publiée. Le composante est en train de travailler avec l'USAID et l'ANSD pour accéder à une telle information.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Pourcentage de nouveau-nés recevant les soins néonataux immédiats grâce à un programme soutenu par le gouvernement américain</td>
<td>Cible An2, Réalisé T1, Réalisé T2, Réalisé T3, Réalisé An2, Taux de réalisation An2</td>
<td>90%</td>
<td>Malgré le levée de la rétention des données et la reprise de la collecte routine, les informations ne sont pas encore disponibles. Cependant, au cours du dernier trimestre l'USAID a appuyé le MSAS pour organiser une collecte active à l'échelle nationale afin de recueillir les données sanitaires. Ces informations en cours de validation dans les régions devraient être disponibles avant la fin du 1er trimestre de l'an 3.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Pourcentage d'enfants qui ont reçu le DTC3 avant leur premier anniversaire</td>
<td>Cible An2, Réalisé T1, Réalisé T2, Réalisé T3, Réalisé An2, Taux de réalisation An2</td>
<td>88%</td>
<td>Les données de l'EDS-c2012-2013 montrent que la couverture vaccinale au Penta 3 s'est améliorée, passant de 83% à presque 89%. Cette progression reflète globalement la situation pour tous les vaccins du PEV.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Nombre de prestataires formés en santé infantile et nutrition grâce à un programme soutenu par le gouvernement américain</td>
<td>Ensemble, Homme, Femme</td>
<td>1,770, 140, 149</td>
<td>Ce gap de 738 agents à former (soit 42%) s'explique par l'intervention d'autres partenaires tels que Micronutrient Initiative et OMS qui ont aussi appuyé aussi le MSAS dans le renforcement des capacités en matière de santé et nutrition de l'enfant. La composante travaille avec le MSAS et ses partenaires, notamment lors de l'élaboration des PTA, pour mieux définir les besoins en assistance technique et financière qu'elle peut supporter. Noter que la formation en santé infantile et nutrition inclut la formation classique en PCIMF, nutrition et prise en charge de la diarrhée chez l'enfant par le SRO/Zinc.</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Enoncé des Indicateurs</td>
<td>Désagrégé par</td>
<td>An2</td>
<td>Cible An2</td>
<td>Réalisé T1</td>
</tr>
<tr>
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<tr>
<td>11</td>
<td>Pourcentage d’enfants de moins de 5 ans ayant la diarrhée et traités avec le SRO</td>
<td></td>
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<td></td>
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<tr>
<td>12</td>
<td>Nombre de cas de paludisme traités dans les programmes appuyés par l’USAID (population générale)</td>
<td>Pop.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Nombre de prestataires formés sur le diagnostic de laboratoire du paludisme (microscope et TDR) grâce à un programme soutenu par le gouvernement américain</td>
<td>Ensemble</td>
<td></td>
<td>309</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homme</td>
<td></td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Femme</td>
<td></td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>Nombre de prestataires formés sur le traitement préventif intermittent (TPI) grâce à un programme soutenu par le gouvernement américain</td>
<td>Ensemble</td>
<td></td>
<td>309</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homme</td>
<td></td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Femme</td>
<td></td>
<td>9</td>
<td>13</td>
</tr>
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<td>#</td>
<td>Enoncé des Indicateurs</td>
<td>Désagrégé par</td>
<td>An2</td>
<td>Commentaires et Justification pour tout dépassement ou non atteinte de l’objectif annuel &gt; 10%</td>
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<td></td>
</tr>
<tr>
<td>15</td>
<td>Nombre de prestataires formés à la prise en charge du paludisme avec les ACT grâce à un programme soutenu par le gouvernement Américain</td>
<td>Ensemble</td>
<td>309</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homme</td>
<td>10</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Femme</td>
<td>9</td>
<td>13</td>
<td>16</td>
</tr>
</tbody>
</table>

**Sous-Composante 2 : Amélioration du fonctionnement des services de soins dans les postes et les centres de santé, ainsi que dans les hôpitaux régionaux**

<table>
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<tr>
<th>#</th>
<th>Enoncé des Indicateurs</th>
<th>Désagrégé par</th>
<th>An2</th>
<th>Commentaires et Justification pour tout dépassement ou non atteinte de l’objectif annuel &gt; 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Pourcentage de points de prestation de services assistés par l’USAID qui connaissent des ruptures de stock de produits contraceptifs, durant la période objet de reportage</td>
<td></td>
<td>30%</td>
<td>ND</td>
</tr>
<tr>
<td>#</td>
<td>Enoncé des Indicateurs</td>
<td>Désagrégé par</td>
<td>An2</td>
<td>Commentaires et Justification pour tout dépassement ou non atteinte de l’objectif annuel &gt; 10%</td>
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<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17</td>
<td>Pourcentage de structures de santé ayant reçu une ou plusieurs visites de supervision au cours des trois derniers mois</td>
<td>Ensemble</td>
<td>Cible An2 73%</td>
<td>Réalisé T1 30%</td>
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<tr>
<td>18</td>
<td>Nombre de visites de supervision par le personnel des structures de santé aux sites de services communautaires (cases de santé et OSDOM)</td>
<td>Ensemble</td>
<td>1176</td>
<td>574</td>
</tr>
<tr>
<td>19</td>
<td>Nombre de SRA effectuées par les postes et centres de santé publiques</td>
<td>Ensemble</td>
<td>2000</td>
<td>574</td>
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Sous Composante 3 : Amélioration de la gestion des ressources humaines au niveau des structures sanitaires du secteur public

<table>
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<th>An2</th>
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<tr>
<td>20</td>
<td>Nombre de PPS disposant de description de poste pour tous les postes de travail</td>
<td></td>
<td>Cible An2 500</td>
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<td>#</td>
<td>Enoncé des indicateurs</td>
<td>Désagrégé par</td>
<td>An2</td>
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<td>------------------------</td>
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<td></td>
<td></td>
<td></td>
<td>Cible An2</td>
</tr>
<tr>
<td>21</td>
<td>Nombre de structures privées ayant été envoyées dans le TutoratPlus</td>
<td>34</td>
<td>ND</td>
</tr>
</tbody>
</table>

*ND = Non disponible

**Pour rappel les soins néonatals immédiats sont partie intégrante des soins essentiels du nouveau-né (SENN). Cependant seuls les soins néonatals immédiats peuvent être documentés via le SIG du Ministère de la Santé.
## Annex 2: Summary of TutoratPlus implementation

<table>
<thead>
<tr>
<th>Medical Region</th>
<th>District enrolled</th>
<th>Estimated number of SDPs</th>
<th># persons receiving orientation in TutoratPlus</th>
<th># Tutors selected</th>
<th># of back-up tutors selected</th>
<th>Total # of SDPs who did the SA</th>
<th># private and semipublic SDPs who did the SA</th>
<th># SDPs that developed an action plan</th>
</tr>
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<tbody>
<tr>
<td>Louga</td>
<td></td>
<td></td>
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<td></td>
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<td>Dakar</td>
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</tr>
<tr>
<td>Sédhiou</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Louga</td>
<td>Darou Mousty</td>
<td>11</td>
<td>2</td>
<td>33</td>
<td>35</td>
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* The SA was suspended in these two districts due to providers' boycott of activities.
### Annex 3: Summary of IPQS training

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## Annex 4: Integration of FP and immunization

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### Annex 5: Summary of results of implementation of integrated advanced strategies

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<td>291</td>
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<td><strong>1400</strong></td>
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<td><strong>6755</strong></td>
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<td><strong>2075</strong></td>
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Annex 6: Summary of trainings on infection prevention and the protection of the environment

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<th>Regions</th>
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<th>Number of individuals trained</th>
<th>Achievement</th>
<th>Number of SDPs affected</th>
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<tr>
<td></td>
<td></td>
<td>M</td>
<td>W</td>
<td>Total</td>
</tr>
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<td>Fatick, Dakar, Kaolack, Matam, Tamba, Louga, Kaffrine, Saint Louis, Thiès, Kolda, Ziguinchor, Sédhiou</td>
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<td>746</td>
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Annex 7: Free consultations provided by ASGO for people in Diamniadio

Services were offered to the community from 9:30 am to 6:00 pm. A total of 10 service points were open: 2 for cervical cancer screening, 2 for screening breast disease, 2 for gynecological and obstetric ultrasound, 2 for screening high-risk pregnancies, and 2 for family planning. While clients waited for consultations, several teams went to the different waiting rooms and took turns leading discussions on various topics related to reproductive health. Overall, 822 people received consultations at the Diamniadio Health Center, including:

- 251 gynecological and obstetric ultrasounds
- 134 deliveries of contraception in the context of family planning
- 146 patients underwent colposcopy to screen for cervical cancer
- 104 patients received a gynecological consultation for different reasons, among whom 53 were referred to facilities in Dakar for various reasons (infertility, ovarian disease, etc.)
- 116 participated in breast cancer screening using the breast self-examination method
- 46 individuals received a general medical consultation, particularly for hypertension

As for the team sent to the Bargny Maternity Ward, it consulted with112 people requesting contraception and screening for breast disease or gynecological disease, in particular uterine fibrosis.

Overall, 934 people received care on that day.

The ASGO promised to offer its expertise to improve the skills of staff involved in maternal and perinatal care and to regularly participate in supervising these two facilities. During the debriefing session held with the Head Physician and his staff, it was decided that the Diamniadio team would submit a list of its needs to the ASGO for further study.