

REPUBLIC OF BENIN
MINISTRY OF HEALTH
DIRECTORATE OF FAMILY HEALTH



the **ACQUIRE** project

**INTRODUCTION OF
POSTABORTION CARE
IN THREE PILOT SITES IN BENIN**

Final Evaluation

Prepared for Benin Ministry of Health by:

**Dr. Sosthène Adisso
Dr. Komi Napo**

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ACQUIRE Benin
C/783 Boulevard du Canada
O1 BP 5924, Cadjehoun
Cotonou, Benin
Tel: (229) 30 89 67
Fax: (229) 30 89 68
Mobile: (229) 90 12 02
E-mail: office-benin@intrahealth.org
www: acquireproject.org

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For further information on this report, please contact the authors.

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THE AUTHORS

Dr. Sosthène Adisso is an Obstetrician Gynecologist Physician, Assistant-Lecturer at the Faculty of Health Sciences (FHS) of Cotonou, Assistant Director of the University Clinic of Gynecology and Obstetrics of Cotonou, National Technical Focal Point for Postabortion Care.

Dr. Komi Bougonou Napo is a physician at the University Clinic of Gynecology and Obstetrics of Cotonou, with a Master's degree in Population, Development and Reproductive Health.

THE CO-AUTHORS

Arlette Akouëïkou, Midwife of Public Health and National Focal Point for emergency obstetrical and neonatal care at the Directorate of Family Health, Ministry of Public Health of Benin

Dr. Perle Combarry, Sociologist, Resident Representative of IntraHealth International in Cotonou

Dr. Aimé Attolou Gbohoun, Gynecologist Obstetrician, with a Master's degree in Public Health, Responsible for Quality Assurance at Hospital of the Mother and the Child, Lagune (HOMEL), Cotonou

Dr. Antoine Lokossou, Gynecologist Obstetrician, Chief Assistant Lecturer at the Faculty of Health Sciences, Cotonou

Professor René Xavier Perrin, Gynecologist Obstetrician, Physician and Head of Department, Coordinator of the Hospital of the Mother and the Child, Lagune (HOMEL), Professor at the Faculty of Health Sciences of Cotonou.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALK	Acceptable Level of Knowledge
ANC	Ante Natal Consultation
CFA	Communauté Française d'Afrique
CHC	Community Health Center
COGEA	Administrative Management Committee
D/DOH	Departmental Directorate of Public Health
DFH	Directorate of Family Health
DG/MOH	Director General of the Ministry of Public Health
DHC	Departmental Health Center
DHS2	Demographic Health Survey 2
DUHC	Departmental and University Hospital Center
EONC	Emergency Obstetrical and Neonatal Care
F	Francs
FHS	Family Health Service
FP	Family Planning
HOMEL	Hospital of the Mother and the Child Lagune
IP	Infection Prevention
MDG	Millennium Development Goal
MFSW	Ministry of Family and Social Welfare
MVA	Manual Vacuum Aspiration
NA	Not Available
PAC/FP	Postabortion Care/Family Planning
PNS	Policy, Norms and Standard
RAC	Aerial Communication Network
RH	Reproductive Health
STD	Sexually Transmitted Disease
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

Maternal deaths resulting from obstetrical emergencies have plagued Benin. Complications from unsafe or incomplete abortion are a major contributor, accounting for 17% of such deaths.

In 2002, Benin began implementation of a strategy for emergency obstetrical and neonatal care integrating postabortion care (PAC) and family planning (FP). In 2003 the Ministry of Health authorized a situational analysis of postabortion care. The analysis involved a facility assessment related to PAC/FP services in three pilot health facilities selected by the ministry.

Implementation of postabortion care began in 2005 after an update of the analysis conducted at the three pilot sites, each located at a specific level of Benin's health system: at the national level, the Hospital of the Mother and the Child, Lagune (HOMEL); at the departmental level, the Departmental and University Hospital Centre (DUHC) of Borgou/Alibori in Parakou; and at the peripheral level, the maternity clinic of the Community Health Centre (CHC) of Parakou.

The evaluation described in this report took place six months after the introduction of PAC/FP at the three sites. The aim of this evaluation, a cross-sectional descriptive analysis, is to assess the implementation of the project and its influence on PAC/FP services.

The evaluation indicates that infrastructure has improved overall and manual vacuum aspiration (MVA) practice is competently performed by providers; however, equipment for managing emergencies is inadequate, with availability varying over time and across health facilities.

All supervisors and providers recognize that complications of abortion constitute a major community issue because of the potential consequences, including hemorrhage, sterility and death; 79.4% of providers and 88.9% of supervisors are not ill at ease dealing with or giving advice to someone who has received an abortion. The overall knowledge standard of reproductive health (RH)/PAC/FP has improved since the situational analysis related to the initial postabortion inventory, infection prevention, MVA practice and counseling during PAC/FP services.

More than 90% of the providers know the objectives set for their activities within the framework of PAC/FP and what is expected of them. It should be noted that about 60% of the providers say that they have received feedback on their performance from the Chief Medical Officer and also from clients.

Supervision is more frequent and 87% of providers say that supervisors meet their expectations, against 66% at the time of the situational analysis. However, feedback on supervision has not improved. 80% of the administrative personnel are aware that PAC usually constitutes emergency cases and report that arrangements are made so that the poor can benefit from emergency care before paying.

Only one-third of the backup staff (e.g., receptionists, ambulance drivers) is aware of the existence of postabortion care. When they are informed, it is through informal contacts or during sensitivity/working sessions. However, backup staff recognizes that changes observed since the inception of the program are felt in more responsive management and satisfaction of clients. They are unanimous in support of PAC/FP.

All PAC/FP services are available and offered every day in the week.

The major recommendations of the evaluation are as follows:

For the Ministry of Health:

- Always have available enough PAC/FP equipment and supplies, particularly the equipment for MVA; information, education and communications (IEC) (mainly at

Borgou DUHC); and for ultrasounds (mainly at Parakou CHC), specific drugs, and supplies.

- Improve affordability of emergency care by facilitating cost recovery when services are provided before payment. To this end, the establishment of community funds and health associations should be encouraged.
- Undertake periodic monitoring of the program.
- Expand the program to other sites.
- Improve provider motivation by diversifying motivating factors according to the achievable expectations of providers.
- Put in place a modern system of communication in CHC (land or mobile telephone, WAN system).
- Maintain the knowledge and skills standards of providers and supervisors trained in RH/PAC/FP through periodic refresher courses and teaching supervision visits.
- Ensure the knowledge and skills standards of providers and supervisors as well as the involvement of the administrative and backup personnel during the expansion period.
- Undertake a reporting exercise of the evaluation outcome at the level of each pilot site and encourage the administrative authorities to adopt recommendations that would be introduced into current health facility management.
- Educate the community on the relevance of PAC/FP.

For hospital decision-makers:

- Pursue infrastructure improvements in the three sites relating to comfort, confidentiality, hygiene and cleanliness.
- Always have available enough PAC/FP equipment and supplies.
- Reinforce support for backup personnel and providers (midwife, nurse and specialist) especially at the level of the DUHC and CHC.
- Improve affordability of emergency care by facilitating post-service cost recovery after services before payment.
- Organize in-house meetings, consultation meetings with site managers and with the community with a view to facilitating adoption of the program by various actors.

For providers, supervisors and backup personnel:

- Participate in in-house meetings, consultation meetings with site managers and with the community with a view to better adapting the program.
- Give particular attention to the adequate maintenance of MVA equipment.
- Give priority to client-provider interaction.

I. INTRODUCTION

Maternal deaths plague Benin. Between 1989 and 1996, the estimated maternal mortality rate in Benin was 498 deaths for 100,000 live births [DHS2]. In 2000, the adjusted rate reported by WHO was 850 deaths for 100,000 live births [WHO 2004]. Maternal deaths occur primarily during obstetrical emergencies. Among the principal causes of maternal deaths is unsafe or incomplete abortion, with a mortality rate of 17%. Among such abortions, 81% of cases are females under 19 years old [ALIHONOU, 1995].

In support of the improvement of women's lives, Benin adopted the Declaration of Policy and Population in 1996, adopted a policy for the promotion of women in 2000, and promulgated law No. 2003-04 relating to sexual health and reproduction in the Republic of Benin [MFPSS, 2003]. All this testifies, in compliance with the Millennium Development Goals (MDG), to Benin's commitment to the holistic promotion of women. At the forefront of this promotion is reproductive health, including measures favourable to postabortion care. Such measures include Policy, Norms and Standards as well as protocols on family health services, the integration of reproductive health in the curricula of baseline training in health schools in Benin, and the support of development partners in the implementation of reproductive health, including postabortion care (PAC) and family planning (FP).

In 2000, Benin began implementation of a multidimensional and multisectoral approach to emergency obstetrical and neonatal care giving top priority to obstetrical emergencies and integrating PAC/FP. Subsequent to the participation of Benin in the regional workshop on maternal death held in 1996 in Dakar, and the regional Francophone Africa workshop on postabortion care in 2001 in Dakar, the Ministry of Public Health (MOH) authorized a situational analysis on postabortion care.

The analysis addressed PAC/FP in three pilot health facilities selected by the MOH, focusing on the assessment of infrastructure and resources available for PAC/FP; specification of current PAC/FP services; the description of performance factors and the formulation of recommendations.

The implementation of postabortion care began in 2005 after an update of the situational analysis at the three pilot sites, each representing a specific level of the Benin health system: at the national level, the Hospital of the Mother and the Child, Lagune (HOMEL); at the departmental level, the Departmental and University Hospital Centre (DUHC) of Borgou/Alibori in Parakou; and at the peripheral level, the maternity clinic of the Community Health Centre (CHC) of Parakou.

The evaluation described in this report took place six months after the introduction of PAC/FP at the three pilot sites. It addressed the the following specific issues:

- What is the extent of implementation of postabortion care in its various components at the three pilot sites?
- What have been the effects of the project on the performance of PAC/FP providers?
- What have been the effects of the project on the availability, affordability, quality and use of services?
- What have been the effects of the project on maternal morbidity and mortality?

II. OBJECTIVES

2.1 General objectives

Assess the implementation of the project and its effect on PAC/FP services.

2.2 Specific objectives

- Outline the real conditions for PAC/FP implementation in pilot facilities (infrastructures, equipment, drugs, accessibility to PAC/FP services).
- Document changes in attitudes, knowledge and skills of providers in regard to PAC/FP services, particularly the use of MVA, counselling and family planning.
- Map out the current level of performance in PAC/FP implementation at the pilot sites.
- Specify the perceptions and interventions of supervisors with reference to PAC/FP, and their impact on management of postabortion complications by providers.
- Determine the involvement of administrative authorities and the backup personnel of the pilot centers in the implementation and monitoring of PAC/FP.
- Document indicators on the availability, accessibility and quality of PAC/FP services, as well as on abortion-induced morbidity and mortality.
- Issue recommendations for the next stages of PAC/FP implementation.

III. SCOPE AND METHODOLOGY OF THE STUDY

3.1 Scope of the study

The evaluation was conducted at the three pilot sites where PAC/FP has been implemented: the Maternity Hospital of the Mother and the Child of Lagune (HOMEL), the Maternity Hospital of the Departmental and University Hospital Center (DUHC) of Parakou, and the Community Health Centre (CHC) of Parakou.

3.2 Nature of the evaluation

It is a descriptive cross-sectional evaluation relating to the implementation of the PAC/FP program, and which took five weeks.

3.3 Development of tools

Most of the tools used in this evaluation have been adjusted from the data collection tools used for the situational analysis, including one situational tool developed by the Population Council. Some of the tools have been developed in order to better comply with the objectives of this evaluation.

Eight tools have been prepared for data collection. They refer to infrastructures, equipment, drugs, accessibility to PAC/FP services, performance of providers, interventions of supervisors, involvement of the administrative authorities and of the backup personnel of pilot centers, indicators on the availability, accessibility and quality of maternal services and on mortality.

- The first tool evaluates changes in the functionality of infrastructures of the pilot sites. It allows the assessment of PAC/FP management along the client flow, from the reception room to the family planning room.

- The second tool is the **inventory sheet** of the pilot site. The changes evaluated refer to the availability of services and staff, premises, material and equipment, referral and counter-referral.
- The third tool is an **interview guide for PAC/FP supervisors** related to perceptions on abortion and the role of supervisors in offering PAC/FP services.
- The fourth tool is a **guide for interviewing administrative personnel** of the health facility related to perceptions on abortion and the role of the administrative personnel in the offering of PAC/FP services.
- The fifth tool is the **interview guide for providers**. This tool comprises a series of questions related to providers' perceptions on abortion, their knowledge of PAC/FP and their perceptions on factors that can influence their performance.
- The sixth tool is the **interview guide for backup personnel** to specify their involvement in PAC/FP and their perceptions
- The seventh tool comprises the **checklist of providers' skills** regarding MVA, the client-provider interaction (before, during and after the procedure), and FP counseling.
- The eighth tool consists of a **data collection sheet** relating to services.

3.4 Methodological approaches

The various methodological approaches used are as follows:

- Individual interviews with providers, supervisors, management and backup personnel
- Simulated observation of the practices of uterine evacuation by MVA, client-provider interaction (before, during and after MVA procedure) and FP counselling sessions.
- Inventory of infrastructures, equipment, drugs and supplies
- Documentary review of project documents such as work plans, training materials, monitoring reports
- Service data review.

3.5 Main stages

The evaluation of PAC/FP implementation was achieved in five phases: planning, technical preparation, data collection, analysis and preparation of the technical report and reporting.

- **Phase 1: Planning (December 2005)**

During the preparation phase, the research team:

- Formulated the terms of references
- Adjusted and developed tools
- Inventoried and collected reference documents

- **Phase 2 : Technical preparation (28 February-2 March 2006)**

The technical preparation was done through:

- Meetings with parties involved (IntraHealth, DFH, HOMEL, Borgou/Alibori DDPH, DUHC/Parakou).
- Identification of resources required, including interviewers.
- Training of interviewers and pre-testing of instruments.
- Finalization of tools and methods.
- Planning and preparation of the logistics.
- Preparation of field data collection.

- **Phase 3 : Data collection (6 to 11 March 2006)**

During visits to the pilot sites, the following tasks were carried out:

- Interviews with administrative personnel and managers of pilot centers with a view to assessing their support and perception of PAC/FP services.
- Interviews with providers with a view to assessing changes in the availability of resources, the organization of services and their attitude toward PAC/FP.
- Interviews with backup personnel to assess their involvement in the program, their perception and attitude toward PAC/FP implemented at the center.
- Observation of providers with a view to evaluating their skills in MVA clinical practice and counseling.
- Inventory of material and drugs with a view to assessing the functionality of infrastructures, the availability of PAC/FP equipment and drugs.
- PAC/FP data collection for indicators of the availability, accessibility and quality of services, as well as abortion-related morbidity and mortality.

- **Phase 4 : Analysis and preparation of the technical report (13 to 25 March 2006)**

This phase has been conducted in five stages:

- Computer-assisted data compilation and processing
- Interpretation
- Validation
- Preparation of the technical report
- Preparation of a Power Point presentation.

- **Phase 5: Reporting**

The reporting of the outcome of this study occurred during the end-of-ACQUIRE project meeting held on 4th May 2006 at the MOH. Key actors at the central, departmental and peripheral level, as well as key partners, participated in that meeting.

3.6 Sampling

Table 1: Sampling according to tools

Collection tools	Size of the sample	Total
1. Inventory sheet of infrastructures and equipment	HOMEL : 1 ; Borgou DUHC: 1 ; Parakou CHC:1 ;	3 pilot maternity hospitals
2. Inventory sheet of material and drugs	HOMEL : 1 ; Borgou DUHC: 1 ; Parakou CHC: 1 ;	3 pilot maternities
3. Interview guide for supervisors of PAC/FP providers	HOMEL : 6 ; Borgou DUHC: 2 ; Parakou CHC: 1	9 persons
4. Interview guide for the administrative personnel (Head of service/director and service managers)	HOMEL : 4 ; Borgou DUHC: 3 ; Parakou CHC: 3	10 persons
5. Interview guide for providers	HOMEL : 18 ; Borgou DUHC: 11 ; Parakou CHC: 5	34 persons
6. Interview guide for the backup personnel	HOMEL : 6 ; Borgou DUHC: 6 ; Parakou CHC: 3	15 persons
7. Observation guide for providers (MVA, counseling, FP)	HOMEL: 18 ; Borgou DUHC: 11 ; Parakou CHC: 5	33 persons
8. Data collection sheet for services	HOMEL : 1 ; Borgou DUHC: 1 ; Parakou CHC: 1	3 pilot maternities

3.7 Preparation of the survey

3.7.1 Recruitment of interviewers and supervisors

For data collection, a total of 15 interviewers were recruited to collect data simultaneously at the 3 sites. Eight interviewers and one supervisor were in charge of data collection at the CHC and the DHUC of Parakou. Five interviewers were in charge of data collection at HOMEL in Cotonou.

Interviewers consisted of physicians and midwives and health service providers with experience in the implementation of surveys in reproductive health. Supervisors belong to the PAC/FP national team.

Interviewers and supervisors were recruited one month before the survey began.

3.7.2 Training in the use of data collection tools

Training lasted 3 days and took place in Cotonou and was provided by the IntraHealth team and the research team in charge of evaluation. This training was based on a participatory method that made it possible for both interviewers and supervisors to adapt data collection tools.

3.7.3 Administrative and logistical organization of training and survey implementation

Before commencement of the survey, the Directorate of Family Health established telephone, e-mail and fax contacts, with written confirmation, among participants at the survey sites and the administrative hierarchy of the Ministry of Health. Letters were also sent to interviewers and supervisors at the same time to mobilize them.

3.8 Data collection and processing

The survey took place according to the timetable established and lasted five days from 6-10 March 2006 in the three pilot sites of PAC/FP implementation.

The HOMEL team comprised 5 interviewers and 1 supervisor, while in Parakou, there were 4 interviewers at DUHC and 4 interviewers at CHC. Only one supervisor was in charge of the two Parakou sites. The roles to be played by each member of the team were decided before the survey began. Supervisors ensured that possible difficulties were resolved.

At the end of each day, team members met to review data collected and activities planned for the following day. Data sheets were given to the statistician at the end of data collection at all sites.

The data processing team was composed of a data operator and an analyst-programmer.

Concerning the inventory sheet of infrastructures, data are entered and corrected in the Excel PACEVAL.xls program, developed by the Population Council (Santana, Sloan, Langer), Ipas (Billings, King) and Pubcomm Group, Inc. (Pobiak).

For the other instruments, subsequent to correction, data were entered in a program from Access 2000 software.

Variables studied concern the functionality of infrastructures, norms and procedures with respect to PAC/FP, skill of providers, motivation and feedback system for providers' work, and support of administrative personnel regarding implementation of PAC/FP.

The analysis has produced:

- Simple frequencies (i.e., the frequency at which a value appears among data) for each variable or indicator.
- Percentages (i.e., the number of units with a given characteristic, divided by the total number of units in the sample and multiplied by 100) and proportions (i.e. a digital expression that compares part of the survey units with the total number of units in the sample).
- Charts to illustrate tables (bar chart, pie chart, etc.).

To measure knowledge, scores entered in the checklist are added for each provider. The percentage of correct answers in relation to the total possible score is calculated for each provider to obtain a comprehensive score for all indicators. Comprehensive scores are then added and the results divided by the total number of providers to obtain a mean score of knowledge for the whole group. Such a score is compared with an acceptable knowledge level (AKL), established at 80%. The mean and median describe the typical performance of the group of providers in the sample. Furthermore, the detailed analysis of correct answers (frequencies and percentages) enables description of the specific strengths and weaknesses of the group.

To measure technical skills, scores entered in the checklist are added for each provider. The percentage of correct procedures in relation to the total possible score is calculated for each

provider to obtain an overall score for all tasks. Overall scores are then added and the result divided by the total number of providers to obtain a mean score of technical skill for the whole group. The score is compared with an acceptable level of performance (ALP), established at 80%. The mean and median describe the typical technical skill of the group. Moreover, the detailed analysis of tasks performed (frequencies and percentages) enables description of the specific strengths and weaknesses of the group.

3.9 Formula of consent and confidentiality

The study has met the requirements of ACQUIRE and IntraHealth International for the protection of people with regard to informed consent and compliance with confidentiality rules. Before starting an interview with a manager or service provider, interviewers asked for a private place to conduct the interview, explained to the interviewees the purpose of the study and its implications, and gave assurances that information supplied would be kept confidential. Interviewers read to interviewees the informed consent sheet prepared for this purpose and asked for permission to carry on the interview, making sure that interviewees understood that they were not compelled to answer questions and that they could interrupt the interview or the discussion anytime.

To guarantee confidentiality of information, the names of the interviewees were not recorded on the tools.

3.10 Constraints and limits of the study

At the CHC of Parakou

A provider was hospitalized before the arrival of the team. His/her skills for MVA and counseling in FP for PAC/FP were not evaluated. Furthermore, the supervisor was sick during the evaluation. The team went to her house to do the interview.

At HOMEL

Workers who could provide statistical information were absent because they were attending training outside the hospital. With the assistance of the Chief Medical Officer, a worker of the statistics service came up to supply information.

All data from Tool No. 8 could not be collected because it was not available from the statistics service. A trained provider could not be evaluated because she was on leave and out of town.

IV. OUTCOME

4.1 Main stages of the PAC/FP implementation process in the three pilot sites

The PAC/FP implementation comprised the following interventions:

- Update of data from the situational analysis of April 2005, especially relating to the audit of facilities, led to the formulation of action plans for the improvement of PAC/FP service environment by actors at the level of each site. Needs identified included training in PAC and FP, improvement in measures for infection prevention, supply of medical-technical materials and emergency drugs, as well as the acquisition of MVA kits.

- Adjustment of training material from Ipas-developed materials.
- Training in PAC/FP of nine supervisors/providers in Parakou and 15 supervisors/providers at HOMEL in October/November 2005. These supervisors/ providers are Gynecologist and Obstetrician physicians, general physicians and superintendent midwives with supervisory responsibilities at each site. In addition, 19 providers in charge of abortion-related complications at pilot sites were trained in PAC/FP in November 2005. The training approach used consisted of a theory phase of three days and a practical phase of three days using the humanistic approach and combining demonstration, practice on a model and clinical practice under the supervision of national trainers.
- Post-training deployment of equipment. DFH supplied complete boxes of cervical dilatation material immediately after the training. MVA kits acquired with David and Lucille Packard Foundation funds were supplied to Borgou DUHC and Parakou CHC in January 2006.
- Monitoring visits to pilot sites. A first visit in January 2006 by Pr. Perrin led to quicker implementation of action plans and deployment of MVA kits in Parakou CHC and Borgou DUHC. A second visit in February 2006, undertaken by a team composed of Dr. Adisso and Mrs Akouëikou and Akogbéto, assessed the actual commencement of PAC/FP services. This visit also identified issues related to MVA kit maintenance at DUHC Borgou. The monitoring results were reported to members of the PAC/FP board and enabled corrective actions necessary to ensure the continuity of care in the 3 pilot sites.

It should be noted that the implementation of various activities, in particular the training of providers, was delayed in regard to initial programming. The major cause was the non-availability of resource persons at the national level because planned activities overlapped with those funded by the national budget within the same period.

4.2 Implementation of data collection

Data collection goals, as shown by the table below, were reached for the most part.

Table 2: Level of targets achieved

Data collection tools	Expectations	Achievements (%)
Inventory sheet for infrastructures and equipment	3 Pilot maternities	3 (100%)
Inventory sheet for material and drugs	3 Pilot maternities	3 (100%)
Interview guide for supervisors of PAC/FP providers	9 supervisors	9 (100%)
Interview guide for administrative personnel (head of service, Director, services managers)	10 administrative officers	10 (100%)
Interview guide for providers	34 providers	33 (97%)
Interview guide for backup personnel	15 backup workers	15 (100%)
Observation guide for providers	34 providers	32 (94%)
Data collection sheet for Services	3 Pilot maternities	3 (100%)

4.3 Characteristics of providers and supervisors interviewed

4.3.1 Characteristics of Providers

During the evaluation, 33 providers were interviewed. They were exclusively midwives. Among them, 32 were observed in simulation for verification of MVA skills and FP counseling. All of them benefited from PAC/FP training and are in service holding positions of emergency management, including cases of postabortion complications. During the situational analysis, only one provider in 41 claimed to have been trained in PAC/FP.

4.3.2 Characteristics of supervisors

In all, 9 supervisors were interviewed during the evaluation. Among them, there were 5 physicians and 4 midwives; one had 5 years supervisory experience, another had 2 years, 5 had 4 months and 2 had 3 months. It should be noted that 66.67% of the supervisors, or 6 out of 9, said they had received training in supervision. All supervisors interviewed during this evaluation have also been trained in MVA practice. All of them hold additional positions apart from supervision. The other positions held include administrative responsibilities (66.7%) and trainer of providers (22.2%).

The situational analysis did not present an index of supervisors.

4.4 Attitudes and perceptions of providers, supervisors, administrative personnel and backup personnel with reference to RH/PAC/FP

A person's attitude and perception in regards to a given phenomenon can determine the behaviour of that person in relation to this phenomenon. Such behaviour can be negative or positive and may have implications on performance factors such as motivation and knowledge.

During the evaluation, providers, their supervisors, the administrative personnel and the backup personnel were interviewed concerning their attitudes and perceptions with reference to RH/PAC/FP, including access to information on FP and used of FP methods in the community.

4.4.1 Attitudes and perceptions of providers

Midwives account for 97.1% of the staff trained in PAC/FP. They are in charge of:

- deliveries (79.4%)
- ANC (55.9%)
- Post natal consultations (38.2%)
- FP (26.5%)

All providers recognized that complications from unsafe or incomplete abortion is an important community issue considering its consequences, the major ones of which can include are hemorrhage, sterility and death.

- ***Access to information on family planning***

Among providers interviewed at the sites, 97.1% supply information on FP to single clients or minors, against 95% observed during the situational analysis; 79.4% of providers are not ill at ease dealing with or giving advice to someone who has received an abortion, against 83% in the situational analysis.

All providers interviewed say other RH services have to be mentioned to clients who have received an abortion, against 98% at the situational analysis. The main RH services to be addressed with patients were listed in the following proportions:

- FP	85%
- STD / AIDS	68%
- Immunization	24%
- Education on sexual life/Cancer testing	15%
- Ante and post natal consultation	15%
- Maternal and Child Health	9%
- Delivery	3%

4.4.2 Attitudes and perceptions of supervisors

All supervisors think that complications from unsafe and incomplete abortion constitute a community issue because such abortions:

- Constitute 50% of emergencies in the first term
- Generate risks and complications: infections, hemorrhage, anemia, sterility, maternal death
- Stem from a lack of information about FP.

The great majority of supervisors (88.9%) are not ill at ease dealing with or giving advice to a patient who has received an abortion because they think that:

- It is necessary to manage all obstetrical emergencies,
- It is an opportunity to inform them and give them advice.

4.4.3 Attitudes and perceptions of the administrative personnel

During the evaluation, 10 administrative workers (director, personnel manager, accountant or head of administrative and financial services) were interviewed about their perception of PAC/FP. The interviews covered decision-making, arrangements made by the center, difficulties met and actions contemplated.

- ***Perception of the relevance of complications from abortions***

As in the situational analysis, all administrative workers interviewed were aware that their health facilities manage cases of complications from unsafe and incomplete abortion. Among them, 80% were aware that such abortions constitute most emergency cases, against 67% at the situational analysis.

- ***Arrangements made by the center***

For 80% of the interviewees, arrangements are made to enable the poor to receive care before payment in emergency cases, against 67% at the situational analysis.

Arrangements made include, as in the situational analysis, the provision of emergency kits, pre-signed prescriptions (blank vouchers) and availability of funds for the management of emergencies.

Cost recovery measures include:

- Involvement of the recovery unit and the social welfare service in 62.5% of cases.

- Recovery workers (green collars) raising client awareness in 12.5% of cases.

Sometimes such arrangements are not standing practices, and they vary with availability of financial means or the understanding of the administrative personnel.

- **Difficulties encountered**

As in the situational analysis, in all centres where management of emergency cases is possible before payment, cost recovery remains difficult. In fact, 75% of workers say they have encountered cases of non payment after management.

During the evaluation, needs related to medical-technical material, supplies and drugs were not totally met in 60% of cases. The gap was accounted for by the non-availability of material and financial problems in 60% of cases.

- **Prospects**

To improve the management of emergencies and cost recovery, the administrative personnel identified the following actions:

- Consider putting in place emergency kits with credit /intervention of the administrative management committee (COGEA)
- Sensitize the communities
- Let payment for treatment be covered by the government
- Simplify disbursement procedures
- Identify indigence criteria
- Put indigence funds at the disposal of the centre.

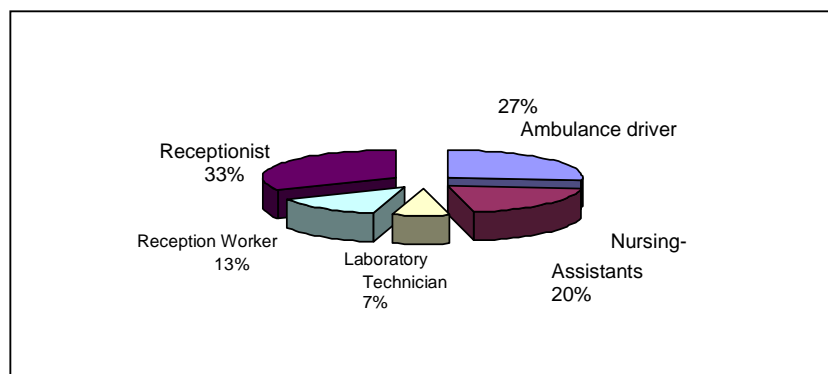
During the situational analysis, proposals formulated by the interviewees to improve emergency management and cost recovery included mainly the setting up of associations and the deployment of emergency kits.

Administrative personnel are involved in management of PAC at various sites. Difficulties related to the limited financial resources of these health facilities are, however, significant obstacles.

4.4.4 Attitudes and perceptions of the backup personnel

Fifteen backup personnel (nine men and six women) were interviewed about their participation in implementation of PAC/FP in the facilities, and their perceptions of and attitudes toward PAC/FP.

Chart 1: Distribution of backup workers by category (n=15)



- ***Involvement in PAC/FP***

In general, only one third of the backup personnel interviewed (5 of 15) were aware of the existence of PAC/FP services within their facility. It should be noted, however, that all CHC backup personnel were informed. Those who knew of PAC/FP services found out through informal contacts and sensitization sessions (40% each) and working sessions (20%).

Roles of backup personnel in PAC/FP management consisted of:

- Reception and client information, 2/5
- Forewarning of the team on duty, 1/5
- Maintenance of material and work place, 1/5
- Conveyance or collection of complete blood counts, 1/5 (mainly at the level of HOMEL and Parakou CHC).

- ***Difficulties***

On the whole, 60% recognize that they face obstacles in their participation in the management of PAC/FP services. Obstacles faced are of three orders:

- The non-payment of treatment fees, according to one-third of the backup personnel of the CHC
- Problems of communication in the national language (1/3 of cases) at HOMEL and Borgou DUHC
- Slowness of the results of lab tests, (1/3 of cases) at HOMEL and at Borgou DUHC.

- ***Change in the offer of PAC/FP services and prospects***

Nearly all backup personnel recognize that there have been changes in the offering of PAC/FP since the commencement of the program. Changes that have been observed include more responsive management (60% of cases) and clients' satisfaction. They are unanimous in support of PAC/FP services. Reasons given are the high cost of curettage as opposed to MVA (60%), the improvement of patients' comfort (20%), and the prevention of sterility (20%).

To improve PAC/FP services, backup personnel suggest the following:

- Empower the centers be autonomous in their management (20%)
- Be able to perform emergency rhesus blood typing and complete blood count (26.7%)
- Equip the centers with means of transportation (30%)
- Equip the centers with a blood bank (10%)
- Motivation personnel (13.3%).

4.5 Performance factors

In general, six interdependent factors influence the improvement or maintenance of providers' performance: clear job expectations, performance feedback, adequate equipment and supplies, motivation, organizational support and knowledge or skills. All providers and supervisors were interviewed during the evaluation on the presence of these factors in their facility.

4.5.1 Clear job expectations

To achieve good performance, it is necessary to have a clear description of the results expected from the work, in line with the objectives of the organization. Typically, such results come from a

variety of sources (national norms, code of conduct of the organization, well-written job-description, a supervisor or a clinic director or a team leader, colleagues, clients and the community). To be more relevant, expectations with reference to the job must be measurable and comparable to norms. This factor addresses the general question: Do providers know what is to be done?

Nearly all providers interviewed (94.1%) stated that objectives have been set for their work in PAC/FP, against 49% during the situational analysis.

The majority of providers interviewed (87.5%) were familiar with the definition of their objectives, against 49% at the situational analysis. Among the providers, 81.3% stated that other categories of workers such as their direct supervisors and chief medical officers are familiar with the definition of these objectives, against 95% at the situational analysis.

4.5.1.1 Knowledge of the job and tasks to be carried out

- 96.2% of providers interviewed said they learned what is expected from them through training activities, against 42% at the situational analysis.
- 97% said that they have been trained according to their job description.
- 75.8% state that they have a job description
- 52% were unable to produce a copy of their job description, against 66.7% at the situational analysis.

4.5.2 Feedback on performance

Once providers have a clear vision of the results expected from them, feedback on performance based on these results can be used to identify and give credit for good performance and improve low-performance areas.

Performance feedback can originate from a supervisor, a colleague, a client, the community or the provider. The feedback should be given adequately in a clear manner, in a descriptive and direct style. It should answer the question : Do providers know if they are doing a good job ?

During the evaluation, 58.8% of providers interviewed said they have received feedback on performance, against less than half in the situational analysis.

Among such providers, 60% said they had received feedback less than one month ago. During the situational analysis, more than half stated that they had received feedback more than one month ago.

As during the situational analysis, feedback was given by the chief medical officer in 50% of cases. It was verbal in 80% of cases and said to be useful by all providers.

Client feedback systems, confirmed by 73.5% of providers, rely essentially (80%) on suggestion boxes, against 49% during the situational analysis.

Over half of the providers said a performance feedback system exists that consists of verbal feedback from the chief medical officer and the use of client suggestion boxes.

4.5.3 Knowledge and skills

This factor allows one to determine if providers have the knowledge and skills required to carry out their duties and assignments. It addresses the basic question: Do providers know how to do the job?

4.5.3.1 Knowledge standard of PAC/FP

A questionnaire was administered to providers to assess their knowledge of various areas of PAC. This questionnaire covered postabortion initial inventory, infection prevention, postabortion care and postabortion family planning.

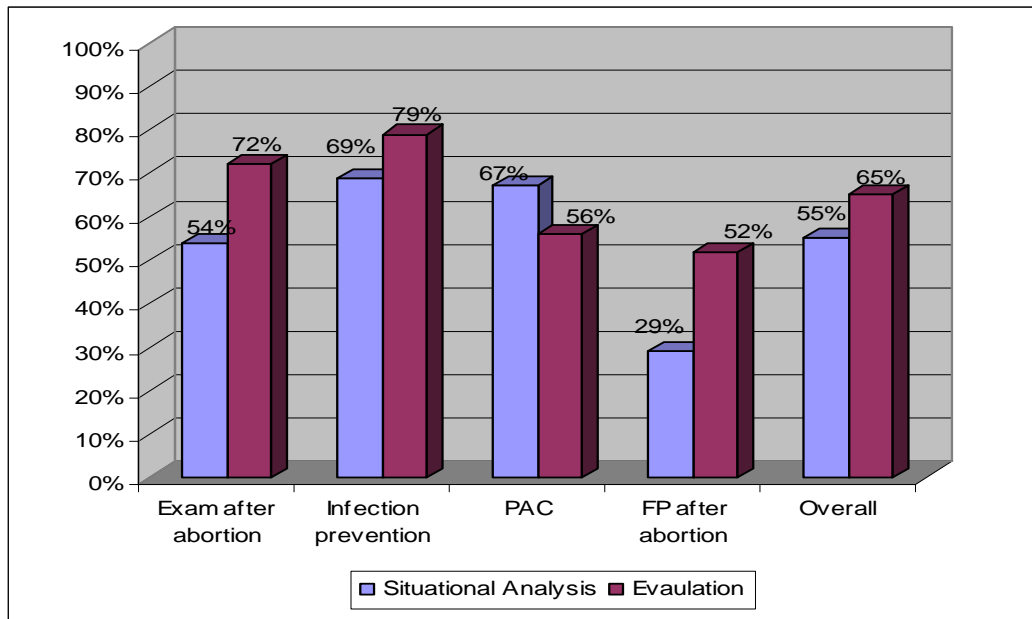
For each aspect under review, scores obtained per provider were compared with the acceptable level of knowledge (ALK), set at 80%.

- **Comprehensive knowledge standard of PAC/FP**

The chart below shows the development of the knowledge standard for PAC/FP overall.

The overall mean knowledge of providers for all items evaluated was 65%, against 55% at the situational analysis. The overall scores of providers' knowledge for the initial inventory and for the prevention of infections have improved from 54% to 72% for the initial inventory and from 69% to 79% for infection prevention. Likewise, the overall score for knowledge in FP after PAC has increased from 29% to 52%. However, there has been a slight drop in the scores for PAC.

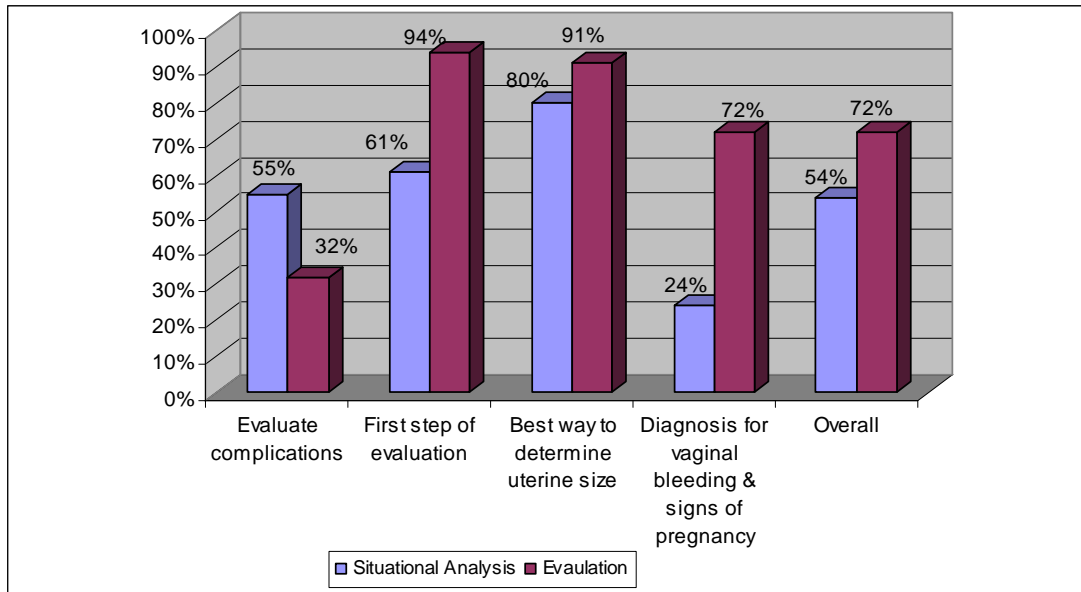
Chart 2: Trend in the overall level of knowledge in PAC/FP (n = 33)



- **Initial postabortion assessment**

The overall mean score of the providers' knowledge for initial postabortion assessment was 72%, and 11 providers out of 33 have reached or exceeded the ALK. This is an improvement from the situational analysis, where the overall score was 54%. Scores varied from 32% to 94%, whereas they previously varied from 24% to 80%.

Chart 3: Trend in the level of knowledge of the initial postabortion exam (n = 33)



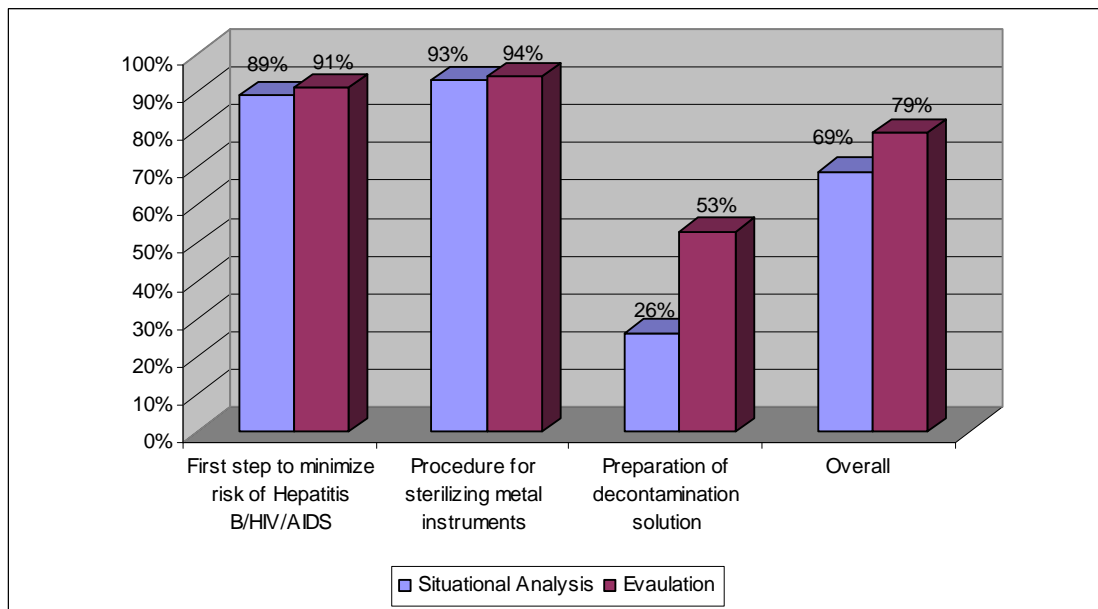
• **Infection prevention**

The overall mean score of providers' knowledge of infection prevention was 79%, and 15 providers out of 33 reached or exceeded the ALK. This was an improvement from the situational analysis, where the overall score was 69%.

Scores varied from 53% to 94%, compared with 26% to 93% in the situational analysis.

A very important improvement should be noted regarding the preparation of the decontamination solution, for which the mean score of the group increased from 26% to 53%.

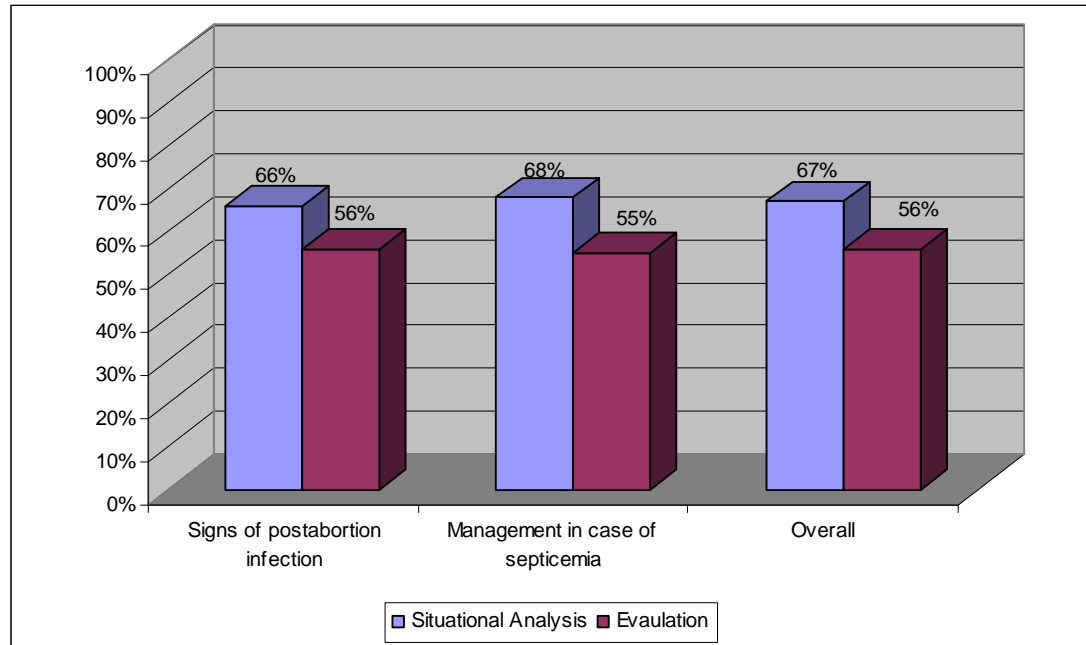
Chart 4: Trend in the level of knowledge of infection prevention (n = 33)



- **Postabortion care**

The overall mean score of providers' knowledge of postabortion care was 56%, and 7 providers out of 33 reached or exceeded the ALK (80%). This is a decrease in comparison with the situational analysis, where the overall score was 67%.

Chart 5: Trend in the knowledge standard of postabortion care (n = 33)



Considering the various areas of knowledge evaluated:

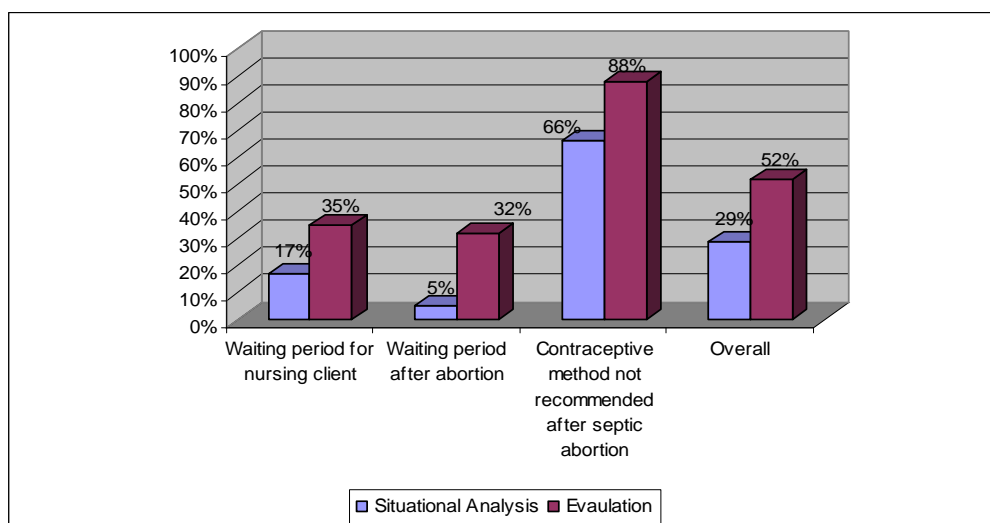
- The knowledge standard of signs of an abortion-induced infection has decreased from 66% to 56% between the situational analysis and the present evaluation.
- The level of treatment in case of a suspected generalised infection (septicaemia) has decreased from 68% to 55% between the situational analysis and the present evaluation.

- **Postabortion family planning**

The overall mean score of providers' knowledge of postabortion family planning was 52%, and 5 providers have reached or exceeded the ALK (80%). This is an improvement from the situational analysis, where the overall score was 29%.

The scores vary from 35% to 88%, while they varied from 5% to 66% at the situational analysis.

Chart 6: Trend in the knowledge of postabortion family planning (n = 33)



With reference to the specific areas of knowledge evaluated:

- The level of women's knowledge regarding time to wait after an abortion before becoming pregnant increased from 5% to 32% between the situational analysis and the final evaluation.
- The level of women's knowledge regarding time to wait after an abortion to become pregnant for a woman (who is not breastfeeding) in the case of unprotected sexual intercourse increased from 17% to 35% between the situational analysis and the final evaluation.

4.5.3.2 Performance standard for MVA practice

Evaluation of clinical skills in the three pilot sites included 32 midwife providers. The acceptable level of performance (ALP) required during this evaluation was set at 80%.

The aspects of the observation related to:

- Various tasks for preparation of the material
- MVA procedure
- Post MVA procedure
- Physical monitoring
- Pain management
- Administration of antibiotics
- Other aspects related to physical health
- Emotional monitoring and support
- Counseling on family planning

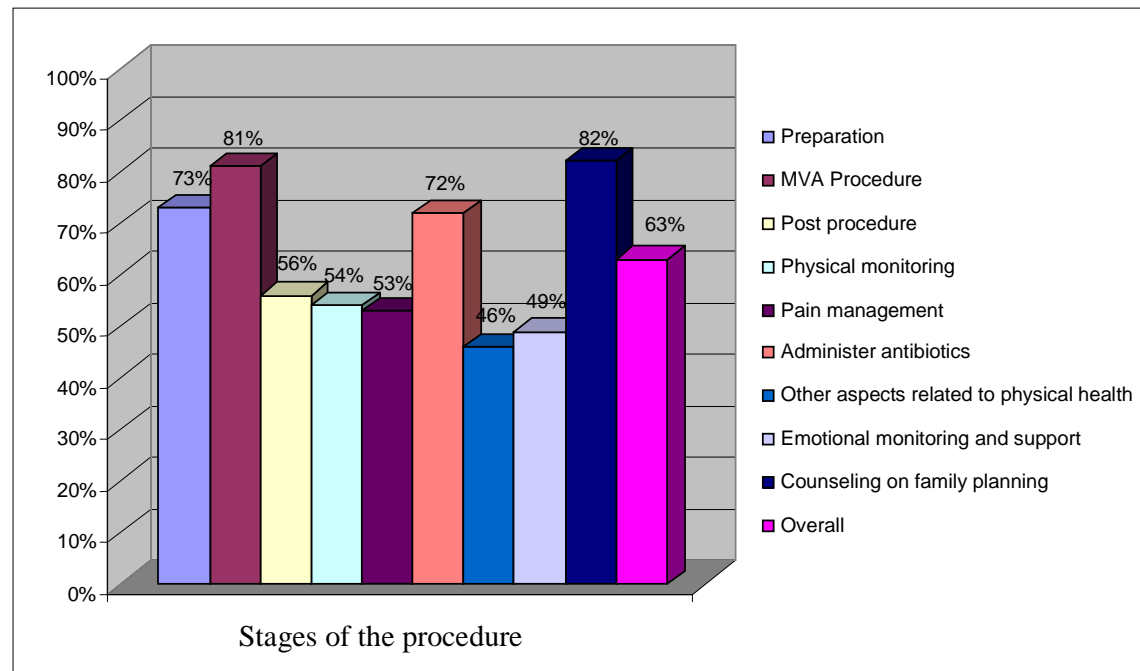
It should be noted that during the situational analysis, none of the health facilities interviewed was practicing MVA. Cases of postabortion complications were managed at national and intermediate levels through curettage and uterine evacuation. Providers were not trained in MVA.

The overall mean score for all stages of MVA practice was 63%, and 65.6% of providers had a performance level for MVA practice higher or equal to the ALP (80%).

Tasks that were better carried out included preparation, implementation of the MVA procedure, administration of antibiotics and counseling on family planning. The weakest tasks included the other aspects related to physical health, emotional monitoring and support.

The chart below represents the overall mean score per area of MVA practice.

Chart 7: Mean score per area of MVA practice (n=32)



▪ **Performance of various tasks related to the preparation of the material (getting ready)**

The overall mean score regarding preparation of the MVA material was 73%, which is close to the acceptable level of performance. It is satisfactory at the level of the departmental hospital. Incomplete elements to be improved are related to:

- Verification and loading of the MVA syringe
- Informing the patient that she may feel some discomfort at certain stages and that she will be advised when to expect this
- Verification that the patient has emptied her bladder
- The use of an apron and washing hands with soap and water.
- Availability of decontamination solution.

• **Performance for MVA procedure**

The overall score for the MVA procedure was 81%, meeting the acceptable level of performance at all sites. Nevertheless, there are elements to be improved related to the following tasks:

- Explain each stage of the procedure before implementing it

- Do a bimanual gynecological examination to assess the size and position of the uterus as well as the degree of cervical dilatation.
- Administer properly a paracervical block anaesthesia
- Dilate the cervix (as needed)
- Inspect the contents removed from the uterus to assess the quantity and aspect, to be sure that the evacuation is complete
- If the cervix is still soft or if the bleeding is persistent, re-start the aspiration.

- **Performance for various tasks of post-MVA procedure**

The overall score for the various tasks of post MVA procedure, 56%, did not meet the acceptable level of performance. Neither was it satisfactory at any site. Elements to be improved are as follows:

- Put both gloved hands into a 0.5% chlorine solution and remove the gloves inside out.
- Carefully wash hands with water and soap and swab them with a clean and dry linen or dry in the open air
- Assess the bleeding and make sure at least once that cramping has decreased before releasing the patient
- Give the patient instructions on care after the procedure

- **Performance for various tasks of physical monitoring after MVA procedure**

The overall score for various physical monitoring tasks after MVA procedure was not satisfactory, estimated at 54%. None of the sites achieved satisfactory scores. Elements to be improved are as follows:

- Make sure that the woman is resting comfortably
- Take vital signs immediately
- Recheck the physical examination record and medical history
- Monitor the physiological status, including vital signs
- Evaluate bleeding and cramping at least twice
- Continue to treat all existing problems
- Evaluate and manage complications

- **Performance for pain management**

The overall score for pain management was 53%, below the acceptable level of performance. At no site was it satisfactory. Elements to be improved are as follows:

- Evaluate the level of suffering
- Administer and monitor the choices for pain relief.

- **Performance for the administration of antibiotics after MVA procedure**

The overall mean score for the administration of antibiotics was 72%, close to the acceptable level of performance. Nevertheless, it was not satisfactory at any site. The administration of antibiotics subsequent to MVA procedure is an element that should be improved.

- **Performance for other aspects related to physical health subsequent to MVA procedure**

The overall score for the other aspects related to physical health subsequent to MVA procedure was 46%, less than the acceptable level of performance. It was unsatisfactory at all sites.

Elements to be improved are as follows:

- Meet the other needs related to physical health and refer as needed in case of anemia, STD/HIV, cervical cancer, violence, infertility.
- Administer or refer for tetanus vaccine
- Administer oxytocin.

- **Performance for emotional monitoring and support after MVA procedure**

The overall score for the other aspects related to emotional monitoring and support subsequent to MVA procedure was 49%, less than the acceptable level of performance. It was unsatisfactory at all sites.

Elements to be improved are as follows:

- Cope sensibly with emotions
- Monitor the woman's emotional condition
- Counsel and refer for emotional-health needs.

- **Performance for family planning counseling**

The performance rate of family planning after MVA procedure was satisfactory at 82%, above the acceptable level of performance. The score at HOMEL, however, was 76.5% and needs to be improved.

The element to be improved is the determination of the desire to be pregnant.

4.5.3.3 Standard performance for counseling during postabortion care

Observation of performance in counseling during postabortion care in the three pilot sites included 32 midwife providers. The acceptable level of performance required during this evaluation is set at 80%. The measurement of performance standard refers to the use of skills in a simulated case using a model.

Elements of this observation are:

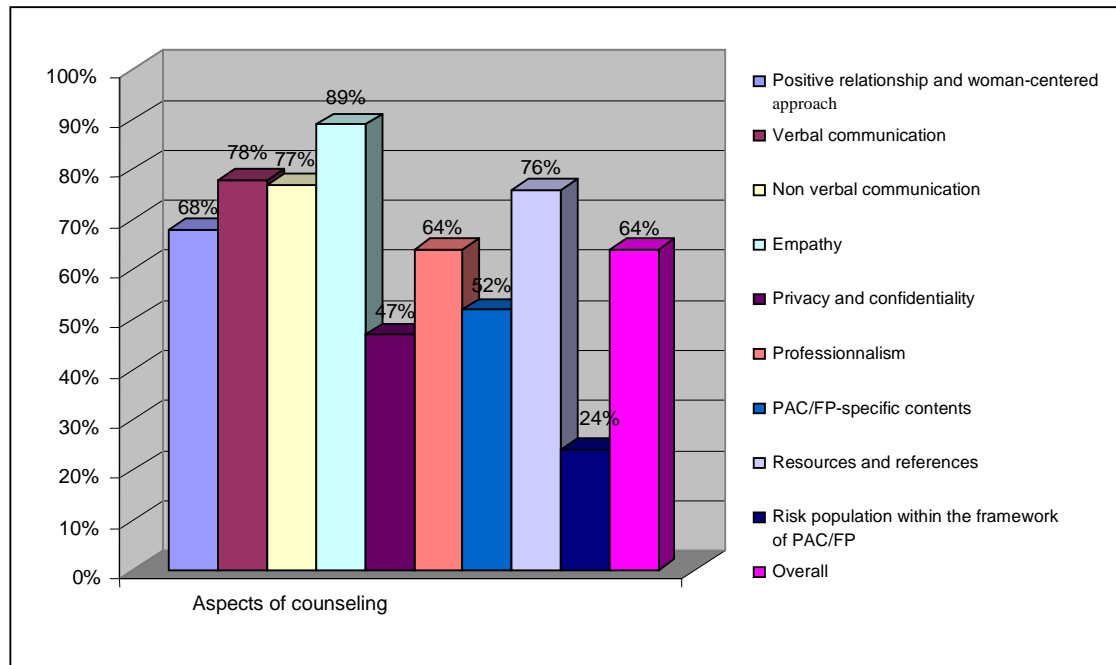
- Positive relationship and woman-centered approach
- Verbal communication
- Nonverbal communication
- Empathy
- Privacy and confidentiality
- Professionalism
- PAC/FP-specific contents
- Resources and references

- Populations at risk within the framework of PAC/FP.

As shown by the chart below, the overall score for counseling during postabortion care was 64%. Among providers, 84.4% of them have met or exceeded the ALP (80%), which is a very good result.

In the three sites, the practice of empathy is satisfactory, with a rate of 88.9%, as well as verbal and nonverbal communication, for which providers have reached a total mean rate of 77.6% and 77% respectively. Consideration of the population at risk and compliance with privacy and confidentiality remain aspects to be improved by PAC/FP providers at all sites. Progress needs to be made, particularly at Borgou DUHC and Parakou CHC.

Chart 8: Mean score per area of counseling during postabortion care (n=32)



Elements of **reception** were satisfactory for all midwives observed during counseling.

Positive relationship and woman-centered approach¹ have a total mean rate of 68% for the three sites. At HOMEL, the mean rate was satisfactory (81.6%); it needs to be improved in the other sites.

Verbal communication was satisfactory at HOMEL (94%) but must be improved at the DUHC and Parakou CHC, where the rates were, respectively, 64.8% and 62.5%.

The mean rate of **nonverbal communication** was also satisfactory at HOMEL, where it was 88.2% but needs to be improved at the DUHC and the CHC, where it was 64.8% and 62.5% respectively.

The practice of empathy was satisfactory at the HOMEL and DUHC, at 92.9% and 90.9%, respectively, but remains to be improved at the CHC, where it was 65%.

¹ Woman-centered approach requires that the provider takes into account factors influencing the medical and psychological needs of the woman and access to services, such as personal problems or her standard of living. The provider must prove himself/herself to be respectful to patients, deal with them confidentially, offer to them the maximum options possible and provide each woman with the quality care to which she is entitled.

Performance in the practice of compliance with **privacy and confidentiality** was to be improved in all sites. The overall performance was 46.9%.

Providers showed **professionalism** at Borgou DUHC, where the performance was 86.5%. Professionalism must be improved at HOMEL and the CHC, where it was 50% and 62.5%, respectively.

4.5.4 Environment and tools

The environment and tools performance factor aims to measure whether providers have the required and adequate tools and supplies as well as the physical environment congenial to a good job. It also encompasses a review of the logistics and maintenance systems to provide satisfactory support for the physical environment and tools required for the job. This factor addresses the question: What is the condition of the work environment and what systems are in place to ensure an adequate environment?

The situational analysis conducted in 2003 assessed the environment of each health facility on the basis of infrastructure, the availability of material, and relationship between human resources and work load. Such elements were also assessed during the evaluation to assess the level of satisfaction subsequent to the introduction of PAC/FP at the three pilot sites.

4.5.4.1 Characteristics of infrastructures

Service provision rooms must fulfill a number of conditions to support quality services. During the evaluation, information was collected about the conditions of various service provision rooms (waiting room, medical examination room, operating room, recovery room, diagnosis room, postabortion care and family planning room).

The condition of the room was assessed with reference to each requirement specified in the table below.

Criteria for the assessment of infrastructure characteristics were:

- comfort
- confidentiality
- hygiene and cleanliness
- material resources required for their use.

The level of satisfaction required was 100%.

MATERNITY HOSPITAL OF HOMEL

• The waiting room

Compared with the situational analysis, there has been an improvement in the level of compliance of the waiting room regarding comfort, hygiene and material resources. However, confidentiality is absent. This was attributed to the remodeling of the emergency reception area at the expense of the waiting room.

• The medical examination room

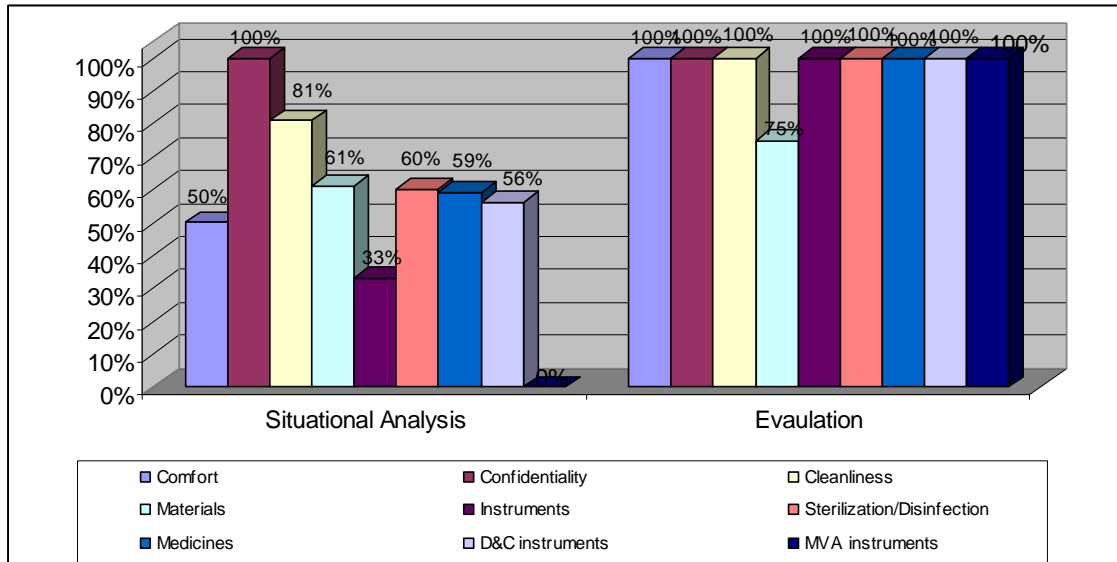
There has been improvement in the level of compliance regarding the various requirements of the examination room, but only comfort met the satisfactory level at 100%. The other elements (confidentiality, hygiene, cleanliness, various materials and instruments) are to be improved.

- **The operating room**

Apart from the various materials (75%), all requirements were satisfactory at 100% at the HOMEL operating room during the evaluation, which constitutes an outright improvement over the situational analysis.

The chart below compares characteristics of the HOMEL operating room at the situational analysis with the evaluation.

Chart 9: Trend in the level of compliance with the requirements of HOMEL operating room



- **The recovery room**

Comfort and various instruments have been improved and were 100% satisfactory. The level of satisfaction for various materials and confidentiality are to be improved.

- **The diagnosis room**

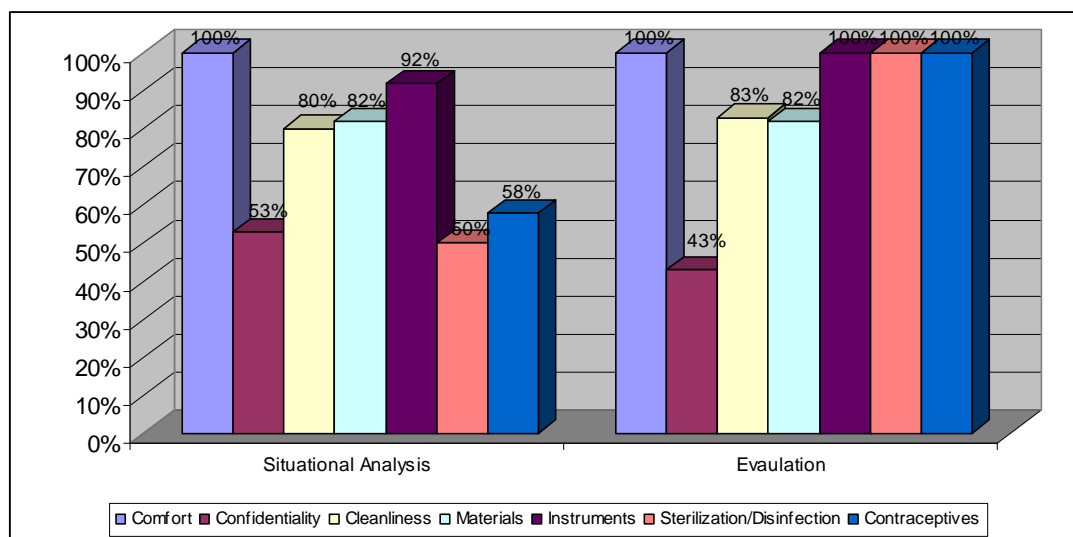
The level of availability of laboratory tests is satisfactory, whereas that of ultrasound tests is at 75%. There is improvement in both cases compared with the situational analysis.

- **The postabortion and family planning room**

The chart below compares characteristics of the postabortion and family planning room at the HOMEL for the situational analysis and the evaluation.

Apart from confidentiality (43%), hygiene (83%) and various materials (82%), all characteristics of the postabortion care and family planning room of HOMEL met the 100% requirement in the evaluation. It is a clear improvement compared with the situational analysis.

Chart 10: Trend in the level of compliance with requirements of the postabortion care room and of family planning room of HOMEL



- **Lay-out and functionality of the premises**

A good lay-out of the premises facilitates the movement of the clients and providers. It takes into account the existence of identification sign boards and the proximity of one service provision room to the other ones.

At HOMEL, identification sign boards are present, the waiting room is contiguous to the examination room, the operating room (MVA) is close to the rest-room and the other RH services are present in the facility. The premises are, therefore, laid out in a functional manner at 100%.

MATERNITY HOSPITAL OF BORGOU DUHC

- **The waiting room**

No requirement is met at the waiting room. Deterioration in comfort and material resources was noted. Confidentiality was absent, and the level of hygiene and cleanliness remained at 50%.

- **The medical examination room**

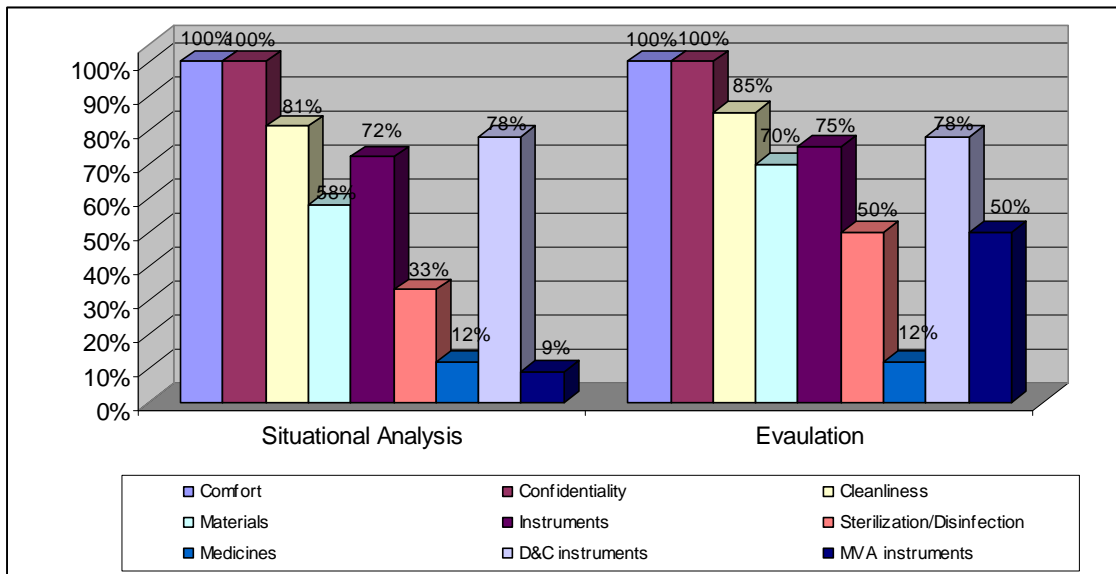
Only the level of comfort has remained adequate and identical to the situational analysis. The levels of hygiene, cleanliness, availability of materials and various instruments decreased.

- **The operating room**

Characteristics of the operating room at Borgou DUHC at the situational analysis and at evaluation are shown in the chart below.

Comfort and confidentiality remained satisfactory. There was improvement in hygiene, cleanliness, various materials of sterilisation/disinfection and the availability of MVA material. D & C drugs and instruments did not improve.

Chart 11: Trend in the level of compliance with requirements for the operating room of Borgou DUHC maternity hospital



• **The recovery room**

Comfort, which was optimal in the situational analysis, decreased from 100% to 83%. Confidentiality, hygiene and cleanliness also decreased.

The availability of various materials increased from 3% to 25%, and the availability of various instruments increased from 30% to 35%, though they remain at an unsatisfactory level.

• **The diagnosis room**

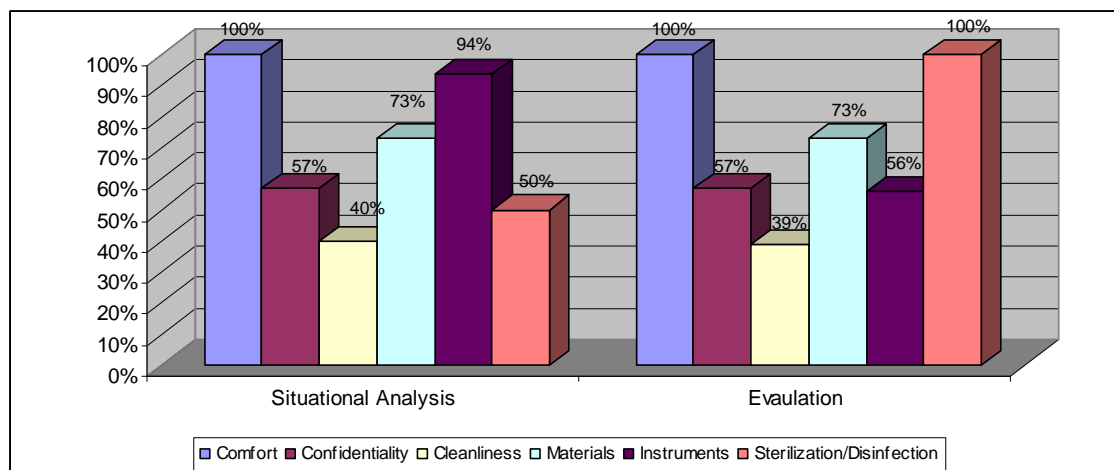
Laboratory tests are always fully available, as they were at the situational analysis. There was an improvement in the availability of ultrasound tests (50%).

• **The postabortion and family planning room**

Characteristics of the postabortion and family planning room of the maternity hospital of Borgou DUHC at the situational analysis and at the evaluation are shown in the chart below.

The level of sterilization/desinfection and of comfort was satisfactory at 100%. There was a clear improvement in the availability of contraceptive methods, increasing from 58% to 80%. Confidentiality, hygiene, cleanliness, various instruments and various materials did not improve from the situational analysis.

Chart 12: Trend in level of compliance with requirements of the postabortion care and family planning room of Borgou DUHC maternity hospital



- **Lay-out and functionality of the premises**

At the maternity hospital of Borgou DUHC, identification sign boards are present, the waiting room is contiguous to the examination room; the operating room (MVA) is close to the rest room, and the other RH services are present in the structure. Premises are, therefore, laid out in a functional manner at 100%.

MATERNITY HOSPITAL OF PARAKOU CHC

The maternity hospital of the CHC is a peripheral structure. Consequently, it has neither an operating room nor recovery room. MVA is completed in the medical examination room.

- **The waiting room**

The waiting room meets no requirements. Comfort decreased, confidentiality remains absent. The levels of hygiene, cleanliness and material resources have increased, respectively, from 50% to 60% and from 0% to 33%.

- **The medical examination room**

Only comfort is at a satisfactory level, as it was in the situational analysis. Confidentiality, hygiene and the availability of materials and various instruments showed improvement.

- **The diagnosis room**

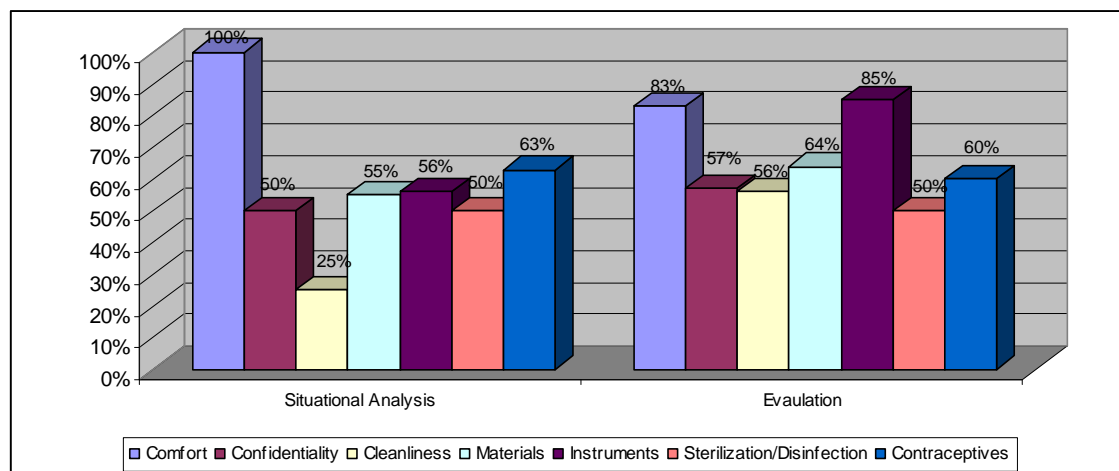
Ultrasound tests are not available. Laboratory examinations have decreased from 93% at the situational analysis to 29% during the evaluation. Such a decrease can be attributed to a lack of reagents.

- **The postabortion care and family planning room**

Characteristics of the postabortion care and family planning room of the maternity hospital of Parakou CHC at the situational analysis and at evaluation are illustrated in the chart below.

No characteristics were satisfactory during the evaluation. Sterilisation/disinfection and the availability of contraceptive methods did not improve, whereas confidentiality, hygiene, cleanliness and the availability of various materials and instruments did.

Chart 13: Trend in the level of compliance with requirements of the postabortion care and family planning room at the maternity hospital of Parakou CHC



- **Lay-out and functionality of the premises**

At the Parakou CHC, identification sign boards are present; the waiting room is contiguous to the examination room; and the operating room (MVA) is close to the rest room. The other RH services are present in the facility. Premises are, therefore, laid out in a functional manner at 100%.

4.5.4.2 Availability of material

This element of the survey concerns the availability of IEC material, supplies, emergency drugs, reference documents and clinical equipment

- **Availability of IEC material**

At the maternity hospital of HOMEL and Parakou CHC, IEC material such as flip charts and posters on FP, contraceptive samples, and video cassettes on contraception are 100% available. The maternity hospital of Borgou DUHC does not have any audio-visual equipment (TV, camera). There is just a poster on the ring method, one on HIV/AIDS and a sample of contraceptive methods.

- **Availability of supplies and emergency drugs**

Supplies and emergency drugs are necessary for quality PAC/FP services. At the evaluation, supplies and emergency drugs were available at about 44%. Out-of-stocks, financial issues, nonavailability of the telephone to relay orders, and non-availability of the ambulance account for the gap.

- **Availability of referral means**

At HOMEL, means of communication (land and/ or mobile telephone) are made available to providers. Ambulances are available and can ensure referrals. At the DUHC, means of communication are available (24h/24) to providers. Existing ambulances do not ensure referrals from the peripheral level to the DUHC. At the CHC, no means of communication (telephone, RAC, mobil phones) are available to providers. No ambulance is available.

- **Availability of referral documents**

Referral documents include norms, standards, protocols and algorithms. They enable the providers to make appropriate decisions in the course of care and should, therefore, be available in all centers.

Table 3: Trend in the availability of referral documents

Referral documents	Favourable frequency (n=3)	
	Baseline survey	Evaluation
Policy document, norms and standards of family health services	2	2
Document of protocols on family health services	1	2
Algorithm of STD/HIV/AIDS	3	2
PAC/RH/FP norms and procedures (apprenticeship sheet, job aid, list of assessment)	3	3

Referral documents are 100% available at HOMEL maternity hospital. At the maternity hospital of Borgou DUHC, there are documents of Protocols on Family Health Services and other documents as well. It should, however, be noted that policy documents, norms and standards of RH are not available to providers. At the maternity hospital of Parakou CHC, all referral documents are available except STD/HIV/AIDS algorithm.

- **Availability of clinical material**

To offer quality PAC/RH/FP services, the provider must have at his/her disposal all clinical material required.

Among the providers interviewed, 76.5% said they have the appropriate material and tools at their disposal to offer PAC/RH/FP services. That is an improvement over the situational analysis, in which 14% of providers said they had the clinical material they needed.

- **Material and tools often lacking**

For 75% of the providers interviewed, the material required to complete uterine evacuation (vials of xylocaine, Pozzi forceps, speculum, héggar candle, source of light, evacuating forceps) was at times not available. Furthermore, MVA material is insufficient according to 37.5% of the providers.

At the situational analysis, the material for infection prevention, asepsis, and physical examination was most often unavailable. These materials were more satisfactory during the evaluation.

- **Causes of non-availability of material**

Among providers interviewed on the causes of material shortages, 50% cited lack of means of communication with the physician, and 12.5% cited the lack of financial means. 37.5% said they didn't know what caused the shortages.

At the situational analysis, 31% of providers stated that they didn't know the cause of the material shortages, whereas 50% mentioned problems related to administration.

- **Attitude toward the lack of material**

Where materials were lacking, providers referred clients to midwives/hierarchical superiors in almost 50% of cases. In 15.4% of cases, providers adapted to the situation or rejected MVA in favor of curettage in the operating room. In 3.8% of cases, providers referred clients.

At the situational analysis, providers referred patients in 5% of cases and asked their supervisors for assistance in 7% of cases.

4.5.4.3 Human resources

- **The waiting room**

As shown in the table below:

At HOMEL: There are no human resources exclusively for the waiting room. Emergency room personnel make up this deficiency since the waiting room was created during a reorganisation of the unit. There was on the whole an improvement over the situational analysis even though it remains insufficient.

At Borgou DUHC: As in the situational analysis, human resources remain insufficient in the waiting room. There is a receptionist during the day.

At Parakou CHC: There is a receptionist and a midwife during the day, an improvement over the situational analysis.

Table 4: Trend in human resources in the waiting room

Human resources	HOMEL Maternity		Maternity of Borgou DUHC		Maternity of Parakou CHC	
	SA	E	SA	E	SA	E
Receptionist Social worker	0%	25%	50%	50%	0%	50%
Nurses / midwives	0%	0%	0%	0%	0%	50%
Stretcher-bearer and others	0%	100%	0%	0%	33%	0%

SA = at situational analysis

E = at evaluation

- **The medical examination room**

At HOMEL: During the evaluation, the level of satisfaction for the availability of a specialist was similar to that of the situational analysis (50%) and should be improved. As regards interns, midwives, and stretcher-bearers, the level was optimal (100%), which is an improvement over the situational analysis, where satisfaction on the availability of midwives was 17% and stretcher-bearers 0%.

At Borgou DUHC: During the evaluation, specialists and general physicians were available, an improvement over the situational analysis, where there were none.

At Parakou CHC: There was no specialist. The availability of human resources was insufficient for nurses / midwives and stretcher-bearers, as it was at the situational analysis.

Table 5: Trend in human resources in the medical examination room

Human resources	HOMEL Maternity		Maternity of Borgou DUHC		Maternity of Parakou CHC	
	SA	E	SA	E	SA	E
Specialist	50%	50%	0%	100%	0%	0%
General physician	0%	0%	0%	100%	100%	100%
Resident / Intern	100%	100%	0%	0%	0%	0%
Nurses / midwives	17%	100%	33%	0%	33%	25%
Stretcher-bearers and others	0%	100%	25%	75%	50%	50%

AS = at situational analysis

E = at evaluation

- **The operating room**

At HOMEL: Human resources were sufficient for the management of emergencies, constituting an improvement over the situational analysis.

At Borgou DUHC: The level of satisfaction for the specialist, midwives and stretcher-bearers was sufficient, marking an improvement over the situational analysis, where the level of satisfaction was 50%, 17% and 25% for specialists, midwives and stretcher-bearers, respectively.

Table 6: Trend in human resources in the operating room

Human resources	HOMEL Maternity		Borgou DUHC Maternity	
	SA	E	SA	E
Specialist	100%	100%	50%	100%
General physician	0%	0%	50%	0%
Resident / Interns	75%	100%	0%	0%
Nurses / midwives	67%	100%	17%	100%
Stretcher-bearers and others	50%	100%	25%	75%

SA = at situational analysis

E = at evaluation

- **The recovery room**

At HOMEL: The level of satisfaction for a specialist was insufficient at 50% and similar to the level for the situational analysis. Nurses were 100% sufficient, an improvement over the 67% at situational analysis. Stretcher-bearer were not sufficient, at 50%, a decline from the situational analysis, where the level of satisfaction was 75%.

At Borgou DUHC: During the evaluation, the levels of satisfaction for all categories improved from the situational analysis but were still insufficient at 50%.

Table 7: Trend in human resources in the recovery room

Human resources	HOMEL Maternity		Borgou DUHC Maternity	
	SA	E	SA	E
Specialist	50%	50%	0%	50%
General physician	0%	0%	0%	50%
Resident / Interns	0%	0%	0%	50%
Nurses / midwives	67%	100%	17%	50%
Stretcher-bearers and others	75%	50%	0%	50%

SA = at situational analysis

E = at evaluation

- **Postabortion care and family planning room.**

At HOMEL: There is neither a general physician nor resident in the postabortion / family planning room. At the evaluation, the level of satisfaction for a specialist was insufficient at 50%, a decline from 100% at the situational analysis. The levels of satisfaction for midwives and stretcher-bearers improved from 17% to 100% and from 25% to 50%, respectively.

At Borgou DUHC: Only midwives perform FP counseling.

At Parakou CHC: During the evaluation, the level of satisfaction for the general physician was 100%, an improvement over the situational analysis. The score for specialists improved but was still insufficient, as was the score for midwives.

Table 8: Trend in human resources in the postabortion care and family planning room

Human resources	HOMEL Maternity		Borgou DUHC Maternity		Parakou CHC Maternity	
	SA	E	SA	E	SA	E
Specialist	100%	50%	100%	0%	0%	50%
General physician	0%	0%	100%	0%	0%	100%
Resident / Interns	0%	0%	0%	0%	0%	0%
Nurses / midwives	17%	100%	33%	75%	33%	25%
Stretcher-bearers and others	25%	50%	50%	50%	50%	50%

AS = at situational analysis

E = at evaluation

4.5.5 Motivations and incentives

Motivation encompasses everything done to encourage people to perform well in their jobs. The central question is: Do workers have any reason to perform up to expectations? Will anyone note it? People must be able to see what they gain from working hard for clients, particularly when the working conditions are tough, the salaries are low and clients are numerous. Even if it is solely the feeling of pride in a job well done, providers need reasons to work in compliance with norms.

In a nutshell, good performance should be approved positively and performance below expectations should meet with neutral or negative consequences.

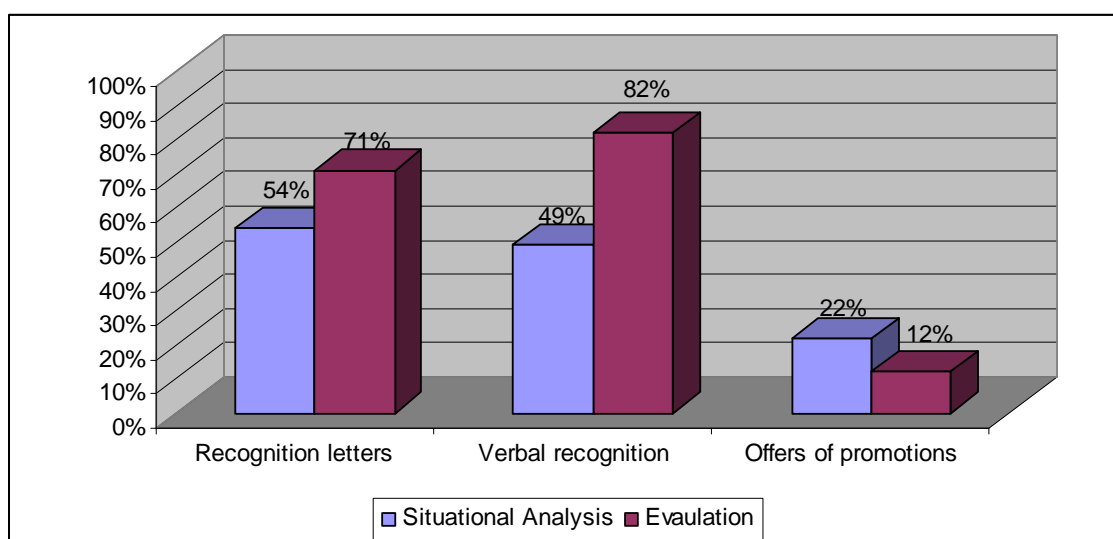
- **Recognition of a job well done**

During the evaluation, 80% of providers said that good work is recognized, against 49% at the situational analysis. Half of these providers said they had been rewarded for a job well done, against 44% at the situational analysis. There was, therefore, considerable improvement in the recognition of jobs well done.

- **Forms of motivation**

The trend in various forms of motivation between the situational analysis and the evaluation is shown in the chart below.

Chart 14: Trend in forms of motivations given to the providers



Percentages of letters of congratulations and verbal congratulations have increased from 54% to 71% and 49% to 82%, respectively, which shows an overall improvement in some forms of motivation.

- **Person extending congratulations**

At the evaluation, congratulations came from the direct supervisor in 78% of cases, against 39% at the situational analysis.

- **Level of satisfaction with the reward system**

Though the majority of providers confirm that good work is recognised, 56% of the providers are not satisfied with the reward system, against 41% at the situational analysis. This system would decrease motivation for 63% of them at the evaluation, against 29% at the situational analysis.

- **Sanctions**

Sanctions applied to poor performance are, by order of frequency, verbal warning, written warning and suspension. All of them were proportionately more important than those of the situational analysis.

4.3.6 Organizational support

This is an important performance factor. Organizational support encompasses all actions taken by the institution to meet providers' needs. Examples of what can be done to support performance include giving providers strategic guidance, clear-cut responsibilities and descriptions related to guidance, a system of backup supervision, good personal relations, positive working standards, and clear organizational processes such as recruitment procedures, deployment, logistics, maintenance, etc.

- **Job grading**

As a rule, hospitals or centers are headed by a director who oversees chief medical officers. Services are divided into sectors led by a superintendent. Within each sector, each provider has a well-defined job.

This type of organization enables good and rapid management of clients according to 50% of the providers at the evaluation, against 29% at the situational analysis. The system contributes to a sound job distribution (each provider with a well-defined job) for 9% of the providers, against 24% at the situational analysis.

- **Decision-making**

During the evaluation, providers said they were involved in decision-making in 32% of cases, against 7% at the situational analysis. Decisions relating to running the unit are, however, made by the chief medical officer in 76.5% of cases. Decision-making comes up most often in meetings in 88% of cases, against 68% at the situational analysis.

- **Supervision**

As at the situational analysis, nearly all providers recognized that supervision is an opportunity to clarify expectations, receive job support and feedback, and improve knowledge and skills.

Among providers, 67.6% said they had benefited from supervision within the past 3 months, against 17% at the situational analysis. Moreover, 15% said they had never benefited from supervision, against 50% at the situational analysis.

The direct supervisor and the departmental supervisor provided the recent supervision in 52% of cases, against 19% at the situational analysis, and 87% of providers said that supervisors meet their expectations, against 66% at the situational analysis, a clear improvement.

The only reason given for dissatisfaction was lack of feedback.

4.6 Current service provisions

This section describes the current availability and accessibility of PAC/FP services in the three pilot sites and provides some service statistics.

4.6.1 Availability of services

This category includes various reproductive health and family planning services.

- **Availability of reproductive health services**

In the three sites surveyed, all RH services are available every day of the week, except for examination of healthy children and immunizations, which are offered only on week days.

- **Availability of MVA services**

The availability of MVA services depends on the presence of trained personnel and, to a large extent, on the availability of adequate surgical and medical material, MVA syringes and cannula sets.

Availability of material required for MVA practice was extensively discussed with the head of each pilot site when data was updated as part of site auditing (see tool No. 1). In fact, the project was not in a position to supply this material, especially MVA syringes. Each site was to have procured them soon from the supplier authorized by Ipas in Benin. This was not done, so MVA did not start immediately after providers' training in October 2005 as planned. In fact, HOMEL, where MVA was practised before the commencement of the program, did not have functional kits; neither did Parakou CHC or Borgou DUHC.

Two MVA kits were offered to Parakou DUHC and one kit to the CHC in January 2006 through the David and Lucille Packard Foundation. Furthermore, the DFH has put complete delivery boxes at the disposal of each site. HOMEL was supplied by authorities at the site after a monitoring trip in February 2006.

The February 2006 monitoring trip highlighted problems related to the maintenance of kits at Borgou DHS. In fact, contrary to instructions given during training, syringe cleaning had been entrusted to untrained nursing assistants, which has resulted in the loss of some parts and placing syringes out of service.

- **Availability of FP methods**

As at the situational analysis, the most used contraceptive methods were pills and injectables, though others were offered. Vasectomy and tubal ligation were not offered.

4.6.2 Accessibility of services

Three components have been studied. They are client flow, the cost of providing service and products, and transportation and communication.

- **Client flow**

Client flow varies among sites.

At HOMEL, clients who have abortion-induced complications go to emergency reception rooms. Then, they receive MVA in the delivery room or in the emergency room and are kept under observation in the dilation room. They receive FP counselling and acquire contraceptives before being released. An appointment is arranged for them in the FP room for a monitoring visit and final adoption of a contraceptive method.

At Parakou CHC, clients are received in the emergency room by the midwife, who performs an examination before providing MVA on the spot. Such clients are put under observation in the admission ward and are released after counseling and with contraceptive products and antibiotics and an appointment for FP.

At Borgou DUHC, having been admitted in emergency, clients are received in the delivery room for counseling and MVA procedures. After post MVA counseling, they are transferred to the hospital ward and then to the family planning service if a contraceptive method is adopted. Clients return to the hospital ward for formal release, with an appointment for FP follow-up one month later.

In the three sites, clients who come back for an FP appointment are admitted directly to FP. If a contraceptive method is adopted, they are given another follow-up appointment.

- **Cost of providing service and products**

The mean cost of MVA at the three sites was 15,000 CFA. It is lower than the cost of curettage, which is 19,000 CFA. The cost of contraceptive products has hardly varied between the situational analysis and the evaluation. It should be noted that the first prescription of contraceptives requires the client to buy them from private pharmacies. Later, the other prescriptions give priority to products that are available in the FP service of the PAC/FP site.

- **Accessibility to RH services**

All RH services are accessible at all sites when clients are in need.

4.7 Use of services

During the evaluation, statistics concerning provision of services were collected from records (delivery, PAC, ANC, FP). Such data cover the period of October 2005 to February 2006. Data on activities related to the use of RH services and indicators related to the management of women presenting with postabortion complications are described in the tables below.

The number of cases for postabortion care received at the three sites, 399 cases, accounts for more than 10% of maternity care services during the period under review. Almost 75% of postabortion cases received were for complicated abortions. Referral cases account for 28% of the postabortion cases.

Regarding postabortion family planning, on average 56.2% of PAC clients received FP counseling before they were released. At Parakou CHC, performance is better, with 68.4% of clients receiving counseling. Likewise, all clients who received counseling at Parakou CHC were released with a contraceptive method, while at Borgou DUHC, only 25.4% of PAC clients who received FP counselling opted for a method before being released.

Table 9: Activities related to the utilisation of PAC from October 2005 to February 2006

Activities related to the management of postabortion complications	HOMEL	Borgou DUHC	Parakou CHC
Total number of deliveries recorded	2274	600	301
Total number of postabortion clients	271	109	19
Including the number referred by lower levels	71 (26.2%)	35 (31.1%)	6 (31.6%)
Including the number with abortion-induced complications	219 (80.8%)	66 (60.5%)	13 (68.4%)
Including the number of uterine evacuations performed	0 (0%)	15 (13.7%)	3 (15.8%)
Including the number of curettages performed	207 (76.4%)	41 (37.6%)	0 (0%)
Including the number of MVA performed	12 (4.4%)	10 (9.2%)	10 (52.6%)
Including the number referred for management at the higher level	0 (0%)	0 (0%)	0 (0%)
Number of PAC/FP clients who have received counseling in FP before being released	NA	59 (54.1%)	13 (68.4%)
Including the number of PAC/FP clients who have received a contraceptive method before being	NA	15 (25.4%)	13 (100%)

released			
Total number of maternal deaths	24	10	0
Including the total number of maternal deaths following an abortion-induced complication	1	0	0

MVA practice was compared with traditional methods of uterine evacuation, taking into account the effective period of the availability of MVA services.

As shown by the table below, the rate of MVA, 10.7%, remains low compared with curettage, 83.2%, because MVA was slow to start at the sites due to the lack of MVA syringes. It's worth noting that MVA performance was outstanding at Parakou CHC compared with the other sites.

Table 10: Indicators related to management of postabortion complications

Indicator	HOMEL	Borgou DUHC	Parakou CHC	Average
Number of curettage performed over the total number of postabortion complications	207/219 (94.5%)	41/66 (62.1%)	0/13 (0%)	248/298 (83.2%)
Number of uterine evacuations performed over the total number of postabortion complications	0/219 (0%)	15/66 (22.8%)	3/13 (23%)	18/298 (6%)
Number of MVA performed over the total number of postabortion complications	12/219 (5.5%)	10/66 (15.1%)	10/13 (77%)	32/298 (10.7%)

V. CONCLUSION

Evaluation results from the three pilot sites show that infrastructure requirements have improved in general, and emergency cases are received in the examination room by qualified personnel (midwife, resident or specialist). MVA practice is carried out at the reception room (HOMEL, CHC) or in the delivery room before management in the FP room, which offers varied contraceptive methods at an affordable cost. The equipment for emergency management is, however, insufficient, with varying availability over time and across health facilities. Likewise, drugs are not always available and FP services are available only during regular working hours. There has been general improvement in human resources, mainly at HOMEL. However, additional backup personnel and providers (midwife, nurse and specialist) are needed at Parakou DUHC and CHC.

Regarding changes that have occurred in the attitudes, knowledge and skills of providers with respect to PAC/FP services, particularly MVA use, counseling and family planning, the evaluation revealed that complications from unsafe or incomplete abortion are perceived by all providers and supervisors as an important community issue. Their attitudes toward this situation are favourable to the practice of PAC/FP with a paramount importance accorded to FP. Such aspects constitute important assets for the continuation of the program. The comprehensive knowledge standards and performance in RH/PAC/FP have improved since the situational analysis, especially the initial postabortion examination, infection prevention, MVA practice and counseling during PAC/FP, which guarantees a better quality of services offered.

Concerning the other performance factors, the evaluation shows that providers are more familiar with the definitions of their objectives and better grasp their tasks. Performance is reinforced by feedback from supervisors and suggestions made by the clients in a constantly improving environment. However, the motivation system is not yet coping with the aspirations of providers. Organisational support is more efficient, but providers regard feedback from supervisors as insufficient.

The evaluation was also aimed at determining the perceptions and actions of supervisors, administrative authorities and backup personnel with respect to PAC/FP. Results show that administrative personnel are conscious of problems surrounding emergency cases, and postabortion complications in particular. The decision to provide treatment before payment for the poor is laudable. Nevertheless, difficulties in cost recovery must be addressed with a view to guaranteeing the system's sustainability. Backup personnel are involved in management of postabortion clients at various sites.

While still in need of improvements, quality PAC/FP services are currently available and accessible in the three pilot sites. However, the use of MVA in relation to uterine evacuation and curettage remains rather low because of delays in the introduction of MVA stemming from a lack of adequate materials.

VI. RECOMMENDATIONS

6.1 GENERAL RECOMMENDATIONS

This evaluation of postabortion care in the three pilot sites in Benin has prompted recommendations of a general nature to political, administrative and technical authorities, providers and supervisors. These include the following:

For the MOH:

- Always have available enough PAC/FP equipment and supplies, particularly the equipment for MVA, IEC (mainly at Borgou DUHC), and for ultrasounds (mainly at Parakou CHC), specific drugs, and supplies.
- Improve affordability of emergency care by facilitating cost recovery after services provided before payment. To this end, the establishment of community funds and health associations should be encouraged.
- Undertake periodic monitoring of the program.
- Expand the program to other sites.
- Improve the motivation system by diversifying motivation factors according to the achievable expectations of providers.
- Put in place a modern system of communication in CHC (land or mobile telephone, WAN system).
- Maintain the knowledge and skills standards of providers and supervisors trained in RH/PAC/FP through periodic refresher courses and teaching supervision visits.
- Ensure the knowledge and skills standards of providers and supervisors as well as the involvement of administrative and backup personnel during the expansion period.
- Report the evaluation outcomes to each pilot site and encourage the administrative authorities to adopt recommendations that would be introduced into current health facility management.
- Educate the community on the relevance of PAC/FP.

For hospital decision-makers:

- Pursue infrastructure improvements in the three sites relating to comfort, confidentiality, hygiene and cleanliness.
- Always have available enough PAC/FP equipment and supplies.
- Increase backup personnel and providers (midwife, nurse and specialist) especially at Parakou DUHC and CHC.
- Improve affordability of emergency care by facilitating post-service cost recovery after services before payment.
- Organize in-house meetings, consultation meetings with site managers and with the community with a view to facilitating adoption of the program by various actors.

For providers, supervisors and backup personnel:

- Participe in in-house meetings, consultation meetings with site managers and with the community with a view to better adapting the program.
- Give particular attention to the adequate maintenance of MVA equipment.
- Give priority to client-provider interaction.

6.2 SPECIFIC RECOMMENDATIONS

Specific recommendations are pooled by sector of performance factor.

6.2.1 Expectations in relation to work

Providers' involvement should be improved in the definition of the objectives of their positions, and copies of job descriptions should be put at their disposal.

6.2.2 Feedback on performance

Reinforcement of supervisors and chief medical officers' supervisory skills and expansion of the forms of feedback (verbal, in writing, system of suggestion boxes) are imperative.

6.2.3 Knowledge and skills

At the level of **MVA Practice**, emphasis should be on:

- Preparation of the material
- MVA procedure
- Various tasks after MVA procedure
- Various tasks of physical monitoring after MVA procedure
- Pain management
- Administration of antibiotics after MVA procedure
- Emotional monitoring and support after MVA procedure
- Determination of the desire for pregnancy and reproductive needs
- Counseling for postabortion care

At the level of **counseling for postabortion care**, emphasis should be on:

- Evaluation of the woman's needs

- Listening to the client
- Evaluation of the woman's emotional status, her cultural background, her level of understanding and the degree of pain
- Verbal communication

6.2.4 Environment and tools

- **HOMEL Maternity Hospital**

To improve the environment of PAC/FP management, it appears necessary to:

- Build a waiting room.
- Provide drapes or clothing for privacy between beds in the recovery room.
- Arrange a place for women to change their clothes, especially in the examination room and in the recovery room.
- Improve various materials by adding printed materials.
- Improve the availability of soap, bed sheets, toilet paper, washing basins and fresh water dispenser.
- Make available and organize the strict monitoring of tubal ligations in the examination room.
- Improve availability of shoes for health personnel and clients, and masks, gowns, and shoes for persons accompanying patients.
- Make ultrasound available and functional in the diagnosis room.

- **Borgou DUHC**

To improve the environment of PAC/FP management, it appears necessary to:

- Make toilets, soap and toilet paper, water basins and tap water available.
- Facilitate client use of toilets.
- Improve hygiene and cleanliness in the toilets.
- Make available the material for MVA practice: MVA kits have to be increased from 2 to 6
- Increase the quantity of chlorine used for daily decontamination
- Arrange at least a place to change clothes equipped with curtains for clients
- Establish a fund for essential drugs (emergency kit)
- Make all contraceptive methods available.

- **Parakou CHC**

To improve the environment of PAC/FP management, it appears necessary to:

- Have sinks, tap water and soap,
- Ensure easy access to toilets equipped with locking doors and toilet paper,
- Ensure cleanliness in the waiting room and toilets,

- Display the posted additional IEC / BCC material,
- Increase MVA kits at least to three,
- Increase the quantity of chlorine for infection prevention,
- Organize laboratory testing for blood grouping and rhesus factor, HIV and syphilis,
- Upgrade the nursing staff,
- Make all contraceptive methods available,
- Inform the community of the availability of PAC/FP services and encourage their use,
- Consider for PAC/RH/FP the involvement of private and religious health centers,
- Ensure for the extension phase the involvement of managerial/ administrative personnel in the introduction of the intervention.

6.2.5 Availability of IEC material

The availability of IEC material at HOMEL maternity hospital and Parakou CHC should be maintained. At DUHC, audio-visual equipment (TV, videotape recorder/player) and a full set of IEC material is indispensable.

6.2.6 Availability of supplies and drugs

Efforts should be made to always have supplies and emergency drugs on hand, through efficient stock management, allocating an adequate budget to the management of emergencies and making telephone available to place orders and call the ambulance.

6.2.7 Availability of referral documents

At Borgou DUHC, the Policy, Norms and Standards document of family health services and the document of Protocols on family health services should be made available to providers.

At Parakou CHC, the STD/HIV/AIDS algorithm should be made available.

At HOMEL maternity hospital, referral documents should be made available.

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ANNEXES

ANNEXE 1 : Score de compétence en MVA et Counseling

Table 1a: Score moyen par domaine des prestataires de service en MVA

Compétence	HOMEL	DUHC Borgou	CHC Parakou	Moyenne
Se préparer	70.0	80.0	65.0	72.8
Procédure MVA	80.9	81.8	81.3	81.3
Après procédure	54.1	60.0	50.0	55.6
Surveillance physique	52.1	59.7	42.9	53.6
Prise en charge de la douleur	58.8	54.5	25.0	53.1
Administre des antibiotiques	70.6	72.7	75.0	71.9
Autres aspects liés à la santé physique	47.1	54.6	16.7	45.8
Surveillance émotionnelle et appui	35.3	75.7	33.4	49.0
Counseling sur la PF	76.5	89.1	85.0	81.9
Ensemble des étapes	60.6	69.8	52.7	62.8

Table 2a: Score moyen par domaine des prestataires en compétence de counseling pour les PAC/FP

Compétence	HOMEL	DUHC Borgou	CHC Parakou	Moyenne
Approche centrée sur la femme	81.6	50.0	59.4	68.0
La communication verbale	94.1	54.5	70.9	77.6
La communication non verbale	88.2	64.8	62.5	77.0
L'empathie	92.9	90.9	65.0	88.8
Intimité et confidentialité	43.1	51.5	50.0	46.9
Professionnalisme	50.0	86.4	62.5	64.1
Contenu spécifique aux PAC/FP	62.4	41.8	35.0	51.9
Ressources et références	97.1	50.0	56.3	75.8
Population à risque dans les PAC/FP	16.7	34.9	20.9	23.5
Ensemble des aspects	69.57	58.31	53.59	63.70

ANNEXE 2

CARACTERISTIQUES DES DIFFERENTES SALLES DE PRESTATION PAR SITE

MATERNITE DE HOMEL

La salle d'attente

Les caractéristiques de la salle d'attente de HOMEL à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

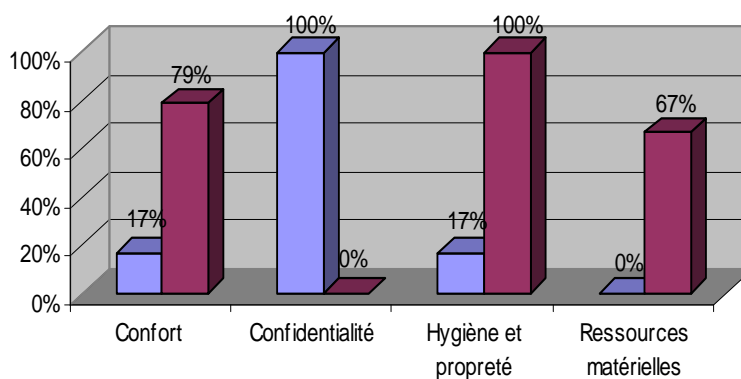
Table 3a : Development du niveau de conformité des modalités de la salle d'attente de HOMEL

Modalités	A l'analyse situationnelle	A l'évaluation
Confort	17%	79%
Confidentialité	100%	0%
Hygiène et propreté	17%	100%
Ressources matérielles	0%	67%

Le confort n'est pas satisfaisant. Il est à 79%. Il y a une amélioration par rapport à l'analyse situationnelle où le confort était à 17%. La confidentialité est absente. Par rapport à l'analyse situationnelle le niveau de confidentialité est passé de 100% à 0%. Ceci s'explique par un réaménagement de la structure de l'accueil des urgences en défaveur de la salle d'attente.

L'hygiène et la propreté sont optimales à 100% alors qu'à l'analyse situationnelle l'hygiène et la propreté étaient à 17%. Le matériel divers n'est pas satisfaisant. Il est à 67%. Il y a une amélioration par rapport à l'analyse situationnelle où les ressources matérielles étaient à 0%.

Chart 1a : Development du niveau de conformité des modalités de la salle d'attente de HOMEL



■ A l'analyse situationnelle ■ A l'évaluation

La salle d'examen médical

Les caractéristiques de la salle d'examen médical de HOMEL à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

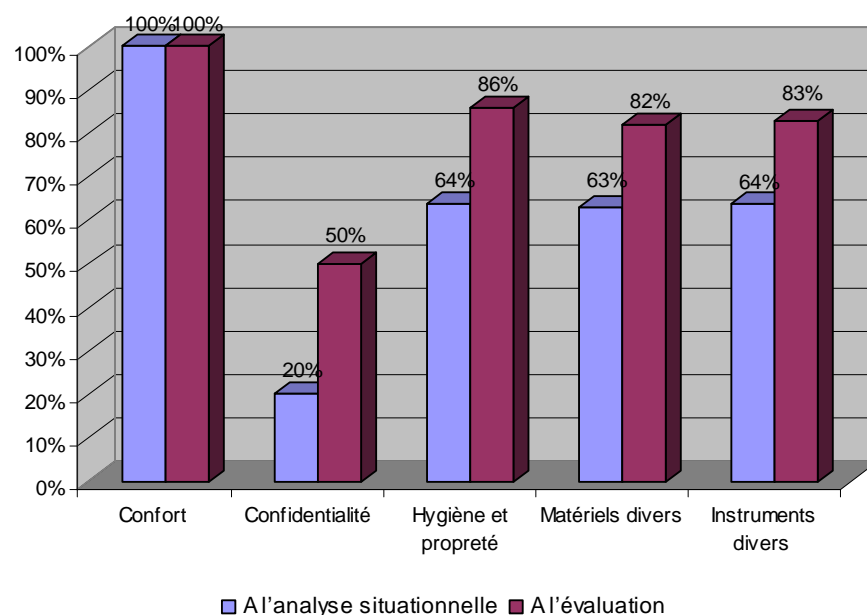
Table 4a : Development du niveau de conformité des modalités de la salle d'examen médical de HOMEL

Modalités	A l'analyse situationnelle	A l'évaluation
Confort	100%	100%
Confidentialité	20%	50%
Hygiène et propreté	64%	86%
Matériels divers	63%	82%
Instruments divers	64%	83%

Le confort est satisfaisant. Il est à 100% et identique à l'analyse situationnelle. La confidentialité n'est pas satisfaisante. Le niveau de satisfaction est estimé à 50% contre 20% au cours de l'analyse situationnelle. Le niveau d'hygiène et de propreté, estimé à 86%, est insuffisant. Cependant il y a eu une augmentation par rapport à l'analyse situationnelle où il était à 64%.

Le matériel divers n'est pas satisfaisant ; il est à 82%. Il y a eu une amélioration par rapport à l'analyse situationnelle où les ressources matérielles étaient 63%. Les instruments divers sont insuffisants et estimés à 83% contre 64% à l'analyse situationnelle.

Chart 2a : Development du niveau de conformité des modalités de la salle d'examen médical de HOMEL



La salle des interventions chirurgicales

Les caractéristiques de la salle des interventions chirurgicales de HOMEL à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 5a : Development du niveau de conformité des modalités de la salle des interventions chirurgicales de HOMEL

Modalités	A l'analyse situationnelle	A l'évaluation
Confort	50%	100%
Confidentialité	100%	100%
Hygiène et propreté	81%	100%
Matériels divers	61%	75%
Instruments divers	33%	100%
Stérilisation/désinfection	60%	100%
Médicaments	59%	100%
Instruments de D & C	56%	100%
Instruments d'MVA	0%	100%

En dehors des matériels divers, toutes les modalités étaient satisfaisantes au niveau de la salle des interventions chirurgicales de HOMEL lors de l'évaluation.

On note une nette amélioration par rapport à l'analyse situationnelle.

La salle de réanimation

Les caractéristiques de la salle de réanimation de HOMEL à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 6a : Development du niveau de conformité des modalités de la salle de réanimation de HOMEL

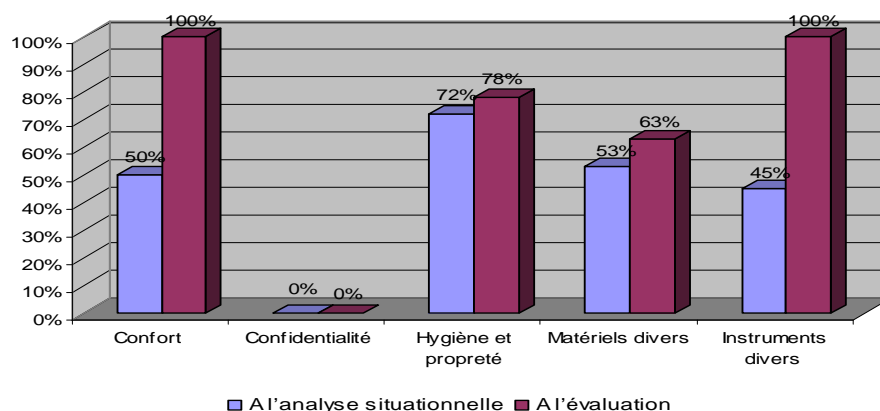
Modalités	A l'analyse situationnelle	A l'évaluation
Confort	50%	100%
Confidentialité	0%	0%
Hygiène et propreté	72%	78%
Matériels divers	53%	63%
Instruments divers	45%	100%

Le confort et les instruments divers sont satisfaisants à 100%. Il y a une amélioration par rapport à l'analyse situationnelle où ils étaient respectivement à 50% et 45%.

Le niveau d'hygiène, de propreté et le matériel divers n'est pas optimal malgré une légère augmentation par rapport à l'analyse situationnelle.

La confidentialité est absente et identique à la situation à l'analyse situationnelle.

Chart 3a : Development du niveau de conformité des modalités de la Salle de réanimation de HOMEL



La salle de diagnostic

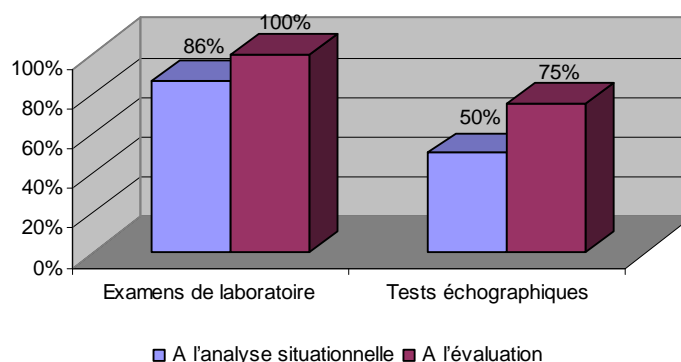
La disponibilité des examens complémentaires en salle de diagnostic (laboratoire) est mentionnée dans le Table ci-dessous.

Table 7a : Development du niveau de disponibilité des modalités de la salle de diagnostic de HOMEL

Modalités	A l'analyse situationnelle	A l'évaluation
Examens de laboratoire	86%	100%
Tests échoCharts	50%	75%

Le niveau de conformité des examens de laboratoire est satisfaisant alors que celui des tests échoCharts est à 75%. Il y a une amélioration dans les deux cas par rapport à l'analyse situationnelle.

Chart 4a : Development du niveau de conformité des modalités de la salle de diagnostic de HOMEL



La salle des soins post abortum et de la planification familiale.

Les caractéristiques de la salle des soins post abortum et de la planification familiale de HOMEL à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 8a : Development du niveau de conformité des modalités de la salle des soins post abortum et de la planification familiale de HOMEL

Modalités	A l'analyse situationnelle	A l'évaluation
Confort	100%	100%
Confidentialité	63%	43%
Hygiène et propreté	80%	83%
Matériels divers	82%	82%
Instruments divers	92%	100%
Stérilisation/désinfection	50%	100%
Méthodes de contraception	58%	100%

Le niveau de la stérilisation/désinfection, des instruments divers et des méthodes de contraception est satisfaisant à 100%. Il y a une nette amélioration par rapport à l'analyse situationnelle.

Le confort est satisfaisant à 100% et identique à la situation de base.

Le niveau de satisfaction de la confidentialité, de l'hygiène, de la propreté et du matériel divers n'est pas optimal.

MATERNITE DU DUHC BORGOU

La salle d'attente

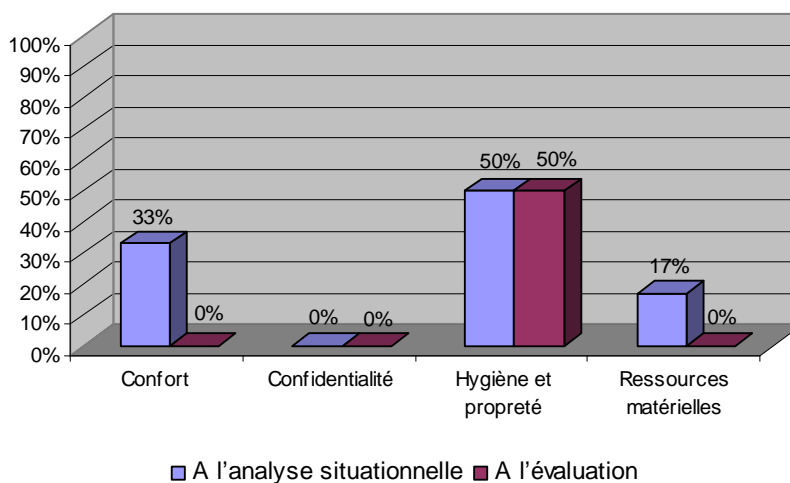
Les caractéristiques de la salle d'attente de la maternité du DUHC Borgou à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 9a : Development du niveau de conformité des modalités de la salle d'attente de la maternité du DUHC Borgou

Modalités	A l'analyse situationnelle	A l'évaluation
Confort	33%	0%
Confidentialité	0%	0%
Hygiène et propreté	50%	50%
Ressources matérielles	17%	0%

Aucune modalité n'est satisfaisante au niveau la salle d'attente. On note une régression du confort et des ressources matérielles. La confidentialité demeure absente de la salle d'attente. Le niveau de l'hygiène et de la propreté n'a pas évolué et est resté à 50%.

Chart 5a : Development du niveau de conformité des modalités de la salle d'attente la maternité du DUHC Borgou



La salle d'examen médical

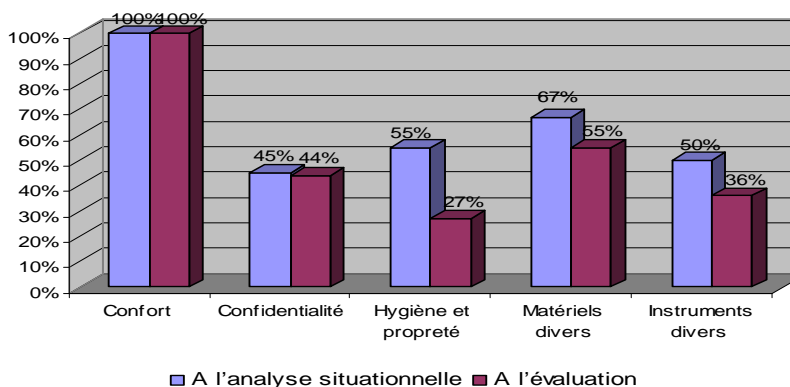
Les caractéristiques de la salle d'examen médical de la maternité du DUHC Borgou à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 10a : Development du niveau de conformité des modalités de la salle d'examen médical de la maternité du DUHC Borgou

Modalités	A l'analyse situationnelle	A l'évaluation
Confort	100%	100%
Confidentialité	45%	44%
Hygiène et propreté	55%	27%
Matériels divers	67%	55%
Instruments divers	50%	36%

La confidentialité n'a pas vraiment été modifiée (45% à 44%). Le niveau de confort est resté adéquat et identique à la situation de départ. On note une régression de l'hygiène, de la propreté, de la disponibilité du matériel et des instruments divers.

Chart 6a : Development du niveau de conformité des modalités de la salle d'examen médical de la maternité du DUHC Borgou



La salle des interventions chirurgicales

Les caractéristiques de la salle des interventions chirurgicales de la maternité du DUHC Borgou à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 11a : Development du niveau de conformité des modalités de la salle des interventions chirurgicales de la maternité du DUHC Borgou

Modalités	A l'analyse situationnelle	A l'évaluation
Confort	100%	100%
Confidentialité	100%	100%
Hygiène et propreté	81%	85%
Matériels divers	58%	70%
Instruments divers	72%	75%
Stérilisation/désinfection	33%	50%
Médicaments	12%	12%
Instruments de D & C	78%	78%
Instruments d'MVA	9%	50%

Le confort et la confidentialité sont demeurés satisfaisants. Il y a une amélioration de l'hygiène, de la propreté, des matériels divers, de la stérilisation / désinfection et de la disponibilité du matériel MVA. Les Médicaments et les instruments de D & C n'ont pas évolué.

La salle de réanimation

Les caractéristiques de la salle de réanimation de la maternité du DUHC Borgou à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 12a : Development du niveau de conformité des modalités de la salle de réanimation de la maternité du DUHC Borgou

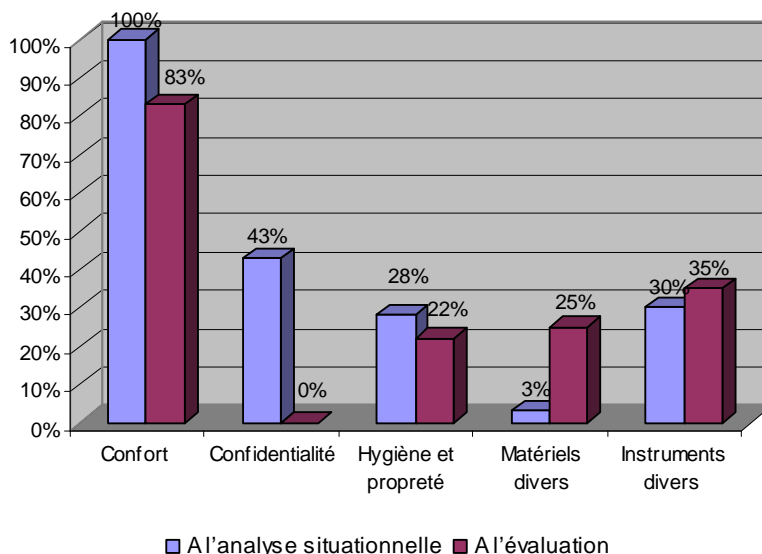
Modalités	A l'analyse situationnelle	A l'évaluation
Confort	100%	83%
Confidentialité	43%	0%
Hygiène et propreté	28%	22%
Matériels divers	3%	25%
Instruments divers	30%	35%

Le confort qui était à un niveau optimal pendant l'analyse situationnelle a subi une légère régression passant de 100% à 83%.

Il y a une régression de la confidentialité, de l'hygiène et de la propreté.

On note une amélioration de la disponibilité des matériels divers a été amélioré passant de 3 à 25% et de la disponibilité des instruments divers qui passe de 30 à 35% bien qu'ils soient à un niveau non satisfaisant.

Chart 7a : Development du niveau de conformité des modalités de la Salle de réanimation de la maternité du DUHC Borgou



La salle de diagnostic

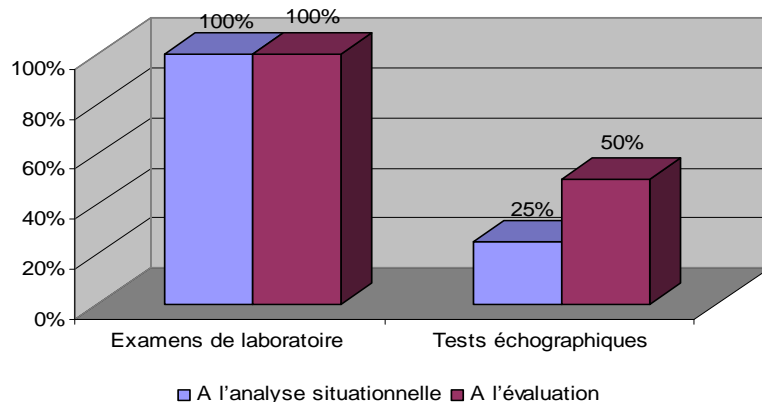
La disponibilité des examens complémentaires en salle de diagnostic (laboratoire) de la maternité du DUHC Borgou est mentionnée dans le Table ci-dessous.

Table 13a : Development du niveau de disponibilité des modalités de la salle de diagnostic de la maternité du DUHC Borgou

Modalités	A l'analyse situationnelle	A l'évaluation
Examens de laboratoire	100%	100%
Tests échoCharts	25%	50%

Les examens de laboratoire sont toujours entièrement disponibles comme à l'analyse situationnelle. Il y a une amélioration de la disponibilité des tests échoCharts (50%).

Chart 8a : Development du niveau de disponibilité des modalités de la Salle de diagnostic de la maternité du DUHC Borgou



La salle des soins post abortum et de la planification familiale.

Les caractéristiques de la salle des soins post abortum et de la planification familiale de la maternité du DUHC Borgou à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 14a : Development du niveau de conformité des modalités de la Salle des soins post

abortum et de la planification familiale de la maternité du DUHC Borgou		
Modalités	A l'analyse situationnelle	A l'évaluation
Confort	100%	100%
Confidentialité	57%	57%
Hygiène et propreté	40%	39%
Matériels divers	73%	73%
Instruments divers	94%	56%
Stérilisation/désinfection	50%	100%
Méthodes de contraception	58%	80%

Le niveau de la stérilisation/désinfection et du confort est satisfaisant à 100%.

Il y a une nette amélioration de la disponibilité des méthodes de contraceptions qui passe de 58% à 80%. La confidentialité, l'hygiène, la propreté, les instruments divers et les matériels divers n'ont pas évolué par rapport à l'analyse situationnelle.

MATERNITE DU CHC DE PARAKOU

La position du Centre de Santé de la Commune dans la pyramide sanitaire nationale explique qu'il ne dispose ni de salle de réanimation ni de la salle des interventions chirurgicales.

La salle d'attente

Les caractéristiques de la salle d'attente de la maternité du CHC de Parakou à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 15a : Development du niveau de conformité des modalités de la salle d'attente de la maternité du CHC de Parakou

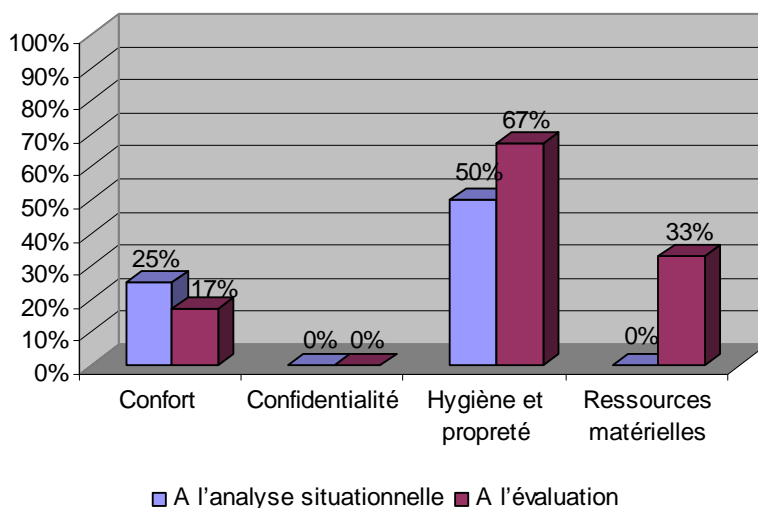
Modalités	A l'analyse situationnelle	A l'évaluation
Confort	25%	17%
Confidentialité	0%	0%
Hygiène et propreté	50%	67%
Ressources matérielles	0%	33%

Aucune modalité n'est satisfaisante au niveau la salle d'attente.

On note une régression du confort. La confidentialité demeure absente de la salle d'attente.

Le niveau de l'hygiène, de la propreté et des ressources matérielles a légèrement augmenté passant respectivement de 50% à 60% et de 0% à 33%.

Chart 9a : Development du niveau de conformité des modalités de la salle d'attente la maternité du CHC de Parakou



La salle d'examen médical

Les caractéristiques de la salle d'examen médical de la maternité du CHC de Parakou à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

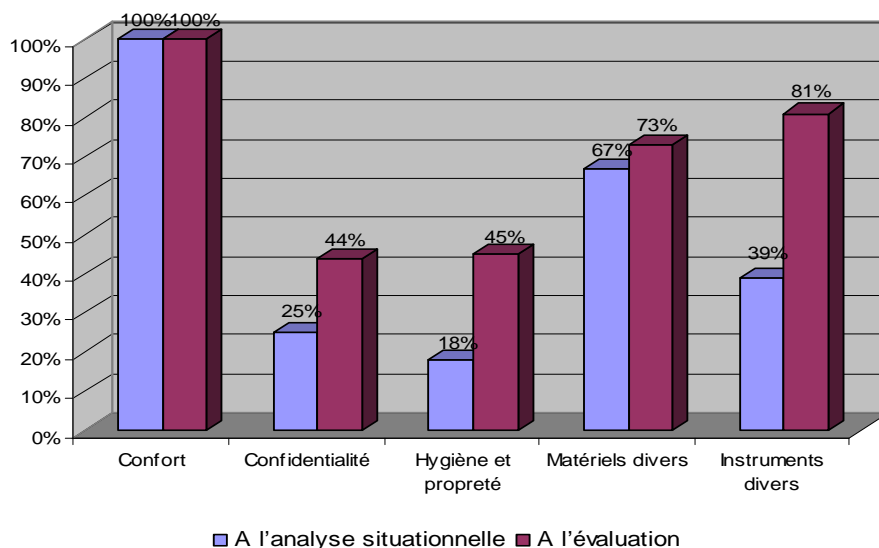
Table 16a : Development du niveau de conformité des modalités de la salle d'examen médical de la maternité du CHC de Parakou

Modalités	A l'analyse situationnelle	A l'évaluation
Confort	100%	100%
Confidentialité	25%	44%
Hygiène et propreté	18%	45%
Matériels divers	67%	73%
Instruments divers	39%	81%

Seul le confort est à un niveau de satisfaction satisfaisant et identique à la situation à l'analyse situationnelle.

On note une amélioration de la confidentialité, de l'hygiène, de la propreté et de la disponibilité du matériel et des instruments divers.

Chart 10a : Development du niveau de conformité des modalités de la Salle d'examen médical de la maternité du CHC de Parakou



La salle de diagnostic

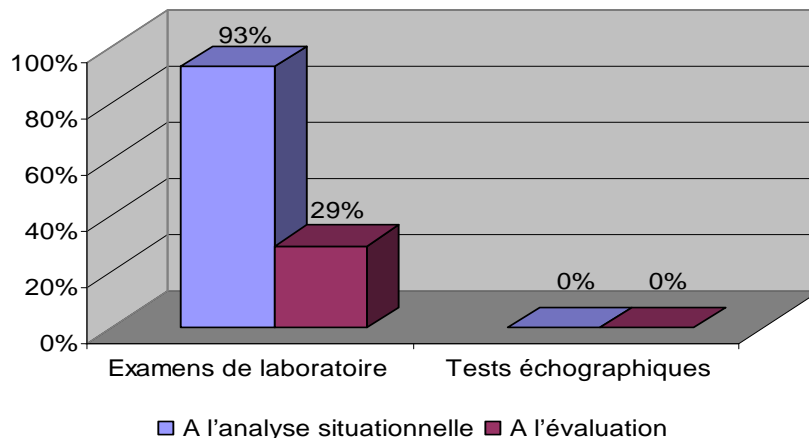
La disponibilité des examens complémentaires en salle de diagnostic (laboratoire) de la maternité du CHC de Parakou est mentionnée dans le Table ci-dessous.

Table 17a : Development du niveau de disponibilité des modalités de la Salle de diagnostic de la maternité du CHC de Parakou

Modalités	A l'analyse situationnelle	A l'évaluation
Examens de laboratoire	93%	29%
Tests échoCharts	0%	0%

Les tests échoCharts ne sont toujours pas disponibles. Les examens de laboratoire ont régressé passant de 93% à l'analyse situationnelle à 29% lors de l'évaluation.

Chart 11a : Development du niveau de disponibilité des modalités de la Salle de diagnostic de la maternité du CHC de Parakou



La salle des soins post abortum et de la planification familiale.

Les caractéristiques de la salle des soins post abortum et de la planification familiale de la maternité du CHC de Parakou à l'analyse situationnelle et à l'évaluation sont mentionnées dans le Table ci-dessous.

Table 18a : Development du niveau de conformité des modalités de la Salle des soins post

abortum et de la planification familiale de la maternité du CHC de Parakou		
Modalités	A l'analyse situationnelle	A l'évaluation
Confort	100%	83%
Confidentialité	50%	57%
Hygiène et propreté	25%	56%
Matériels divers	55%	64%
Instruments divers	56%	86%
Stérilisation/désinfection	50%	50%
Méthodes de contraception	63%	60%

Aucune modalité n'est satisfaisante lors de l'évaluation. Le confort, la stérilisation/désinfection et la disponibilité des méthodes de contraception ont diminués alors que l'hygiène, la propreté et la disponibilité du matériel et des instruments divers sont améliorées.