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IMPROVING CHILD HEALTH IN SENEGAL

BASICS III

Introduction

From 1994 to 2006, USAID/BASICS implemented a comprehensive technical assistance program designed to scale up the use of interventions that have been proven effective in combating the primary causes of infant and child mortality in 22 of Senegal's 56 health districts. Technical areas included—

- Vaccination and immunization
- Nutrition (including essential nutrition actions, community-based growth promotion, and PD-Hearth)
- Essential Newborn Care (ENC)
- Community case management of pneumonia (integrated with diarrhea and malaria case management)

Click [here](#) to download *USAID/BASICS' Senegal Program, 1994-2006*.

Seeking an opportunity to maintain USAID/BASICS' presence in Senegal after expiration of the project's technical assistance agreement with the Ministry of Health in September 2006, USAID and USAID/Senegal jointly recommended that the project support the roll-out of neonatal, nutrition, and community case management interventions in Fatick, a non-USAID-sponsored region. Fatick is comprised of six health districts, 80 health posts, and nearly 300 functional or mostly functional health huts. The region's under-5 population is 123,000, equivalent to 7% of the national population of that age group.

The planned entry of USAID/BASICS into Fatick in 2007 created an opportunity to establish a partnership to coordinate activities of the regions' numerous child survival stakeholders and improve impact through economies of scale. Members would harmonize strategic approaches and jointly plan implementation activities, as well as share in the financing of health programming in the region. From January 2007 to March 2009, USAID/BASICS thus became principle organizer of a successful partnership in Fatick that included the Ministry of Health, local government, implementing agencies, and community groups, and that was formed around the common goal of contributing to the attainment of MDG 4 and 5.

This partnership that was created through the relationships forged between stakeholders, and the coordinated approach to implementation of health interventions is a significant result of collaboration which did not exist before. The regular and active presence of partners at all the meetings convened by the regional Ministry of Health and the regional government, joint advocacy, co-delivery and co-financing of training sessions, and the sharing of information represent an invaluable model for successful implementation of region-wide health interventions through partnership for other parts of the country.

Structure of the Fatick Partnership

The following table provides the detailed roles and responsibilities of participating organizations in the Fatick partnership, including each member's primary objectives in the region.

Table 1
Fatick Child Health Stakeholder Partnership Relationships

Partner	Mission in Fatick	Role in the Fatick Partnership
Ministry of Health, Government of Senegal, and Universities		
Division of Nutrition and Child Survival (DANSE)	Advocacy and technical assistance for the implementation of child survival programs.	<ul style="list-style-type: none"> ▪ Operations research (at the district level) to support the introduction of zinc and new low-osmolarity ORS for the treatment of Diarrhea. ▪ Leadership and oversight to ensure that protocols and other directives relevant to C-IMCI are followed by stakeholders.
Division of Reproductive Health	Advocacy and technical assistance for the implementation of reproductive health programs (including within IMCI and newborn health).	Leadership and oversight to ensure that protocols and other directives relevant to newborn and reproductive health are followed by stakeholders.
Nutritional Reinforcement Program (PRN) of the Prime Minister's Office (through its community executing agencies)	<ul style="list-style-type: none"> ▪ Strategic, financial, and logistical support for the fight against malnutrition. ▪ Implementation of community-level growth promotion and monitoring. 	<ul style="list-style-type: none"> ▪ Establishment of weighing sites and supply of corresponding equipment and supplies. ▪ Implementation of community based growth promotion activities to identify and address cases of malnutrition. ▪ Training of “motivators” for community health volunteers.
<ul style="list-style-type: none"> ▪ Cheikh Anta Diop University of Dakar (UCAD) ▪ Institute for Research on Development (IRD) ▪ Pasteur Institute of Dakar (IPD) 	Operational research in IPT and malaria vaccine development.	<ul style="list-style-type: none"> ▪ Implementation of research sites ▪ Collaboration with the regional and district MOH, and community health workers.
International and Multilateral Agencies, and NGOs		
USAID/BASICS	Introduction of CCM of pneumonia and community-level essential newborn care.	<ul style="list-style-type: none"> ▪ Training of trainers and community health workers. ▪ Post-training follow-up ▪ Supervision
UNICEF	Technical assistance for child survival programs, particularly EPI.	<ul style="list-style-type: none"> ▪ Supply of vehicles, cold chains, vaccines, and related commodities for EPI. ▪ Supply of equipment to health huts for CCM, including scales (for growth monitoring) and timers (for diagnosing pneumonia).
FAD II (African Development Bank health project)	Assistance to infant and child mortality-driven programs via implementation support and capacity building for emergency obstetric care, facility-level IMCI, and supervision and NGO contracting for community-level interventions.	<ul style="list-style-type: none"> ▪ Construction of 3 health centers and renovation of 18 health posts. ▪ Provision of vehicles. ▪ Training of 96 district-level staff in IMCI ▪ Financing of community-level activities (through a grant to the NGO, ACDEV)
WAHO	Financial and technical assistance to support advocacy for the scale-up of child survival interventions.	<ul style="list-style-type: none"> ▪ Hosted workshops to advocate, create, launch, and consolidate the partnership amongst <u>all</u> of the region's child survival stakeholders. ▪ Financing of activities for the scale-up of child survival interventions. ▪ Advocacy to the Economic Community of West African states (CDEAO)

Table 1 (continued)
Fatick Child Health Stakeholder Partnership Relationships

Partner	Mission in Fatick	Role in the Fatick Partnership
International and Multilateral Agencies, and NGOs (cont.)		
World Vision	Implementation of PRN, PMI, and community health program.	<ul style="list-style-type: none"> ▪ Construction of health huts ▪ Training of community health workers. ▪ Training of community <i>relais</i> in malaria, including promotion of insecticide-treated bed net use
CCF/PMI	Implementation of community-level health programs, particularly for malaria prevention and treatment.	<ul style="list-style-type: none"> ▪ Training of community <i>relais</i> and motivators ▪ Implementation of ACT's in health huts ▪ Promotion of insecticide-treated bed net use
Bilateral cooperation with foreign countries		
The Belgian Cooperation's ASSRMKF (Health Systems Assistance for the Kaolack et Fatick Regions) Project	Health systems reinforcement (quality, supplementary insurance systems, training, and supervision).	<ul style="list-style-type: none"> ▪ Provision of vehicles and equipment. ▪ Rehabilitation and supply of health service delivery points. ▪ Training ▪ Institutional support. ▪ Support to the local supplementary insurance system.
National NGOs		
<ul style="list-style-type: none"> ▪ ACDEV (Action for Development) ▪ ARAF 	Implementation of PRN and FAD II.	<ul style="list-style-type: none"> ▪ Construction of health huts ▪ Training of community health workers, particularly in nutrition, C-IMCI and perinatal and Essential Newborn Care.
District and Community Structures		
<ul style="list-style-type: none"> ▪ Regional Council ▪ Rural Councils 	Health sector management, including: construction and upkeep of health huts, recruitment of community health workers, and financing of activities.	<ul style="list-style-type: none"> ▪ Total or partial funding for decentralized health program management. ▪ Recruitment of support personnel (in certain health districts).
Health Committees	Financial support for health services and health promotion.	Assumption of operational costs for health structures, including procurement of drugs.

Results and Achievements

Organized by USAID/BASICS in partnership with the Regional Ministry of Health, and under the auspices of the governor of Fatick, the Fatick partnership formally met for the first time in November 2007 to map out existing health huts (community health sites) and corresponding services supported by existing stakeholders. With the goal of achieving region-wide coverage, the effort helped show where programs needed support to round out yet-complete packages of services, and where CCM would need to be initiated for the first time.

The summary of the resulting program:

	Essential Newborn Care (ENC)	Community Case Management (CCM)
Coverage	<ul style="list-style-type: none"> 89 out of 95 health facilities enrolled. 	<ul style="list-style-type: none"> 171 out of 202 health huts operationalized.
Implementation	<ul style="list-style-type: none"> 21 district-level trainers trained in ENC 103 out of 112 health care workers (mostly nurses) trained in ENC through 6 training sessions and 6 post training sessions.¹ 	<ul style="list-style-type: none"> 59 health post nurses-in-charge trained as trainers in C-IMCI. 233 out of 288 community health workers trained in C-IMCI.
Selected Results	<ul style="list-style-type: none"> Drying and wrapping of newborns rose from 23% (pre-training) to 72%. Early breastfeeding increased from 20% to 71%. Practice of Active Management of the Third Stage of Labor (AMSTL) rose from 1% to 47%. Early postnatal visits (before day 3) went from 11% to 46% and postnatal visits (day 9-15) went from 6% to 30%. 	<ul style="list-style-type: none"> 1,426 cases of childhood illness were seen, of which 42% were cough or acute respiratory infection, 42% fever or malaria, and 16% diarrhea. The outcome of 99% of all cases seen, as reported by community health workers, was full recovery.

Click [here](#) to download *IMCI-C: Manual for Community Health Workers and Matrones*.

Click [here](#) to download *Technical Manual: Essential Newborn Care*.

With respect to ENC, efforts to improve care were coupled with counseling of family members. It is thus important to recognize the relationship between quality improvement and demand creation when considering increases in early postnatal and postnatal visits, as well as early breastfeeding.

In Fatick 37% of sick children presenting at health huts were malnourished (35% mildly malnourished and 2% severely malnourished). Thus nutritional status has an underlying impact on the region's child mortality rate and requires aggressive efforts to prevent malnutrition in the future.

¹ The aim of the follow-up sessions was to supervise implementation of ENC at the facility level, and collect data from patient registers (including those from 6 months previous to training and 6 months after training) to reviewing progress in relation to key indicators.

In addition, a number of key issues related to CCM were identified in relation to the quality of care that ill children received. Firstly, some 21% of malaria cases were not classified, showing the need for refresher training in diagnostics. Secondly, 15% of children diagnosed with pneumonia did not receive appropriate treatment with cotrimoxazole, representing a significant problem that requires reinforced supervision and post-training follow up by the District Health Team. Finally, only 18% of diarrhea cases received zinc and ORS, suggesting the need to better ensure commodity availability.

Lesson learned on partnership-building

The success of the partnership relied heavily on effective, visible leadership by the peripheral Ministry of Health. In this case, the Chief Regional Medical Officer championed the partnership as a mechanism for achieving the MDGs). The existence of a "locomotive" partner (i.e., USAID/BASICS), with proven technical experience in child survival programming proved to be the best asset for leadership and convincing other partners to join this type of partnership.

The partnership was based upon, not only common objectives and shared political will amongst all members, but a commitment to participate actively in collaborative meetings and activities, and to fulfill agreed-upon roles. Just as important, it also relied heavily on the mutual respect of its members, particularly in the recognition of the freedom of choice of activities by each partner. That is, the imposition of a role that goes beyond or outside the mission of any member would not be imposed.

In spite of the efficiency of this partnership, a set of challenges for achieving success in community-level programming remains consistent with other CCM programs, regardless of their structure. These relate specifically to the motivation of community health workers, the quality and the regularity of the supervision, the follow-up of community activities, and especially the effective inclusion of beneficiary populations (through local collectivities) in programming.

Transition

With the departure of USAID/BASICS, USAID's *Programme de Santé-Santé Communautaire* (USAID/PSSC) has now become the Ministry's co-coordinator of the Fatick partnership. A key recommendation for reinforcing the partnership as it moves forward is better establishing local authorities as the central key players for promoting child health because they are the central players in a decentralized health system.