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# Partnership for Development Facility: Mother and Child Health Support Project (MCHSP) in Senegal

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## Abstract

**Introduction**: The objective of this work was to describe the MCHSP/*PASME* device, co-funded since 2014 by the State of Senegal and the French Development Agency (AFD) for five years.

**Method:** The qualitative, transversal and descriptive study had four approaches:①**l**iterature review**,** ②**i**nterviews with structural managers, ③data collection validated by the medical region (MR), and ④direct observations of the construction and/or rehabilitation/ extension sites.

**Results:** Beneficiary structures included three ministerial departments, two non-hospital public health institutions, three medical regions, and one national coordination unit (NCU). The objectives were threefold: ① Strengthen the teams' capacities; ②Increase the supply and demand for family planning; ③Improve the conditions for taking care of pregnancies, deliveries and newborns.

The physical setting included three of the 14 regions of Senegal: Louga in the north; Kolda and Sedhiou to the south, for a total of 14 of the 76 health districts in the country. The institutional framework included a central level (three bodies) and a regional level (two bodies). The logic model was articulated around resources and activities (primary targets) to generate outputs (secondary targets) whose effects contribute to the impact. The implementation was based, for each responsibility center, on an annual work plan (AWP) revised and consolidated by the national coordination unit (UCN), then validated by the steering committee, before being submitted to the French Development Agency (AFD) for its non-objection opinion. It has contributed in a good way to the improvement of some health indicators.

**Conclusion:** This MCHSP/*PASME* scheme is adequate for a better contribution to the reduction of maternal and infant-juvenile morbidity and mortality in Senegal.

**Keywords:** Partnership; French Development Agency (AFD); Reproductive Health (RS); Project; MCHSP/*PASME* ; *Conseil Santé*

## Introduction

The health of mothers and children is a global concern. It was previously taken into account in the Millennium Development Goals (MDGs) 4 (reducing child mortality) and 5 (improving maternal health) [1]. Now, it integrates the 3rd Sustainable Development Goal (SDG): "To enable everyone to live in good health and promote the well-being of all at all ages" [2]. Also, at the G8 Summit in June 2010

in Muskoka / Ontario and at the February 2011 "Population, Development and Family Planning" Conference in Ouagadougou, France committed to support interventions in reproductive health and family planning (RH/FP) in 8 countries including Senegal.

In Senegal, pregnancies remain too early, too frequent, too close together and/or too late [3]. Deaths are related: for 77% of mothers to dystocia, hemorrhage and infection; for 86% of newborns to infection, asphyxia and prematurity [3]. These complications are mainly due to a quantitative and/or qualitative failure of the prenatal and/or postnatal consultations, the fragility of the mothers (malaria, under nutrition, anemia, HIV/AIDS) and the lack of knowledge about how to deal with signs of danger [4]. The country has endorsed the 2005 Paris Declaration, the 2008 Accra Agenda for Action, and the 2009 International Health Partnership and Related Initiatives (IHP+). The second National Strategy for Health Development Plan (NSHDP 2), for its first strategic orientation, accelerates the fight against maternal, neonatal and infant-juvenile mortality and morbidity [5]. The Emerging Senegal Plan (PSE), in Section 2 (human capital, social protection and sustainable development), aims to ensure efficient public health services through the improvement of the quality of health services in general, and the health of the mother and the child in particular [6].

Progress has been made in terms of investments, capacity building, and equipment. The maternal mortality rate per 100,000 live births dropped from 510 in 1992 to 392 in 2011 [3]. From 2005 to 2011, neonatal mortality was reduced from 35 ‰ to 29 ‰, infant mortality from 61 ‰ to 47 ‰, and infant-juvenile mortality from 121 ‰ to 72 ‰ [7]. However, despite these performances, the maternal and infant-juvenile mortality rates remained high. It is for this reason that, since 2015 and for five years, the State has co-financed, with the French Development Agency (AFD), the Mother and Child Health Support Project (MCHSP/*PASME*) whose scheme description is the subject of this work [8,9].

## Methodology

The qualitative, transversal and descriptive study was conducted from 1 January to 31 June 2018. The participatory process involved different levels of responsibility: Ministry of Health, Medical Regions, Health Districts and Public Health Institutions. The approaches used were of four types: literature review, collection of data validated by the medical region (RM), interviews with structural managers, and direct observations.

The literature review covered all the reports, statistical yearbooks and reports focusing on Reproductive Health and Family Planning (RH/FP), within the framework of MCHSP/*PASME*. These documents were provided by the heads of the responsibility centers (coordinator, chief medical officers, directors, department heads).

The collection of data validated by the medical region was done through coordination meetings during which the activities funded by MCHSP/*PASME* are an integral part of the agenda. The planning and execution of these activities is discussed and adopted with the main actors of the regional framework team: Regional Coordinator of Reproductive Health (RH), Planner, and Supervisor.

The interviews with the managers of the structures concerned the problems related to the planning and/or execution of the activities in the regions. An input mask, developed from the Sphinx Software, made it possible to have a user-friendly questionnaire, with closed and open questions about the organization and functioning of MCHSP/*PASME*.

Direct observations were made at the site level as part of the monitoring/evaluation missions. The accompaniment of these missions allowed the visit of all the districts and hospitals which benefited from the research projects, construction and/or rehabilitation/extension of health infrastructures.

The data was the subject of a thematic content analysis which ultimately allowed the description of the device in six (6) points: Objectives, Physical Framework, Institutional Framework, Beneficiary Structures, Logic Model, and Execution.

## Results

## Objectives of MCHSP/*PASME*

The objectives were threefold: Strengthen the capacities of the teams in charge of reproductive health programs; Improve the conditions for taking care of pregnancies, deliveries and newborns; Increase the supply of and demand for reproductive health and family planning (RH/FP) services.

## Physical setting of MCHSP/*PASME*

Senegal had 14 regions, of which 3 were covered by MCHSP/*PASME*: Louga in the north with eight health districts; Kolda and Sedhiou in the south with three HD each (Figure 1). The Louga region covered 24,889 km$^2$ for 950,102 inhabitants (38/km$^2$); that of Kolda 13 771 km$^2$ for 725 690 inhabitants (53/km$^2$); and that of Sédhiou 7,341 km$^2$ for 500,064 inhabitants (68/km$^2$). The total fertility rate and the perinatal mortality rate were respectively 4.8 and 50 ‰ in Louga; 6.8 and 35 ‰ in Kolda; 6.9 and 39 ‰ in Sedhiou (Table 1).

| Indicators | North | South | | Senegal |
|---|---|---|---|---|
| | Louga | Kolda | Sedhiou | |
| Number of polygamous men (15-49 years old) | 11,2 | 16,4 | 30,1 | 11,8 |
| Median age at first intercourse / Women 20-49 years | 18,3 | 16,1 | 16,6 | 19,0 |
| Total fertility rate / females 15-49 years | 4,8 | 6,8 | 6,9 | 5,0 |

| Indicators | North | South | | Senegal |
|---|---|---|---|---|
| | Louga | Kolda | Sedhiou | |
| Proportion of adolescent girls with a live birth | 16,7 | 34,4 | 20,7 | 15,5 |
| FP / modern method women (15-49 years old) in union | 7,4% | 10,5% | 6,4% | 12,1% |
| SNB FP / women (15-49) in union | 28,0 | 26,8% | 23,2% | 29,4% |
| Perinatal Mortality Rate | 50 | 35 | 39 | 38 |
| Proportion of women with ANC / trained providers | 94% | 88% | 89% | 93,3% |
| Proportion of assisted childbirth / trained provider | 63,3% | 33,3% | 34,9% | 65,1% |
| Postnatal care ≤ 2 days / live births | 67,2% | 34,0% | 55,0% | 68,0% |
| Mature 15-49-year-old women | 39,3% | 25,9% | 21,3% | 22,0% |
| Prevalence of HIV (women + men) 15-49 years | 0,1% | 2,4% | 1,1% | 0,7% |
| Proportion of excised women | 3,8% | 84,8% | 86,3% | 25,7% |

**Table 1:** Level of health indicators in the three beneficiary regions of MCHSP/*PASME* and Senegal [N] source: EDS 2010-11


**Figure 1:** Senegal administrative subdivision. Source : Le Sénégal en régions published by Stelle Djisébénia (http://paysdelaterenga.over-blog.com/le-senegal-en-regions.html) 26/09/2018

## Institutional framework of MCHSP/*PASME*

The institutional framework included a central level and a regional level. The central level had three bodies: Steering Committee, Technical Monitoring Committee, and National Coordination Unit (NCU). The UCN, under the supervision of the Directorate-General for Health (DGS), was supported by *Conseil Santé* and the NGO Humanity and Inclusion (HI). The regional level consisted of two bodies: the Technical Monitoring Committee and the Regional Coordination Unit (Figure 2).

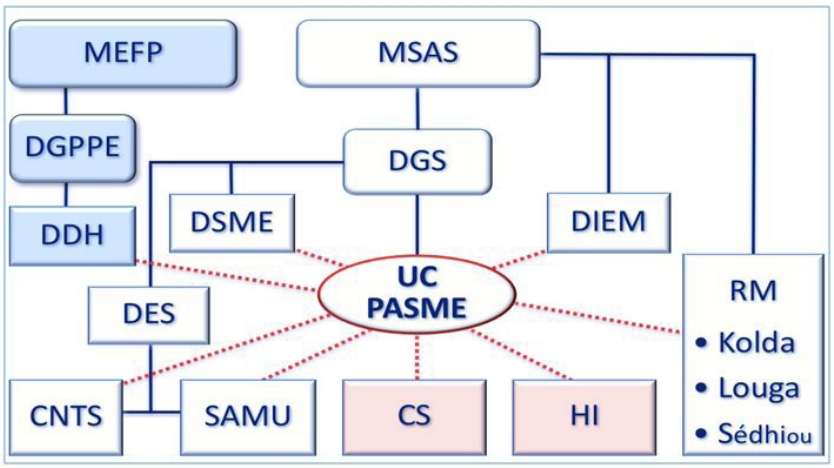


**Figure 2:** Organizational Structure (full train) and functional (dotted) structure of MCHSP/PASME: Conseil Santé (CS); Human Capital Development Directorate (DDH); Directorate General of Planning and Public Policy (DGPPE); Directorate of Infrastructure, Equipment and Maintenance (DIEM); Department of Maternal and Child Health (DCME); Humanity and inclusion (HI); Ministry of Economy, Finance and Planning (MEFP); Ministry of Health and Social Welfare (MSAS); Emergency Medical Assistance Service (SAMU); Medical Regions (MR); Coordination Unit (CU)

## Beneficiary structures of MCHSP/*PASME*

The beneficiary structures were of six types: Department of Maternal and Child Health (DMCH); Directorate of Infrastructure, Equipment and Maintenance (DIEM), Human Capital Development Directorate (HCDD), National Center for Blood Transfusion, Medical Regions of Kolda, Louga and Sedhiou (Table 2), and National Coordination Unit (NCU) of MCHSP/*PASME*.

| Area | Cadre | Beneficiary Structures | Regions | | | |
|---|---|---|---|---|---|---|
| | | | L | K | S | T |
| RESEARCH | Hospitals | Maternity and pediatrics | 1 | 1 | 1 | 3 |
| | Health Districts | Health centers | 3 | 1 | 1 | 5 |
| EXTENTION AND/OR REHABILITATION | Hospitals | Maternity | 1 | 1 | 1 | 3 |
| | | Pediatrics | 1 | 1 | 1 | 3 |
| | | Operating room | - | 1 | - | 1 |
| | Health Districts | Nutritional Recovery Center | - | 1 | - | 1 |
| | | Expanded Program on Immunization (EPI) | - | 1 | - | 1 |
| | | Maternity (CS Kolda and Sedhiou) | - | 1 | 1 | 2 |
| | | Multipurpose room (CS Sedhiou) | - | - | 1 | 1 |
| | Reception and Call Control Center (RCCC) | | - | 1 | - | 1 |
| CONS-TRUCTION | Hospitals | Blood Transfusion Center | 1 | - | - | 1 |
| | | Blood transfusion station | 1 | 2 | - | 3 |
| | Health Districts | Type 1 Health Center (CS1) | 1 | - | - | 1 |
| | | Type 2 Health Center (CS2) | 1 | 1 | 1 | 3 |
| | | Mini SAU and operating theater | - | 1 | - | 1 |

**Table 2:** Projects planned under the MCHSP/*PASME* at the level of Louga (L), Kolda (K), Sedhiou (S) and total (T)
CS1: Health center without surgical operations block; CS2: Health Center with surgical operations Block

## MCHSP/*PASME* Logic Model

The resources (human and financial) allow the execution of activities for the benefit of primary targets (construction and rehabilitation/extension of infrastructure, provision of vehicles, equipment and materials, training supervision of administrative and technical staff and awareness of the population). Outputs go to secondary targets: strengthening of the technical platform, team planning capabilities, support of technical staff, and community involvement. The effects (improved quality of family planning services, antenatal care, delivery, caesarean, and post-natal consultation, as well as increasing their use) are of likely to contribute to the impact: reduction of maternal and infant-juvenile mortality (Figure 3).

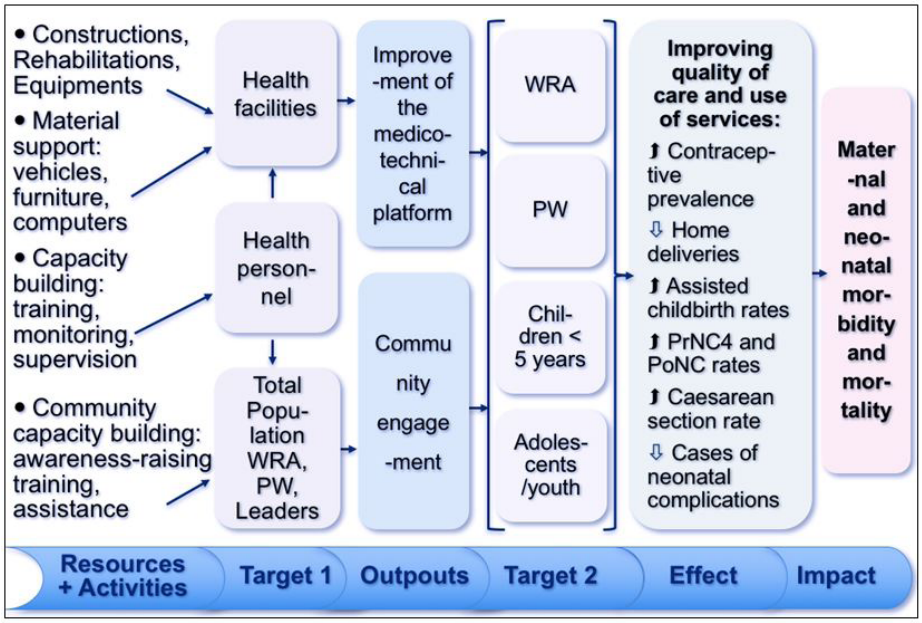


**Figure 3:** MCHSP/PASME Logic Model: Women of Reproductive Age (WRA); Pregnant women (PW); Prenatal consultation (PrNC); Post-natal consultation (PoNC)

## Execution of *PASME*

Execution is based on an annual work plan (AWP) for each responsibility center. The AWP, revised and consolidated by the national coordination unit, must then be validated by the steering committee before being submitted to AFD for a non-objection opinion.

From 2016 to 2017, there was an improvement in the contraceptive prevalence rate (9.5% ⇨10.80%), completion rates in CPN (38.26% ⇨55.42%), proportions of abortions that have benefited from intrauterine manual aspiration (24.28% ⇨26.00%) and deliveries assisted by skilled personnel (48.05% ⇨66.54%), as well as from the number of maternal deaths (39.28% ⇨26.00%).

## Discussion

## limitations

The main limitation of this work is its restriction to the only scheme of MCHSP/*PASME* whose feasibility was attested by a study in October 2012 [10]. Indeed, the project evocation directly reflects the activities, results and impacts, which can only be discussed after sharing the MCHSP/*PASME* mid-term evaluation report [11]. They could then be published later. Meanwhile, the scheme could be described in six bridges: objectives, physical frameworks, institutional framework, beneficiary structures, logic model, and execution.

## Objectives of MCHSP/*PASME*

The three objectives cover most reproductive health and family planning (RH/FP) concerns for which actions can lead to reductions in maternal and infant mortality [3,9]. Building the capacity of the teams in charge of RH/FP programs gives them more expertise in providing better quality services. Improving the conditions for taking care of pregnancies, deliveries and newborns strengthens the motivation of service providers and, consequently, the environmental and technical quality of the services offered by MCHSP/*PASME*. Increasing the supply of and demand for RH/FP provides better coverage of the population in RH/FP service, particularly within the physical setting.

## Physical setting of MCHSP/*PASME*

The physical setting of MCHSP/*PASME* is composed of the three most disadvantaged regions. For the extended and the population density, the region of Louga occupies the 3$^{rd}$ and 11$^{th}$ places; Kolda the 6$^{th}$ and 9$^{th}$ places; and Sédhiou the 9$^{th}$ and 6$^{th}$ places [12]. Populations are scattered over large areas and long distances reduce the accessibility of reproductive health and family planning (RH/FP) services. This justifies, in part, the low level of the main indicators of RH/FP (total fertility rate, contraceptive prevalence and perinatal mortality) which classify, in descending order, Louga, Kolda then Sedhiou, and whose repositioning requires a good institutional framework [13].

## Institutional framework of MCHSP/*PASME*

The institutional framework includes a central level and a regional level. At the central level, three bodies are set up (steering committee, technical monitoring committee, and coordination unit) to coordinate the activities planned in the logical framework. At the regional level, two bodies (technical monitoring committee and coordination unit) are responsible for the day-to-day management of MCHSP/*PASME*. The national coordination unit has relations, not hierarchical, but functional with the ministerial departments, and contractual with *Conseil Santé* and Humanity and Inclusion. *Conseil Santé* medical service, to provide technical assistance, hired five experts. The two, long-term residents, were: one in Louga, and the other in Kolda and Sédhiou. The other three, intermittent, were placed: one in the Department of Maternal and Child Health (DMCH), and the other two in the Directorate of Infrastructure, Equipment and Maintenance (DIEM). The expertise was thus well shared with all the beneficiary structures.

## Beneficiary structures of MCHSP/*PASME*

Beneficiary structures all directly or indirectly affect the implementation of MCHSP/*PASME*. The Department of Maternal and Child Health (DMCH) coordinates preventive and curative activities concerning reproductive health and family planning (RH/FP) [14]. The Directorate of Infrastructure, Equipment and Maintenance (DIEM) is responsible for infrastructure monitoring (design and execution) and equipment (acquisition, installation, maintenance) [14]. The Directorate of Human Capital Development (DHCD), Directorate General of Planning and Public Policy (DGPPE) belonging to the Ministry of Economy, Finance and Planning (MEFP), provides strategic support for population policies. The National Blood Transfusion Center coordinates strategies for improving the availability of blood in health facilities and supports the establishment of a blood transfusion center or post. Medical regions are the level of execution of MCHSP/*PASME* activities: training and supervision of staff, maternal and neonatal death audits, information sharing, construction and/or renovation/extension of infrastructure. The National Coordination Unit (NCU) initiates, drives and/or accompanies all activities (planning, implementation and monitoring/evaluation) related to MCHSP/*PASME*. She oversees the other responsibility centers and organizes the national meeting for quarterly monitoring of technical and financial executions. The strengthening of these centers of responsibility justifies the technical support of *Conseil Santé* and the NGO Humanity and inclusion (HI), which follows the logic model.

## MCHSP/*PASME* Logic Model

The logic model is the baseline that guides the expectation of predefined goals. Human resources are available and financial resources positioned at each responsibility center by AFD to facilitate mobilization. The activities were well chosen for the primary targets: construction and rehabilitation/extension of structures, provision of vehicles, equipment and materials, training and supervision of staff, awareness of the population. Outputs (strengthening technical and team planning and technical staffing capacity, and community engagement) are calibrated for secondary targets (women of reproductive age and/or pregnant, children and adolescent(s)/youth). The effects (improved quality of family planning services, antenatal care, deliveries, caesareans, and post-natal consultation, as well as the increase of their use), to better contribute to the impact (reduction of maternal and infant-juvenile mortality) calls for a good execution.

## Execution of MCHSP/*PASME*

The implementation of MCHSP/*PASME* is based on annual work plans (AWPs) that go through several verification steps for their operationalization. Each responsibility center prepares and submits its AWP to the National Coordination Unit (NCU). The NCU reviews and consolidates the AWP and sends it to the steering committee, which must validate it before submission to the AFD for non-objection notification. At each stage of the circuit, the AWP can, if necessary, be returned to the lower level for correction. No AWP activity can be performed before obtaining the non-objection notification; but once it is obtained, all the activities planned in the PTA can be performed. The fear at this level is the repetition of union strike slogans, which could hinder the rate of execution of certain activities and, therefore, reduce the level of performance of MCHSP/*PASME*. This device has significantly improved the motivation of staff and impacted, in part, health indicators.

## Conclusion

The Mother and Child Health Support Project (MCHSP/*PASME*) is part of the National Program for Reproductive Health (NPRH) and in line with the Emerging Senegal Plan (PSE). It is set up to contribute to the fight against maternal and infant mortality. Its intervention system is in perfect harmony with Senegal's strategic orientations. The activities, if carried out as foreseen by the logical framework, must give good results, with a positive impact expressed by the reduction of maternal and infant mortality.

## References

1. United Nations (2013) Millenium Objectives for development Report, New York PP : 60.

2. United Nations / Regional Information Center (UNRIC) (2019) Sustainable Development Goals (SDGs). Selection of online resources. Info point. Library, Information sheet.

3. Ministry of Health, Public Hygiene and Prevention / Department of Health / Division of Reproductive Health. (2011) Strategic Plan for Reproductive Health 2012-2015: 38.

4. MSAS / DGS / DSRSE (2014) Assessment of emergency obstetric and neonatal care needs in Senegal 2012-2013 Report: 135.

5. Ministry of Health, Public Hygiene and Prevention (2009) National Health Development Plan (PNDS) 2009-2018. PP: 86.

6. Senegal Emerging Plan (PSE) February 2014: 137.

7. Senegal / National Agency for Statistics and Demography (ANSD) (2014) Demographic and Continuous Health Survey (EDS-Continue).

8. AFD financing agreement (2013).

9. AFD CNS financing agreement (2015).

10. Project feasibility study "strengthening the reproductive health system in Senegal, especially in the Louga region", AFD: 5-76.

11. Fataneh Zarinpoush (2018) Project evaluation guide for non-profit organizations; Canadian vonlunteerism Initiative / Canadian Initiative for Volunteering; 2006 Imagine Canada: 83.

12. Senegal / National Agency for Statistics and Demography (ANSD) (2015) Senegal in brief / Regions / Population and Areas.

13. Senegal / National Agency for Statistics and Demography (ANSD) and ICF International - 2012. Demographic and Health Survey with Multiple Indicators in Senegal (EDS-MICS) 2010-2011. Calverton, Maryland, USA: ANSD and ICF International : 1-320.

14. Senegal (2018) Ministry of Health and Social Action (MSAS) Directions.