3RD ECOWAS FORUM ON BEST PRACTICES IN HEALTH

Book of Abstracts

"Promoting Multi-sectoriality to achieve Maternal, Newborn, Child and Adolescent and Youth (MNCAYH) Health-related Sustainable Development Goals"

23 - 25 October 2018

Alisa Swiss Spirit Hotel, Accra, Ghana

USAID FROM THE AMERICAN PEOPLE

KFW

AFD

IBP Initiative
Scaling up what works in family planning/reproductive health

CONTENT

WELCOME ADDRESS OF THE DIRECTOR GENERAL OF WAHO - *Prof. Stanley OKOLO*

EECOWAS Member countries are making strenuous efforts to strengthen their health systems and implement proven high impact interventions in the most efficient manner, with the ultimate aim of achieving the health-related Sustainable Development Goals (SDGs). The health systems performance varies from one country to another, along with variable standards, approaches, initiatives and impacts. High level performance requires best practices across the health components (governance system, health service delivery, human resources for health, health financing, health information systems, health technologies, community participation, and partnership and health research) to be identified, documented, shared and scaled up at the national level.

It is in this context that, the Assembly of Ministers of Health, held in April 2014 in Monrovia, adopted a resolution establishing the ECOWAS Forum on Best Practices in Health. The Forum aims to promote and disseminate best practices in health, thus accelerating the efficient and effective implementation of the ECOWAS member countries' priority programs. It serves as a platform for identifying key strategic issues, best practices, innovative and promising approaches for improved health.

Since the adoption of this Resolution, WAHO has organized two forums – one in July 2015, and the other in October 2016. These forums targeted best practices that positively impact the health of mothers, newborns, children, adolescents and youth. They influenced the preparation and adoption of the Resolution on Task Shifting and Sharing, which aims at addressing the human resources gaps in health. They have enabled countries to initiate steps to replicate or scale up some best practices that have been disseminated at the forums.

The third forum, which is being held in Accra-Ghana, from 23-25 October 2018, focuses on the theme: *"Promoting Multi-sectoriality to achieve Maternal, Newborn, Child and Adolescent and Youth (MNCAYH) Health-related Sustainable Development Goals".* The subthemes are practices of Governance and Sustainability; Public Private Partnership and Information Technology; Non-Communicable Diseases and Traditional Medicine that impact MNCAYH.

I expect that delegates will have fruitful exchanges on the best practices that will be presented, and that countries will adopt them and eventually scale them up.

Let me use this opportunity to thank the donors and development partners, who have supported this platform of best practices as well as countries in their efforts to replicate and scale up the identified best practices. In particular, I sincerely thank the USAID Regional Office for West Africa for supporting WAHO to initiate the forum concept, through the Leadership Capacity Strengthening Project. I would also like to express my gratitude to the IBP Secretariat of the World Health Organization and all its members, the German Development Bank (KFW), Agence Française de Développement (AFD) and the Royal Netherlands for their technical and financial support for this regional initiative.

Long live ECOWAS!
Long Live Regional Integration!

Prof. Stanley OKOLO
Director General

WELCOME TO THE THIRD ECOWAS FORUM ON BEST HEALTH PRACTICES.

Accra - Ghana. | 23-25 OCTOBER 2018 |

Organized by

The West African Health Organization

A Specialized Institution of the Economic Community of West African States

In collaboration with the Partners:

3RD ECOWAS FORUM ON BEST PRACTICES IN HEALTH

Date: **23 - 25 October 2018** Venue: **Alisa Swiss Spirit Hotel, Accra, Ghana**

INFORMATION NOTE

Welcome to Accra

Please find below general information on administrative and other arrangements made for the smooth running of the Forum.

DATE AND VENUE

The Opening Ceremony and the sessions will take place from 23 – 25 October 2018 at the Alisa Swiss Spirit Hotel, Accra

- Tel : +233 (0) 302 214 233/44
- Mob : +233 (0) 570 008 223
- E-mail : eventives.alisa@swissspirithotels.com

A shuttle service will be provided to and fro the meeting venue for participants staying in the other hotels. Departure time will be 7.30 am each morning.

ENTRY VISA

Participants from ECOWAS Member States do not need an entry visa to Ghana. Those from non ECOWAS countries would need an entry visa which can be obtained from the Ghana Embassy in your country or obtain the visa upon arrival at the airport.

- Visa fees is 150 USD.

VACCINES

Your immunization card should show evidence of valid yellow fever and meningitis vaccination.

WELCOME AT THE AIRPORT

Shuttle services between the airport and hotels will be provided by the hotels.

ACCOMMODATION

Participants will be lodged in the hotels herewith attached.

REGISTRATION

Participants will be required to register on site and obtain identification badges prior to the opening of the meeting on 22 October 2018 from 8.00am – 5.00pm. The venue for registration will be at the Entrance of the Alisa Swiss Spirit Hotel. For identification and security reasons, the official badge should be worn by all participants at all times during the meeting session and at official social functions.

DAILY SUBSISTENCE ALLOWANCE (DSA)

Participants who are being sponsored by WAHO shall be paid DSA through bank transfer after the meeting. Their accommodation shall be paid by WAHO directly to the hotel.

CATERING FACILITIES

Coffee Breaks and Lunch will be served free of charge to participants during the meeting.

WEATHER

The weather is fine in October .

3RD ECOWAS FORUM ON BEST PRACTICES IN HEALTH

USEFUL ADDRESSES AND CONTACTS	
WAHO Liaison Officer • Mrs Mercy Aburam +233 244 603 032 / mercyaburam@gmail.com **FORUM COORDINATOR** • Dr. Namoudou KEITA, PO/Primary Health Care +226 75 03 08 08 / nkeita@wahooas.org **SECRETARIAT** • SANON Clémence +226 75 58 57 35 / clemence.sanon@wahooas.org	**LOGISTICS** For logistics matters (flight tickets, hotel booking, transportation, please contact: • Mrs AMOUKOU Lalaissa PO Administration/WAHO Mobile: +226 74 21 75 36 E-mail: lamoukou@wahooas.org • **Cc**: Mrs Kadjo : Tél : +226 76 32 04 88 E-mail : wahotravels@wahooas.org

LIST OF HOTELS FOR ACCOMMODATION

Hotel	Available Rooms	Occupants	Room rate	Additional information
Accra City Hotel Barnes Road Accra, Ghana Tel: +233 302633863/577600447 Email: reservationsaccracityhotel.com / info@accracityhotel.com	100	Partners	**$157** **$155.00 per Standard Room – single occupancy** **$175.00 per Superior Room – single occupancy**	Indicate the booking code (WAHOOCT18) when making a reservation Accommodation with Breakfast
Alisa Swiss Spirit Hotel 21 Dr. Isert Road - North Ridge P. O. Box 1111 Accra - Ghana Tel: +233 (0) 302 214 233 / 44 Cell: +233 (0) 570 008 223 Email: eventives.alisa@swissspirithotels.com	135	WAHO Staff & WAHO country delegates	**$110** **With Breakfast**	
Coconut Groove Regency Hotel 5 John Kasavubu Rd, Accra, Ghana Tel: +233 (0) 263 008 156/ 306 070 200 Email: Afua.taylor-ashie@coconutgrovehotelsghana.com / regencyreservations@coconutgrovehotelsghana.com	50	Partners	**$90** **With Breakfast**	
Central Hotel Ridge Branch 10 Julius Nyerere Rd, Accra, Ghana Tel : +233 (0) 302 258 257/307 010 600 Email: info@centralhotels.com.gh	50	Partners	**$80** **With Breakfast**	
Prestige Suites Lokko Road, Osu Accra, Ghana Tel: +233 (0) 577 700 317 Email: prestigesuiteshotel@gmail.com	25	Abstract holders	**$70** **With breakfast**	

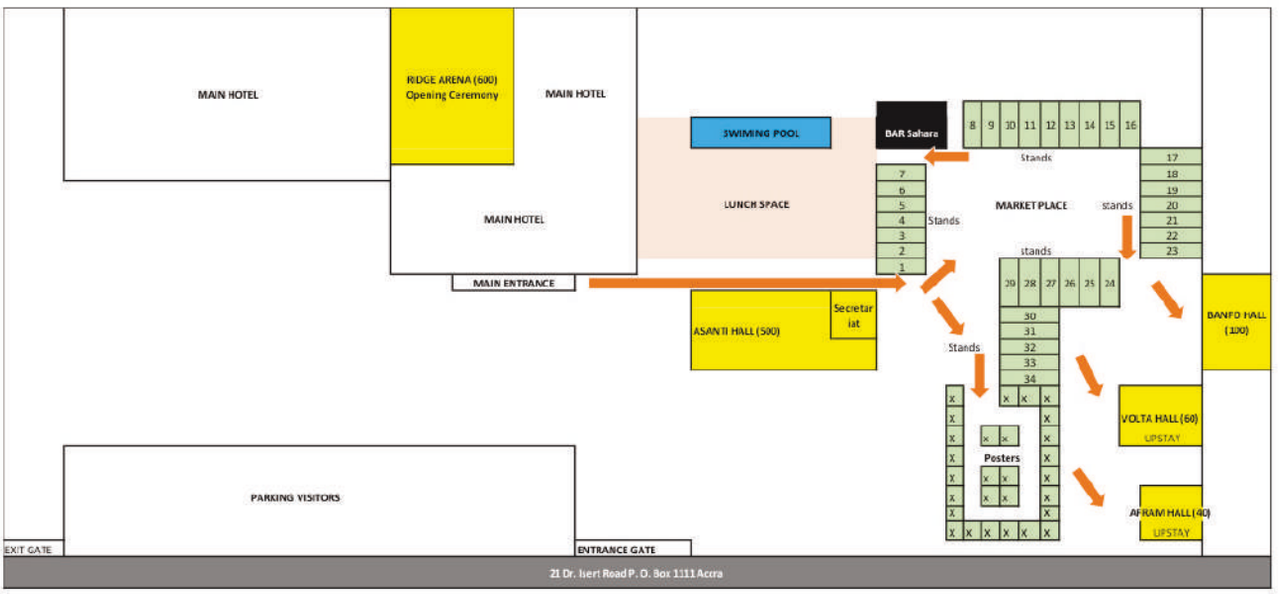
Regional Technical Work Group of the Forum

Dr. Mamadou KONE	WAHO Country Expert, Ministry of Health and the Anti- AIDS campaign, Côte d'Ivoire
Maria da Luz LIMA	WAHO Country Expert, Ministry of Health, Cabo Verde
Dr Anthony NSIAH-ASARE	WAHO Country Expert, Ghana Health Service
Prof. Edgard-Marius OUENDO	Director of the Regional Institute of Public Health, Benin
Dr. Dionisio CUMBA	Director of INASA, Guinea-Bissau
Prof. Babatunde SALAKO	Director General of the Nigerian Institute of Medical Research (NIMR), Yaba-Lagos, Nigeria
Dr. Olga AGBODJAN-PRINCE	WHO/IST, Ouagadougou, Burkina Faso
Mme. Marie SOULIE	UNFPA Regional Office, Dakar, Senegal
Dr. René EKPINI	UNICEF Regional Office, Dakar
Mme. Asa Kristina CUZIN-KILH	WHO/IBP Secretariat, Geneva, Switzerland
Mme. Sheila MENSAH	Advisor in Communication, Monitoring Evaluation Advisor, EDS Activity Manager, USAID/West Africa
Internal Organizing Committee, WAHO	WAHO, Bobo-Dioulasso, Burkina Faso

WAHO Organizing Committee and Ministry of Health, Ghana

Name	Organization	Function
Local Organizing Committee, Accra, Ghana		
Hamidu Adakurugu	Ministry of Health, Ghana	Director Administration & Legal
Kofi Adusei	Ministry of Health, Ghana	Head of the Regenerative Health Unit &NutritionProgramme
Daniel Degbotse	Ministry of Health, Ghana	Head, Monitoring & Evaluation Unit
Rahilu Haruna	Ministry of Health, Ghana	WHO Focal Point
Mercy Aburam	Ministry of Health, Ghana	WAHO Focal Point
Dr. Samuel Adjei	National Security	Medical Director
Nora Marmon Halm	Ghana Immigration Service	2IC International Relations Cooperation
Rosemary Pabbi	State Protocol	Deputy Director of Protocol
Samuel Ofosu Boateng	Foreign Affairs	Deputy Director, Africa Division

Internal Organizing Committee, WAHO, Bobo-Dioulasso, Burkina Faso	
Dr BUSIA Kofi	Director of the Healthcare Department; General Forum Coordinator
Dr KEITA Namoudou	Professional, Primary Healthcare; Technical Coordinator of the Forum
Dr MONGBO Yves	Health Professional/Child, Adolescent, Youth and the Aged
Prof. SOMBIE Issiaka	Research Professional
Mme AMOUKOU Lalaissa	Professional, Administration
Dr. Ivonne CARVEY	Executive Assistant, General Directorate
Forum Rapporteurs	
Dr Yves Armand Medessi MONGBO	Health Professional/Child, Adolescent, Youth and the Aged
Dr Aissa Ado BOUWAYE	Health Professional/ Maternal and Neonatal Health
Prof. SOMBIE Issiaka	Research Professional
Dr William BOSU	Professional Non-Transmissible Diseases
M. Sani ALI	Professional/Planning
Dr Cletus ADOHINZIN	Professional/Regional RH-FP/GIZ Programme


MAIN HOTEL
RIDGE ARENA (600)
Opening Ceremony
MAIN HOTEL
MAIN HOTEL
MAIN ENTRANCE
SWIMMING POOL
BAR Sahara
LUNCH SPACE
MARKET PLACE
Stands
stands
ASANTI HALL (500)
Secretariat
BANFO HALL (100)
VOLTA HALL (60)
UPSTAY
Posters
AFRAM HALL (40)
UPSTAY
PARKING VISITORS
EXIT GATE
ENTRANCE GATE
21 Dr. Isert Road P. O. Box 1111 Accra


ALISA HOTELS

Forum Programme Overview

TIME	23 OCTOBER		TIME	24 OCTOBER		TIME	25 OCTOBER	
	Registration/Coffee break			Registration/Coffee break			Registration/Coffee break	
			08:30	ASANTE HALL 3rd Plenary: Governance & Accountability Task shifting Interventions, WHO/IBP Ouagadougou Partnership		08:30	ASANTE HALL KNOWLEDGE CAFE	
09:00	RIDGE ARENA OPENING CEREMONY		10:30	ASANTE HALL	BANFO HALL			
				Oral presentations Community & Task shifting	Oral presentations Youth/Adolescent & Social Media			
				AE1	AE9	11:30	ASANTE HALL 5th Plenary: Non-Transmissible Diseases & MNCAYH Prof. Ama Aikins	
12:15	ASANTE HALL 1st Plenary: Introductory statement on Governance & Accountability Prof. Irene AGYEPONG, College of Physicians and Surgeons, Ghana Presentation to the Forum Dr Namoudou KEITA, WAHO			AE4	AE10			
				AE11	AF12			
				AE12	AE12			
				AF2	AF9			
				AF7	AF14		6th Plenary: Traditional Medicine & MNCAYH Prof. Olanrewaju Rita-Marie AWOTONA Nigerian Professor of Pharmacognosy	
				AF6	AF11			
				AE8	AF10			
13:00	BUFFET LUNCH		13:00	PACKED MEALS– POSTERS AND EXHIBITIONS		13:00	BUFFET LUNCH	
14:00	ASANTE HALL 2nd Plenary: Governance & Accountability Maeve MCKEAN, USAID HEARD Project		14:00	ASANTE HALL 4th Plenary: Public Private Parnership & ICT Mr. Mbaye Khouma SYLLA PPP Expert Gloria Quansah Asare, Ghana Health Service Temitayo Erogbogbo, MSD for Mothers		14:00	ASANTE HALL	BANFO HALL
							Oral presentations No-Transmissible Diseases & MNCAYH	Oral presentations Traditional Medicine & MNCAYH
							DF3	CF1
							DF1	CF2
							DF2	
							DE1	
15:00	ASANTE HALL	BANFO HALL	15:00	ASANTE HALL	BANFO HALL			
	Oral presentations Governance	Oral presentations Offer of healthcare & Training		Oral presentations Public Private Parnership & ICT(1)	Oral presentations Public Private Parnership & ICT(2)	16:00	WAHO EXPERTS MEETING PRESENTATIONS OF POSTERS & EXHIBITIONS	
	AE6	AE2		BE1	BF1			
	AF15	AE4		BE2	BF2			
	AF1	AE5		BF3	BF4			
	AF4	AE7	16:30	BF5	C. Foundation			
	AF13	AF3		16:30–18:00 PRESENTATIONS OF POSTERS & EXHIBITIONS				
	AE13	AF8						
	AP1	AF5						
17:30	PRESENTATIONS OF POSTERS & EXHIBITIONS					18:00	CLOSING CEREMONY	
			19:00	GALA DINNER				

Mole National Park, Northern Region

OPENING SESSION

Hall: Ridge Arena | 23 October 2018

Master of Ceremonies: Mr. Kwame Sefa Kayi of Peace FM

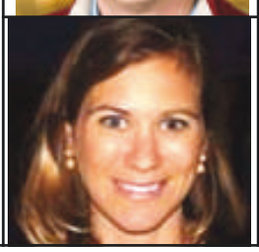
Time		Activities
08:30 - 09:30	-	Arrival and Seating of Participants
09:30 - 10:00	-	Arrival and Seating of Officials
10:00 - 10:05	-	ECOWAS Official Anthem
	-	Ghana National Anthem
10.05 - 10:10	-	Opening Prayer
10:10 - 10:50	-	Welcome address by the Principal Secretary of the Ministry of Health (5 mins)
	-	Statement by USAID Regional Director for West Africa (5 mins)
	-	Statement by Dr. Moeti Matshidiso, WHO Regional Director for Africa (5 mins)
	-	Statement by Prof. Stanley OKOLO, Director General of WAHO (10 mins)
	-	Keynote address by Hon. Kwaku Agyeman-Manu, Minister of Health, Ghana (10 mins)
10:50-10:55	-	Musical Interlude
10:55-11:10	-	Opening address by His Excellency Nana AKUFO-ADDO, President of the Republic of Ghana
11:10-11:15	-	Musical Interlude
11:15-11.20	-	Vote of thanks
11:20-11.25	-	Closing Prayer
11.25-11.30	-	Ghana National Anthem
11.30-11.40	-	Group Photo
11.40-11.45	-	Opening of Exhibitions
11.45-12.00	-	Refreshments

Main Forum Facilitator:

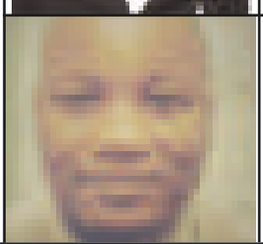
Prof. Akinyinka OMIGBODUN

Professor Akinyinka O. Omigbodun was appointed Professor of Obstetrics & Gynaecology at the University of Ibadan, Nigeria in October 1997. His research interests include reproductive biology especially of female genital tract cancers, population and public health, and the education of healthcare professionals. He has been the recipient of many coveted international awards, including the Audrey Meyer Mars Fellowship of the American Cancer Society in 1992 and an award by the American Society for Reproductive Medicine for distinct contribution to science in 1996. He was the Provost of the College of Medicine, University of Ibadan from August 2006 until July 2010. He served in several key positions the West African College of Surgeons (WACS) before becoming the 28th President of WACS from 2015 – 2017. Professor Omigbodun was the Foundation Chairman of the Board of Management of the Consortium for Advanced Research Training in Africa (CARTA) and he is the current Chairman of the Regional Council for Health Professionals' Education in the ECOWAS Region, an organ of the West African Health Organization (WAHO). Nigeria's Osun State Government bestowed the State's Merit Award on him in September 2010, for his contributions to the Science and Practice of Medicine. He was elected a Fellow of the Nigerian Academy of Science (FAS) in 2012 and a Fellow of the Royal College of Obstetricians & Gynaecologists of the United Kingdom, ad eundem, in 2017. He has published over 130 scholarly articles and book chapters. He is the Editor-in-Chief of the Proceedings of the Nigerian Academy of Science and editorial adviser to several other journals.

<table>
<tr><th colspan="3">DAY 1: Tuesday, 23 October 2018</th></tr>
<tr><th>Time</th><th colspan="2">23 OCTOBER</th></tr>
<tr><td></td><td colspan="2">COFFEE BREAK AND REGISTRATION</td></tr>
<tr><td>12:15</td><td colspan="2">Hall: ASANTE HALL
Governance & Accountability
Moderator: Sheila MENSAH, USAID

Main Keynote Speaker:</td></tr>
<tr><td></td><td>  </td><td>Governance of Health Systems & Accountability for SMNEAJ in relation to SDG
Prof. Irene AGYEPONG, University of Ghana, GHS
Irene A. Agyepong is a Public Health Physician with the Dodowa Health Research Center of the Research and Development directorate of the Ghana Health Service. She is also a member of the Public Health Faculty of the Ghana College of Physicians and Surgeons.</td></tr>
<tr><td></td><td>  </td><td>Presentation to the Forum
Dr Namoudou KEITA, WAHO
Dr. KEITA Namoudou has been in charge of Primary Healthcare and Strengthening of WAHO Health Systems since 2008. He is the Technical Coordinator of the ECOWAS Best Practices Forum in Health, playing a key role in the organization of the 1st Forum in Ouagadougou in 2015 and the 2nd Forum in Grand Bassam in 2016.</td></tr>
<tr><td>13:00</td><td colspan="2">BUFFET LUNCH</td></tr>
<tr><td>14:00</td><td colspan="2">Hall: ASANTE HALL
2nd Plenary:
Governance & Accountability
Stakeholders' commitment in the establishment of priorities in science and research implementation.
Moderator: Prof. Issiaka SOMBIE, WAHO
Organizers: USAID HEARD Project
Main Keynote Speaker:</td></tr>
<tr><td></td><td>  </td><td>Stefano Bertozzi, Dean Emeritus, Professor, School of Public Health University of California, Berkeley.</td></tr>
<tr><td></td><td>  </td><td>Maeve McKean, Senior Policy Advisor, Center for Immigrant, Refugee and Global Health at City University of New York (CUNY), USAID's Health Evaluation and Applied Research Development (HEARD) Project.</td></tr>
</table>

15:00	Hall: ASANTE HALL	Hall: BANFO HALL
	Oral presentations **Governance** **Moderator:** WHO Resident Representative, Ghana	Oral presentations **Service Delivery & Training** **Moderator:** Mme Fatoumata Jarrai DAFFEH, Nursery and Midwifery School, Gambia, Banjul
	AE6 - Inclusion of the economic reinforcement activities for improving the outcomes of maternal, neonatal and infant health: lessons drawn from partnership with confessional organizations in Cameroon. **By Kenneth Muko**	**AE2** - Alternative Delivery Positions. **By MS. CECILIA AMA AMPADU**
	AF15 – Feasibility of Obstetric Fistula surgery on Mali's health pyramid (Reference Health Centres): Pilot experiments of the CSRef of Koulikoro. **By Demba Traoré**	**AE4** - Evaluation of interventions conducted by the communities for creating pregnancy care demand provided by qualified personnel in the rural areas of Nigeria: Short-term outcomes of the design of well-nigh experimental research. **BY Friday E. Okonofua**
	AF1 – Overcoming power dynamics between caregivers and clients for improving social accountability and responsibility in access to, and quality of, reproductive health services in the affected communities. **By Dr. Ghislaine Alinsato**	**AE5** – Best practices for improving the adoption of assisted-delivery services by qualified personnel: intervention conducted in the form of a school training on pregnancy. **By Aaron Kampim/Matild Aberesse**
	AF4 – Towards the implementation of the Maputo Protocol on the rights to sexual and reproductive health for the reduction of early and undesired pregnancies as well as unsafe abortions in Burkina Faso. **By Cécile THIOMBIANO YOUGBARE**	**AE7** – Strengthening capacities for assisted deliveries by qualified personnel – Approach to high frequency and low dosage. **By Amos Asiedu**
	AF13 – Funding Family Planning interventions by local communities. By ZEKPA Apoté Tovinyéawu	**AF3** – Strategy of Itinerant midwives (SAFI). **By Mme Amy MBACKE**
	AE13 – "SMART" couples work together to improve health outcomes. **By Dorothy Brewster-Lee**	**AF8** – Mentorship support to health caregivers in the health districts of Djibo and Gorom-Gorom (Sahel Region in Burkina-Faso) with a view to improving sexual and reproductive healthcare (SRH). **BY Hyppolite Kouadio GNAMIEN**
	AP1 – Planning in health and best practices: analysis of the availability and promptness of maternal, new-born, child, adolescents and Youth health services in Bissau and Biombo. **By André Beja**	**AF5** – Improvement of the geographical accessibility of services for the treatment of women suffering from obstetric fistula in Mali: decentralization of fistula surgeons following the mentorship approach. **By Demba TRAORE**
17:00	PRESENTATION OF POSTERS	
18:30	EXHIBITION VISITS	

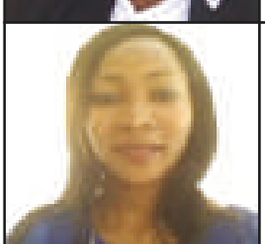
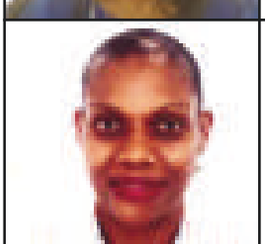
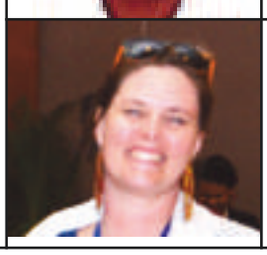
<table>
<tr><th colspan="3">DAY 2: Wednesday, 24 October 2018</th></tr>
<tr><th>Time</th><th colspan="2">24 OCTOBER</th></tr>
<tr><td></td><td colspan="2">COFFEE BREAK AND REGISTRATION</td></tr>
<tr><td>08:30</td><td colspan="2">Hall: ASANTE HALL
3rd Plenary:
Governance & Accountability
Moderator: Mario Festin WHO, Geneva
Organizers: WHO/Geneva,
Documentation on national task shifting interventions in Family Planning in 8 West African countries.</td></tr>
<tr><td></td><td>  </td><td>Ouagadougou Partnership (OP) Experience – Lessons learnt and Prospects
Dr Rodrigue NGOUANA, Ouagadougou Partnership Coordination Unit, 10 min</td></tr>
<tr><td></td><td>  </td><td>WHO Guide for the identification and documentation of the Best Practices of Family Planning Programmes
Åsa Cuzin, WHO/IBP, 8 min</td></tr>
<tr><td></td><td>  </td><td>15:00
Main conclusions on the documentation of Task shifting practices in the Ouagadougou Partnership countries
Séni Kouanda, Institute of Research in Health Sciences (IRSS), 12 min</td></tr>
<tr><td></td><td>  </td><td></td></tr>
<tr><td>10:30</td><td>Hall: ASANTE HALL
Oral presentations
Community & Task Shifting
Moderator: Dr Anthony NSIAH-ASARE, Ghana Health Service
Co-Moderator: Mario Festin WHO, Geneva</td><td>Hall: BANFO HALL

Oral presentations
Youth/Adolescent & Social Media
Moderator: Salamatu Futa, USAID/WA</td></tr>
<tr><td></td><td>AE1 - The development of Proactive Community Case Management to improve child survival in periurban Mali: a collaboration between the Malian Ministry of Health and the non-profit Muso.
By Ari Johnson</td><td>AE9 - Contraceptive use and unintended pregnancy among young women and men in Accra, Ghana.
By LEONARD GOBAH</td></tr>
</table>

	AE4 - Assessing community-led interventions for creating demand for skilled pregnancy care in rural Nigeria: Mid-term results from a quasi experimental research design. **By Friday E. Okonofua**	**AE10** – Adoption of an option beyond abortion": Initiative in Saving Mother and Child. **By GIFTY ASANTE**
	AE11 - The role of the health facility committees in sustaining the free maternal and child healthcare programme of Enugu State, Nigeria. **By Chinyere. C. Okeke**	**AF12** – Family Planning and Reproductive Health for First-Time Parents: A combined approach to behavioural change in Zinder, Niger. **By ASSANI OSSENI Akim**
	AE12 - Family planning utilization and factors associated among women receiving abortion services in health facilities of central zone towns of Tigray, Northern Ethiopia: A cross sectional Study. **By Goshu Hagos**	**AF9** – Adolescent and Youth Health Tribune: a platform for strengthening Youth access to information and services through social media. **By TAO Oumar**
	AF2 – A model of adaptation of a successful innovation: From "Academic Leadership" to "Community Leadership" for Behavioural Change in SSRAJ (LCC). **By Abdoulaye Ousseini**	**AF14** – The Facebook 'Entre Nous' page, a promising channel for improving knowledge and attitudes in sexual and reproductive health (SRH) in adolescents and Youth in Côte d'Ivoire. **By MARIE FEDRA BAPTISTE**
	AF7 - Burkina Faso's task shifting experience in Family Planning in two health districts: Dandé and Tougan. **By Dr André Yolland KY**	**AF11** – Improving the sexual and reproductive health of adolescents and Youth/Family Planning in Niger through the introduction of comprehensive sex education in the curricula of colleges and high schools in Niger. **By Dr ALI HALIMA MOUMONI**
	AF6 – Upscaling of Family Planning in Immediate Post-Partum in three health districts (Adzopé, Agboville and Akoupé) in Côte d'Ivoire. **By Ernest K. Yao**	**AF10** - Experiences of documentation and upscaling of the social media approach of Tékponon Jikuagou (TJ) for reducing unmet needs (BNS) in Family Planning (PF) relating to socio-cultural barriers. **By Mariam Diakité**
	AE8 - Labour pain perception: experiences of Nigerian mothers. **By Adebayo Akadri**	
13:00	PACKED LUNCH – PRESENTATION OF POSTERS – EXHIBITION VISITS	
		Hall: ASANTE HALL **4th Plenary:** **Public Private Partnership & ICT** **Keynote speaker: Mbaye Khouma Sylla, PPP Expert**

	 **How can Public private partnerships help improve maternal health?** **The Ghana experience and challenges:** **Gloria Quansah Asare, Ghana Health Service, Ghana**  **Private sector role. CHAMPION Trial as a result of PPP. Access to MH medicines and HSC** **Temitayo Erogbogbo, MSD for Mothers', Switzerland**	
15:00	Hall : ASANTE HALL Oral presentations **Public Private Partnership & ICT (1)** **Moderator: Dr Maria da Luz LIMA, INSP, Cabo Verde**	Hall: BANFO HALL Oral presentations **Public Private Partnership & ICT (2)** **Moderator: Mbaye Khouma Sylla, PPP Expert**
	BE1 - How and why frontline health workers in a low resource setting used a multifaceted mHealth intervention to support primary care maternal and neonatal health decision-making. **By Hannah Brown Amoakoh**	**BF1** – Mobile health contribution to health information and dissemination to pregnant women and mothers of children under 5 years. **By Hamidou Sanou**
	BE2 - Multi-systems approach in improving maternal and new-born health outcomes: A case study of Saving Mothers Giving Life Initiative (SMGL) in Cross River state, Nigeria. **By Kazeem Arogundade**	**BF2** - ICTs and social media, engine for the promotion of RH/FP by Youth Ambassadors. **By Emilienne ADIBONE ASSAMA**
	BF3 – Computerization of Human Health Resource Management, a decision aiding tool for improving health services: The Experience of Mali. **By Mamadou M'Bo**	**BF4** – Improvement of the Integrated Management of Child Illnesses (IMCI), of Family Planning and monitoring of new-borns and pregnancies: Case of the implementation of the CommCare application in Benin. **By Gbadébô Aude-Elvis ODELOUI**
	BF5 – Use of Information and Communication Technologies (ICTs) for the continuing training of health professionals in Emergency Obstetric and Neonatal Care (EONC): case of the "safe delivery" application. **By BANGBOLA Karamatou Ognilola**	**Concept Foundation** - Call to action on Quality of MH Medicines in West Africa, public private partnerships, HSC and #Medswecantrustcampaign. **By Arinze Awiligwe**
	1630 – 1800	
	PRESENTATION OF POSTERS – EXHIBITION VISITS	
1900	**GALA DINNER**	

DAY 3: THURSDAY, 25 October 2018

Time	25 OCTOBER	
	COFFEE BREAK AND REGISTRATION	
08:30	Hall: ASANTE HALL **KNOWLEDGE CAFE - An interactive exploration of tools and approaches for strengthening FP programmes** **Moderator : IBP Secretariat** **Organizers: IBP/WHO**	
		**Session 1: Thinking outside the box: A decision-making tool for designing services suited to the Youth** **Language:** ENG, FR **Organizers:** E2A/Pathfinder, Ginette Hounkanrin
	 	**Session 2: Task shifting for long-action and reversible contraception (LARC) is a reality – West Africa's experiences** **Language:** ENG, FR **Organizers:** MSI, Anne TAIWO and Matié YANOGO
		**Session 3: Social norms, social media guide, social media cartography, Exploration Guide and tool kit** **Language:** ENG, FR Organizers: Institute for Reproductive Health (IRH), Mariam Diakite
		**Session 4: High Impact Practices** **Language:** ENG **Organizers:** USAID, Sheila Mensah
		**Session 5: Tools for aiding local civil society to become key stakeholders of Sexual and Reproductive Health Rights (SDSR)** **Language:** ENG, FR **Organizers:** Equipop, Elise Petipas

		**Session 6: 'That's life!' – First soap opera associated with the Communication Campaign for Social and Behavioural Change (CCSC) for Family Planning and procreation rights in West and Central Africa** **Language:** ENG, FR **Organizers:** UNFPA, Marie Soulie and Norbert Coulibaly and Norbert Coulibaly
		
		**Session 7: Strengthening Family Planning capacities** **Language:** ENG, FR **Organizers:** Jhpiego, Blami Dao and Bethany Arnold and Bethany Arnold
		
		**Session 8: Outils de planification familiale fondée sur des preuves - le manuel de PF et le guide du formateur (Training resource Package)** **Langue**: ENG **Organisateurs:** World Health Organization (WHO), Mario Festin
11:30		Hall : ASANTE HALL **5th Plenary:** **Non-Communicable Diseases & MNCAYH** **Keynote Speaker: Prof. Ama Aikins, University of Ghana** **Moderator: Prof. Babatunde SALAKO, NIMR, Nigeria**
		**6th Plenary :** **Traditional Medicine & MNCAYH** **Keynote speaker:** Prof Olanrewaju Rita-Marie AWOTONA Nigerian Professor of Pharmacognosy, Legacy University in Banjul - Gambia **Moderator:** Prof. Babatunde SALAKO, NIMR, Nigeria
13:00		**BUFFET LUNCH**

14:00	Hall: ASANTE HALL Oral presentations **Non-Communicable Diseases & MNCAYH** **Moderator:** Prof. Naby Baldé, University of Conakry	Hall: BANFO HALL Oral presentations **Traditional Medicine & MNCAYH** **Moderator:** Dr Kofi BUSIA, WAHO
	DF3 – Community approach for improving the management of snake bites in a rural commune in Guinea "Experience of the Associative Medical Centre (CMA) in Timbi Madina". **By Dr Abdoulaye Aguibou Barry**	**CF1** – Community-Based Approach for Traditional Medicine Practitioners to improve Mother and Child health indicators. **By KROA Ehoulé**
	DF1 - Psycho-cognitive and Physiotherapy stimulation for stimulating malnourished children. **By BAGNOA Tuenwa Clément**	**CF2** – Involvement of Traditional Birth Attendants in the emergency obstetric management system in Mali. **By Prof Rokia Sanogo**
	DF2 – Facilitating Family Planning services for female mental patients. **By Amy SAKHO**	
15:30	**DE1**: Prevention of Non-Communicable Disease in High Risk Adolescents and Young Adults: An Intervention Study In Northern Senegal. **By Sidy Mohamed SECK**	
16:00	WAHO EXPERTS MEETING PRESENTATION OF POSTERS EXHIBITIONS	

The Jubilee House, Office of the President, Accra.

ABSTRACTS
ORAL PRESENTATIONS

ABSTRACTS - ORAL PRESENTATIONS

Good Governance and accountability for the Maternal, Newborn, Child, Adolescent and Youth Health (MNCAYH)

AE1: The development of Proactive Community Case Management to improve child survival in periurban Mali: a collaboration between the Malian Ministry of Health and the nonprofit Muso

Authors: Ari Johnson, Oumar Thiero, Caroline Whidden, Belco Poudiougou, Djoumé Diakité, Fousséni Traoré, Salif Samaké, Diakalia Koné, Ibrahim Cissé, Mama Coumaré, Mohamed Berthé, Madeleine Beebe, Kassoum Kayentao

Introduction:
Despite significant progress since 1990, the child mortality crisis continues to be a major cause of preventable death globally. Roughly half of this global burden lies in sub-Saharan Africa, the only region in the world where both the number of live births and the under-five population are expected to rise in the coming decades. At 115 children per 1,000 live births, Mali has one of the highest under-five mortality rates in the world. These deaths are concentrated in rural communities, with children of poorer, less educated women nearly twice as likely to die compared to the children of wealthier, more educated women. Since 2008, the Malian Ministry of Health has been partnering with the non-profit Muso to test solutions to our child mortality crisis. Together we developed Proactive Community Case Management (ProCCM), the approach presented herein. We evaluated the impact of this approach through a 7-year interrupted time series study that measured early access to care and under-five mortality over the course of a proactive community case management (ProCCM) intervention in periurban Mali.

Methodology:
Using a cluster-based, population-weighted sampling methodology, we conducted cross-sectional household surveys at baseline, 12, 24, 36, 48, 60, 72 and 84 months in the intervention area. The ProCCM intervention had five components: (1) active case detection by CHWs, (2) CHW doorstep care, (3) monthly dedicated CHW supervision, (4) removal of user fees, (5) reinforced primary care facilities through infrastructure improvements and staff training. Under-five mortality was calculated using Cox proportional hazard survival regression. We measured the percentage of children initiating antimalarial treatment within 24 hours of symptom onset and the percentage of children reported febrile within the previous 2 weeks.

Key Findings:
During the intervention, the rate of early effective antimalarial treatment of children 0–59 months more than doubled, from 14.7% in 2008 to 35.3% in 2015 (OR 3.198, P0.0001). The prevalence of febrile illness among children under 5 years declined after 7 years of the intervention from 39.7% at baseline to 22.6% in 2015 (OR 0.448, P0.0001). Communities where ProCCM was implemented have achieved an under-five mortality rate at or below 28/1000 for the past 6 years. In 2015, the under-five mortality was 7/1000 (HR 0.039, P0.0001).

Conclusion:
Community-based health systems strengthening may facilitate early access to prevention and care and improved child survival. ProCCM is designed to remove financial, geographical, gender and infrastructural barriers that reduce and delay access to care and ultimately reduce under-five mortality through two primary mechanisms. First, increased access to earlier effective treatment can directly reduce the likelihood of progression to severe illness and death. Second, in the case of malaria, diarrhoeal disease and pneumonia, earlier treatment can reduce the time period during which a patient can infect others.

Recommendations:
Further research is urgently needed on ProCCM and its core strategies, to determine their respective role in improving morbidity and mortality. A randomised controlled trial of ProCCM's proactive case detection approach is currently underway across 137 cluster sites, designed to address some of these limitations (Clinical- Trials.gov NCT02694055). Governments and implementers can learn from these Findings and consider how they may be applicable within their respective contexts

AE2: Alternative Birthing Positions

Authors: Cecilia Ama Ampadu, Emmanuel Srofenyoh, Kofi Adusei, Prince Adomako

Introduction:
In Ghana, women who have ever had home delivery state their reason as the option they have in choosing a preferable birthing position, unlike at the health facility where they are made to lie on their back with their feet in stirrup position. The stirrup position seems preferable to the attending medical staff since it enables him or her to have easy access to do the delivery. Unlike to the staff, it provides discomfort and excessive stress for the labouring mother who is made to push her baby, all by herself, without the helpful force of gravity, which characterizes delivery in either the sitting or squatting position. Evidence have shown that sitting and squatting positions can prevent many complications to the mother and the baby as compared to the stirrup position. With regard to this, the birthing chair was designed and introduced, on a pilot basis, to provide pregnant women with alternative birthing positions at the facility level. The tool is also intended to improve utilization of supervised and skilled delivery services and bridge cultural barriers. This is because it offers opportunity for pregnant women to deliver in hospitals and not in their homes. The chairs are two. The sitting delivery chair and the squatting delivery chair. The chair is stainless steel, adjustable and collapsible. It was introduced to some health facilities on a pilot basis. The introduction of the chair comes with interventions involving identification and selection of facility, training of health professionals, sensitization of pregnant women at ANC prior to delivery.

Methodology:
The intervention involves identification and selection of facility, procurement of delivery chairs, training of health professionals, sensitization of pregnant women at ANC, advocacy, documentation, monitoring and evaluation. The chair was introduced to the following facilities on a pilot basis: Greater Accra Regional Hospital, August 2015; Asutuare Health Centre, October 2015; Amasaman Government Hospital, September 2017; and Tema General Hospital, June 2018. Data on deliveries using the birthing chair is not being captured in the current maternal and child reporting format. An improvised data collection tool, however, is being used to document the deliveries on the squatting and sitting delivery chairs. Already the concept of squatting and sitting chair has been incorporated into the curriculum of health trainees. There is the need to incorporate documentation of the alternative delivery positions into the current delivery register, and review current policies to accommodate alternative birthing positions. Training and user manuals, and demonstration videos need to be developed. Key stakeholders include the Ministry of Health and the Ghana Health Service.

Key Findings:
Pilot was accepted by medical staff (nurses, midwives and doctors) in the piloting facilities and clients are patronizing. 453 deliveries have been conducted with the chairs without any complication. A report has been produced for three piloting centres. In all these deliveries, one hundred percent success has been recorded. No single complication, morbidity or mortality occurred. The delivery chair has been successfully used for the following complex cases: • Delayed second stage • Intra-uterine foetal death (IUFD) • Shoulder dystocia • Face to pubis presentations • Cord around neck • Big babies The chair proudly won the 2013 African Union Public Service Innovation Award. It has been endorsed by the Government Midwives Association of Ghana and certified by the Ghana Standards Authorsity. In 2016, it was adopted as one of the best practices for maternal and neonatal health in the sub region by WAHO at the Second ECOWAS Good Practices Forum in Health held in Abidjan, Cote D'Ivoire. The piloting has revealed a possible replicability and scale-up of this practice in all facilities from primary to tertiary with available skilled personnel. Generally, there was great satisfaction amongst clients and health workers about this intervention.

Conclusion:
The Ghana-made birthing chair provides women in labour the option to deliver in health facilities either sitting, squatting or lying. This gives women the opportunity to choose their preferred birthing position. The health facility will therefore be a conducive place for women to deliver in their preferred position. With this, women are more likely to deliver in health facilities more than in homes. Thus, increase skill delivery nationwide. We know that skilled delivery is safe and reduce the risk of women dying during childbirth. This will help Ghana achieve the overall goal of reducing maternal and neonatal mortality and morbidity. The piloting has revealed a possible replicability and scale-up of this practice in all health facilities from primary to tertiary with available skilled personnel. Generally, there was great satisfaction amongst clients and health workers about this intervention.

Recommendations:
To ensure continuous success and scale up, the following are recommended: 1. Proper documentation be done in all the piloting health facilities 2. Review current policies to accommodate alternative birthing positions 3. Further incorporate into pre-service institution curriculum 4. Develop training materials for the squatting and sitting delivery positions. 5. Intensify advocacy, education and training for pregnant women, stakeholders and health workers

AE3: The Strategic Approach to reducing Maternal and Newborn Mortality in Sub-Saharan Africa. A case study of 'Saving Mothers Giving Life Initiative' (SMGL), Nigeria.

Authors: Sulaiman Gbadamosi, Oluwayemisi Femi-Pius, Kazeem Arogundade, Olayiwola Jaiyeola Femi Quaitey

Introduction:
Nigeria faces persistently high maternal and neonatal mortality. 2013 DHS analysis revealed a maternal mortality ratio (MMR) of 576 per 100,000 live births and a neonatal mortality ratio of 37 per 1,000 live births. Significant regional variation exists and in CRS, MMR reaches as high as 2,000 deaths per 100,000 live births. In 2014, Pathfinder began working with SMGL—rolling out the program across 18 local government areas (LGAs) in CRS. Foundational elements of SMGL included a context-setting health, state-wide, health facility assessment (HFA) which revealed that health facilities with the capacity to provide EmONC services are disbursed across large geographic areas, leaving many women more than two hours from skilled care through the public and private health system. The HFA revealed a MMR of 872 per 100,000 live births and NMR of 160 per 1000 live births. Subsequently, 107 health facilities were selected to be supported by SMGL based on delivery data, geographical spread, infrastructure and availability of skilled birth attendants.

Methodology:
SMGL implementation period spanned 2015-2019. All 18 LGAs in the state were arranged into 10 clusters based on WHO criteria. Community stakeholders engagements were conducted in the state, Data analytics and use have been instituted Extensive Emonc and FP trainings were rolled out for all cadre of HCWs. Joint technical supportive supervision are conducted routinely. Essential equipment were supplied to supported facilities. A unique community-led emmergency transportation system- ETS which ensured that all emmergency cases in the communities can be transported to supported facilities for safe delivery was instituted

Key Findings:
The result of the above methodology is the creation of one of the most agile, data centric, comprehensive, result oriented, stakeholders-led, model Reproductive Maternal Newborn Child Health initiative in sub Saharan Africa. Within 2 years of commencement of the initiative, MMR for supported facilities now stands at 142 as compared to 313 in baseline. Also NMR stands at 34 as compared baseline of 58. Percent of women who received uterotonics in the third stage of labor is presently at 100% as compared to 48% at baseline. Percent of Live births put to breast and kept warm within 30 minutes of birth in a health facility is presently 95% as compared 35.5% baseline figure. Furthermore, Percent of newborns not breathing at birth successfully resuscitated is presently 98% as compared to a baseline of 79.5%. 100% of SMGL supported facilities now report to national information system as compared to 96% at baseline. Further the quality of documentation has also improved considerably. The USAID AOR – Dr Joseph Monehin said "The quality of your work is good and it is very encouraging. Ambu bags can be seen in all your facilities. Your facilities use of Chlorhexidine gel for chord care, you have IECs that speaks to active management of third stage of labor. Partograph is also being used widely; We Care Solar is also available. I am also happy HCWs understand the resuscitation process".

Conclusion:
SMGL Initiative Nigeria is on track to achieve the objective of reducing MMR and NMR by 15% and 10% respective. The initiative has successfully created a unique data centric model for future programming within the sub-Saharan Region to learn. The implication of this for future RMNCH and FP programming in LMIC is indeed instructive. SMGL initiative has been truly impactful. Honorable commissioner for Health Cross River State was quoted to have said recently "Pathfinder International is indeed the best International NGO in Cross River State.

Recommendations:
The concept of being "Strategic" within the context of the SMGL initiative means starting with the end in mind. In view of this, the following key recommendations are being posited: • The use of data must be mainstreamed and used at all levels. • Robust stakeholder's engagement is a key element of success in this initiative.. • Phased Roll-out of interventions in geographic areas ensures initial lessons learned can improve quality of interventions in subsequent areas. • It is more result oriented to deploy Midwives and Nurses to train CHEWs • as against using Professors and Doctors. Joint supportive supervisions are more result oriented • Quarterly supportive supervisions are more result oriented when carried out jointly between Implementing Partner and other stakeholders (Government and Professional Bodies)

AE4: Assessing community-led interventions for creating demand for skilled pregnancy care in rural Nigeria: Mid-term results from a quasi-experimental research design

Authors: Friday E. Okonofua, Ntoimo Lorretta Favour, Yaya Sanni, Ogungbangbe Julius, Imongan Wilson, Ermel Johnson

Introduction:
The World Health Organization estimates that 58,000 maternal deaths occur in Nigeria annually, accounting for 19% of global maternal deaths. The majority of these deaths occur in rural communities and are linked to extreme poverty, weak health care systems and the lack of access of women to health services, among other factors. Despite that policymakers recognize that primary health centres (PHCs) should play a key role in improving rural women's access to skilled pregnancy care, PHCs are often poorly utilized. The poor demand and utilization of PHCs for skilled pregnancy care has in turn been attributed to limited community engagement, participation and ownership of PHC activities. The objective of this paper is to describe a community-led implementation research aimed at increasing the access of pregnant women to skilled pregnancy care in Etsako East and Esan South-west Local Government Areas of Edo State, Nigeria. The study is being implemented in three phases – formative research, intervention phase, and an evaluation phase. While the formative research phase has been completed, the intervention phase has progressed to the mid-term period, with the active participation of the local community. This presentation reports the mid-term results of the implementation phase of the project.

Methodology:
This on-going project began in 2015 and will be completed in 2020. In phase one, we used a mixed-method qualitative and quantitative research design to obtain data from women and men in 20 communities in the Local Government Areas. We then engaged community stakeholders (including community leaders, women leaders, policymakers, youth and the civil society) to use the Findings of the formative research to design community acceptable sets of complex (multiple) interventions to increase women's access to skilled pregnancy care in PHCs. In phase 3, the project is being evaluated with process and outcome indicators, using a quasi-experimental research design.

Key Findings:
The interventions consist of the development of Ward Development Committees (WDCs) linked to community elders/decision-makers; community fund-raising/health insurance; transportation of women to PHCs using a Rapid SMS system; community awareness and sensitization events; the establishment of Drug Revolving Funds in PHCs; advocacy activities; and the re-training of health providers. At intervention mid-term, the results show active community participation and commitment with 80% of the activities being led and implemented by the WDCs in collaboration with the PHCs; significant funds (about US$9,800.0) donated so far by the project communities to support PHC activities; a large number of women registering and paying for the community health insurance scheme; substantial infrastructural improvements of the four PHCs in the intervention sites; a nearly 200% increase in the number of women visiting the PHCs for antenatal and delivery care; and several case reports of averted severe morbidity and mortality from women using the reformed PHCs. Advocacy activities led to increased commitment to the project by the Federal Ministry of Health, the Edo State Ministry of Health, the Edo State Primary Health Care Development Agency and the Edo State Government. Such increased commitments led to 1) Edo State announcing the prioritization of improved delivery of PHCs in the State; 2) the deployment of a Youth Corp doctor to supervise PHC services in one of the project communities, with the salary part-paid by the Local Government Area Council; and 3) the increased deployment of nurses and midwives to the PHCs in the communities.

Conclusion:
The results of this project emphasize the importance of community engagement and participation in efforts to improve PHC delivery for skilled pregnancy care especially within the context of rural communities. Such community engagements can increase project support and effectiveness, strengthening its impact and sustainability over time. By working with communities to create workable and sustainable theories of change, the project has simultaneously addressed multiple bottlenecks including cultural factors, gender issues, maternal and community risk factors, as well as inadequate policy response that hinder women's access to skilled pregnancy care in rural areas.

Recommendation
These impressive results at project mid-term suggest that the delivery of PHCs with the active involvement of community stakeholders is critical to increasing the demand for skilled pregnancy care in rural Edo State of Nigeria. We recommend that a policy based on community engagement and ownership should be adopted as part of the strategic implementation of PHCs in the region. However, as communities differ considerably, the interventions that work in one community may not necessarily work in another community. Thus, it is essential that substantial needs assessment and discussion be undertaken with community stakeholders at the onset, and those communities themselves "own" the interventions rather than approaches based on "outsider' imposition. We believe very strongly that this approach holds high promise for improving the access of rural women to skilled pregnancy care and reducing the presently high rate of maternal mortality in the country.

AE5: Good Practices to Improve Uptake of Skilled Delivery Services: The Pregnancy School Intervention
Authors: Aaron Kampim, Matilda Aberese-Ako, Oscar Bangre, Fabian Sebastian Achana, Abraham Rexford Oduro

Introduction:
The Northern Region of Ghana lags behind in maternal, neonatal and child health care. The region recorded the second highest institutional maternal mortality ratio (174/100,000LBs) and neonatal deaths (8.1/1000LBs), according to the 2013 annual reproductive and child health review report. The Northern Region also recorded one of the lowest skilled deliveries (46.8%) only ahead of the Volta region (43.4%) in the year under review. The situation is even more critical in the Bunkpurugu-Yunyoo district, which recorded 36% skilled delivery coverage. Several demand and supply side factors have been noted to demotivate women from utilizing skilled delivery services (which account for the low skilled delivery coverage). Results of a baseline study in the Bunkpurugu-Yunyoo district confirmed that women's experiences of poor attitude of health workers and socio-cultural factors such as myths, traditional beliefs and practices hindered the decision to seek skilled delivery care. Although, the already established Antenatal Care (ANC) services provide an opportunity to promote healthy behavior among pregnant women, the depth of interaction in such sessions is often less due to limited time. The pregnancy school aimed at intensifying interaction between health providers and pregnant women (and their families), in order to improve utilization of skilled delivery care.

Methodology:
The pregnancy school was implemented in the Binde and Bunkpurugu sub-districts of the Bunkpurugu-Yunyoo district, over a period of seven months. Quantitative and qualitative approaches were used to collect data to assess the impact of the intervention on the uptake of skilled delivery services. The quantitative approach used data extraction sheets whiles the qualitative approach used In-Depth Interviews (IDI) and Focused Group Discussions (FGD). Quantitative data collected was analyzed using Microsoft Office Excel to generate descriptive statistics. The qualitative data was analyzed using Nvivo to generate thematic quotes for narrations.

Key Findings:
Eight pregnancy schools were successfully established, four in each sub-district. For the period, a total of 541 pregnant women enrolled. Of the 541 pregnant women, 242 were from Binde sub-district whiles 299 were from Bunkpurugu sub-district. The period recorded a total of 256 deliveries out of which 220 (85.9%) were health facility (skilled) deliveries, whiles 36 (14.1%) were home deliveries. The results also show that, of the 256 deliveries, 105 were from Binde and 151 from Bunkpurugu. For the 105 deliveries from Binde, 12 (11.4%) were home deliveries and 93 (88.6%) were health facility deliveries. Also for the 151 deliveries from Bunkpurugu, 24 (15.9%) were home deliveries and 127 (84.1%) were health facility deliveries. Overall, the pregnancy school intervention contributed to 18.7% increase in skilled delivery coverage in each of the intervention sub-districts (Binde and Bunkpurugu). Specifically, general skilled delivery coverage increased from 70.8% to 89.5% in Binde, and from 46.5% to 65.2% in Bunkpurugu. Findings from the qualitative evaluation suggest

that the pregnancy school improved participants' knowledge of the need to utilize skilled delivery care. Also, bringing health workers and clients together through the pregnancy school boosted interactions between health workers and clients. This killed the myth of the chasm between the health workers and community members and so enabled a more relaxed approach to the use of health services. The Findings also showed that the interaction during the pregnancy school helped pregnant women to build confidence and prepare well for delivery.

Conclusion:
The Findings generally showed that, the pregnancy school as an intervention successfully improves the uptake of skilled delivery services. Specifically, the intervention successfully created demand for skilled delivery services by educating and creating awareness among pregnant women and their families. The intervention also cordially bonded pregnant women and healthcare providers, which resulted in friendly skilled maternity service provision.

Recommendation:
The following measures are recommended to help improve and sustain the pregnancy school intervention: ✶ Community sensitization about the initiative to help increase community awareness and patronage. ✶ Effective supervision and the need to train more health workers to facilitate in the sessions would also help to sustain the program. ✶ Donor support could be sought for to ensure regular training for pregnancy school facilitators.

AE6: Integrating Economic Strengthening Activities to Improve Maternal, Newborn and Child Health Outcomes: Lessons Learned from Partnerships with Faith-based Organizations in Cameroon

Authors: Kenneth Muko, Margaret Brawley, Jennifer Martin

Introduction:
One in every six children in Cameroon does not live to see her fifth birthday. Most child deaths in the country result from malaria, diarrhea, pneumonia, and neonatal causes (all further exacerbated by malnutrition). Faith-based organizations (FBOs) are responsible for 30 – 70% of healthcare delivery in Africa (World Health Organization, 2017), and they work to improve health outcomes across Cameroon. These institutions, especially Congregations of Women Religious (CWRs), play a critical role in strengthening systems of maternal, neonatal and child health (MNCH). CWRs are embedded in the communities they serve and have valuable, trustworthy relationships with community members, but they are constrained by limited resources and training. Building the capacity of CWRs to implement effective, sustainable MNCH programs is a challenge in Cameroon. The majority of MNCH programs are implemented by non-profit organizations, often for short periods, and with limited funding. Identifying feasible, long-term strategies to strengthen and maintain community-managed MNCH programs remains a challenge worthy of continuing consideration. Medicines for Humanity (MFH) creates impact at grassroots level and develops long-term sustainability in MNCH indicators by investing in and strengthening the the capacity and skills of CWRs using a combination of training, mentoring, supervision, and economic strengthening activities (ESAs).

Methodology:
In September 2013, MFH partnered with four CWRs to support 37 Catholic sisters, 19 midwives, 28 nurses, and 226 CHWs in Cameroon's North West and South West Regions. Trainings were held to strengthen competencies around delivery practices, management of childhood illnesses, nutrition activities, and project management. MFH also supported CHWs to deliver health education, refer sick children, and support households. Additionally, since 2014, MFH has implemented ESAs for CHWs. Baseline data was collected at the beginning of the integrated phase of the project (when ESAs were introduced in October 2014) and compared with subsequent data collected in March 2017.

Key Findings:
CWRs already have a vested interest in and commitment to the communities they serve. Investing in them and increasing their capacity enables CWRs to further their outreach and impact, resulting in increased access to and sustainability of high-quality healthcare and improved health outcomes as demonstrated by the following indicators: The number of child deaths dropped by 18.2 to 31% across the eight project sites within three years. This is much lower than the average 5.1 to 6.6% yearly reductions observed in Ethiopia and Rwanda. Equally reductions were observed in malnutrition (28%-52%), malaria(29%-36%), pneumonia(15%-24%) and diarrhea(33%-38%). Pre

and post-natal visits increased by ranges of 22% to 37% and 18% to 24% respectively. CHW performance improved by an average of 32% and there was an average 28% increase in CHW retention rate. Key lessons learned through this project include: • The most effective training sessions had significant input from trainees in curriculum design and the planning and facilitation of the trainings. • Building feedback loops, frequent trainee monitoring and mentoring field visits, and utilizing collected data and local input to foster changes and design refresher workshops proved to be very useful. • Don't make assumptions about individual's skills and comprehension. Take time to understand trainees' level of knowledge and build upon that foundation. • Investment of resources in ongoing monitoring, mentoring, and support improves CHW retention, sustainability, and quality of services. • CHWs want to invest in their own community. Don't underestimate their influence. Some CHW groups used earned ESA income to support wider community initiatives such as provisions for orphans and infrastructure/supplies for local schools. • The support services and education provided by CHWs in the community freed up valuable time of clinic staff. Nurses were able to spend less time on preventive education for health issues (like danger signs in pregnancy, appropriate feeding practices, and hygiene promotion) and prioritize treatment and future care. • ESAs strengthen social cohesion, communication, and community partnerships.

Conclusion:
Strategies to strengthen and maintain high-quality, accessible MNCH programs need to prioritize capacity building for grassroots institutions, including FBOs. With the right support, CWRs can develop sustainable MNCH programs with strong outreach components that improve health outcomes for vulnerable people who otherwise have limited access to healthcare. Integrated approaches aimed at addressing specific MNCH challenges can have significant impact. Strengthening the economic capacities of community stakeholders, including CHWs, increases access to healthcare and is critical to ensuring sustainability. MFH's work with CWRs and their CHWs has been recognized by the Cameroon government and showcased as a demonstrable model for replication.

Recommendations:
In order to sustainably reduce child mortality rates in underserved areas of the world, NGOs need to implement health interventions proven to save lives, tailor projects to specific sites, and recognize the critical role of CWRs and CHWs. Based on MFH's experience in Cameroon, the following recommendations can be made: • Ensure that trainees at every level have input into training goals and curriculum design and confirm they are well-supported with post-training field visits and refresher workshops inclusive of trainee feedback and program flexibility for change. • Prioritize monitoring, mentoring, and support throughout the life of the project to establish a strong foundational community force, motivation and retention. • Integrate ESAs as a key component of all CHW programs from the beginning and develop the ESAs in collaboration with local partners and the beneficiaries to maximize feasibility, effectiveness, growth and most importantly, success.

AE7: Building Capacity for Skilled Delivery Care – The Low-Dose High-Frequency Approach

Authors: Amos Asiedu, Martha Serwaa Appiagyei, Etta Forson Addo, Patience Darko, Dora Agbodza, Julia Duodu

Introduction:
In Ghana, the newborn mortality rate has stagnated at 29 deaths per 1,000 live births, which represents 67% of all infant mortality, and the stillbirth rate is 22 per 1,000 total births. Quality improvement efforts in government and mission hospitals identified problems hindering progress in reducing these mortality rates including deficits in technical knowledge and skills of health care providers to manage labor complications and access to basic supplies to provide essential and emergency newborn care. To address these barriers, a new low-dose/high-frequency (LDHF) approach to training health care workers was introduced and evaluated in 40 public and mission hospitals in Ghana between March 2014 and March 2017 and aimed to update midwives' knowledge and skills and improve maternal and newborn outcomes at 40 hospitals in Ghana. The focus was on demonstrating effects of the intervention on midwives' knowledge and skills at one year after training, and on intrapartum stillbirth and newborn mortality rates in the twenty-four hours following birth.

Methodology:
The study was a prospective, cluster-randomized evaluation. Eligible hospitals in three regions of Ghana were stratified by number of deliveries per month, and then randomized into one of four training cohorts. The intervention included two 4-day on-site (low-dose)

trainings followed by weekly (high-frequency) midwife-led practice sessions, and one year use of SMS messages about content covered during the low-dose sessions and in-person and telephone supervision by regional mentors. Health worker competency was evaluated using Objective Structured Clinical Examinations (OSCEs) at three time points: before each training, immediately after each training and one year after the second training. Health service statistics were used to evaluate impact on mortality.

Key Findings:
In the 40 evaluation sites, 403 SBAs consented and were enrolled in the study. OSCE scores on topics covered in the first 4-day training were 43% pre-training and 87% post-training; skills retention after one year was 73%. OSCE scores on topics covered in the second training were 52% pre-training, 92% post-training and 80% after one year. Data from 40 hospitals showed a 70% reduction in risk of 24-hour newborn mortality rates and 62% reduction in risk of intrapartum stillbirth comparing the 6 months prior to intervention to 0-12 months post-intervention. A qualitative evaluation revealed, providers made tremendous improvements in quality of care at the time of labor, birth and the immediate postnatal period (in all areas taught during the knowledge and skills-focused training). Comments from informants indicated that they were likely to use the newly learned interventions since they felt "empowered to work effectively and with boldness". In addition, this training approach is more practice than theory-oriented and all health workers from the maternity were invited to the on-site trainings.

Conclusion:
The LDHF approach improved midwives' competency to provide high-quality, respectful maternal and newborn care. The intervention significantly reduced risks of intrapartum stillbirth and newborn mortality within 24 hours of birth. Also, stakeholders who accepted this approach to training promised to sustain it and advocated for scale-up to other part of the country.

Recommendations:
We recommend that the adoption of similar approaches in Ghana and other low-resource countries has the potential to improve service quality and advance progress towards health development goals.

AE8: Labour pain perception: experiences of Nigerian mothers

Authors: Adebayo Akadri, Oluwaseyi Odelola

Introduction:
Childbirth is a joyful event, but it exposes the mother to one of the severest forms of pain reported. Labour pain perception is influenced by a variety of physiologic, psychosocial and environmental factors; hence women of different sociocultural backgrounds may experience and cope with labour pain differently. This study was designed to assess labour pain perception among parturients.

Methodology:
This was a cross-sectional study involving 132 pregnant women who vaginal delivery at two tertiary hospitals in south west Nigeria. A structured questionnaire was administered to women within 24 hours of delivery to record details of labour and delivery. Labour pain perception was assessed using the Visual Analogue Score (VAS). Data analysis was done using IBM–SPSS Statistics for Windows version 21.0 (IBM Corp., Armonk, NY, USA).

Key Findings:
The mean age of the parturients was 30.6±4.8years. The mean pain perception of the parturients as assessed by VAS was 7.0. Sixty-six (50%) parturients rated labour pain to be severe (VAS 7.1). Majority of the respondents 114(86.4%) desired some form of pain relief. The Body Mass Index (BMI) of respondents and birth weight of their babies had statistically significant association with pain perception ($p=0.010$; $p=0.038$ respectively). Factors associated with increased odds of having severe pain perception include unbooked status, secondary level education, BMI30, and gestational age ≥37 weeks.

Conclusion:
Women in south west Nigeria perceived labour pain as severe and many desired pain relief during labour. Occupation, BMI, gestational

age and babies' birth weight were significant mediating variables in women's experience of labour pain.

Recommendation
Modern methods of labour analgesia should be offered to parturients to reduce the unmet need for obstetric analgesia and improve women's childbirth experience.

AE9: Contraceptive use and unintended pregnancy among young women and men in Accra, Ghana

Authors: Leonard Gobah, Kate Grindlay, Phyllis Dako-Gyeke, Thoai D. Ngo, Gillian Eva, Sarah T. Reiger, Sruthi Chandrasekaran, Kelly Blanchard

Introduction:
Youth (15-24 years) comprise 20% of Ghana's population. According to the 2014 Ghana Demographic and Health Survey, 51% of married females aged 15-19 and 34% aged 20-24 had an unmet need for family planning. Six percent of married and sexually active unmarried 15-19 year olds and 21% of married and sexually active unmarried 20-24 year olds were using any modern contraceptive method. More than half (58%) of all births in the prior five years to Ghanaian women aged 15-19 and one-third of births to those aged 20-24 were unintended. The benefits of preventing unintended pregnancies, particularly among young women, span social, health, and economic domains allowing for the best chances for healthy, productive lives. Recognizing the potential for significant negative impacts of unintended pregnancy, the Reducing Maternal Mortality and Morbidity program was launched in Ghana in 2006 to improve access to family planning and comprehensive abortion care services. Despite efforts to expand sexual and reproductive health services in Ghana, little is known about young people's participation or factors contributing to contraceptive use and unintended pregnancy. There is particularly little known about the determinants of young people's sexual and reproductive health in Ghana.

Methodology:
From September - December 2013, we conducted a cross-sectional study with youth aged 18-24, who spoke English, Twi, or Ga, and reported sexual intercourse in the six months prior to the survey, in Accra, Ghana. We employed a stratified random sampling technique in two low- and middle-income communities. In-person surveys (45-60 minutes) were conducted by field workers in private locations in recruitment communities, including markets, social clubs, and sports venues. Descriptive statistics, chi-square tests, and Fisher's exact tests were used. Logistic regression was performed to analyze determinants of modern contraceptive use among males and females and unintended pregnancy among females.

Key Findings:
Overall, 100 males and 250 females participated. Respondents were on average 21 years old, unmarried with a steady non-cohabitating partner, and Christian. Males had significantly higher levels of education compared to females. Ninety-one percent had one current partner. Only 2% of females ever had a cervical cancer screening and 44% had ever been tested for a sexually transmitted infection (STI); fewer males (21%) had ever been tested for STIs ($p \leq 0.001$). Forty-four percent reported current modern contraceptive use. In multivariable regression, males and females were significantly more likely to report modern contraception use if they had a secondary education (adjusted odds ratio (AOR) 2.1, $p=0.01$), tertiary education (AOR 4.3, $p=0.01$), or vocational/technical schooling (AOR 2.8, $p=0.03$) (compared to primary); had ever talked with someone about contraception use (AOR 4.7, $p \leq 0.001$); felt unsupported by a healthcare provider for contraceptive use (AOR 2.2, $p=0.005$); or did not feel somewhat or very likely to get pregnant accidentally (AOR 2.7, $p \leq 0.001$). While $\geq$70% of participants recognized most contraceptive methods, awareness of some methods—including long-acting methods—was lacking. Nearly all respondents (91%) felt at least one modern method was unsafe. Nearly half of all females (45%) reported their last pregnancy was unintended, and 63% of females and 58% of males felt at risk for future unintended pregnancy. Women were more likely to experience unintended pregnancy if they had ever given birth (AOR 6.7), their sexual debut was 8-14 years versus 20-24 years (AOR 3.4), or they had 3-4 lifetime sexual partners versus 1-2 (AOR 2.4).

Conclusion:
Unintended pregnancy was common, and despite the majority of males and females feeling at risk for future unintended pregnancy, only 44% of sexually active youth were using a modern contraceptive method. Targeted interventions are needed to improve understanding

of long-acting methods and the safety of modern methods, and consequently to increase modern contraceptive access and use. Additionally, contraception use is not merely an outcome of awareness, knowledge, and availability, but is influenced by complex factors including decision-making processes, negotiating abilities, and power relations. As such, interventions must focus on building the self-efficacy of youth and the provision of empowerment skills.

Recommendations:
There are several policy recommendations to address these Findings. First, efforts to increase dialogue around contraception may improve uptake among young people in Accra. A substantial proportion of participants had not talked with anyone about contraception, and having talked with someone about contraception was associated with modern contraceptive use. Further, the finding that early sexual debut was related to unintended pregnancy highlights the importance of early interventions in sexual and reproductive health education. Additionally, targeting sexual and reproductive health education interventions to people with lower levels of education may help to reach young people most in need, as lower education level was associated with a decreased odds of modern contraception use. There is need to improve understanding of long-acting methods and the safety of modern methods. Finally, the low levels of cervical cancer screenings among females and STI testing, particularly among males, should be addressed.

AE10: "Adoption an Option Beyond Abortion": Initiative In Saving Mother And Child

Authors: Gifty Asante, Angela Abugri, Esi Therson Cofie, Alice Soti, Theodora Akpalu

Introduction:
Underlying the causes of maternal death is a complex web of social, political, and economic forces that undermine women's access to essential maternal healthcare and reproductive health information. The high rates of unwanted pregnancy and unsafe abortion are of great concern. Data from the Ghana Demographic and Health Survey (GDHS 2008) indicate that one out of seven births is unwanted, one birth out of five is mistimed, more than one third of all births are unplanned, and only one in six married women of reproductive age uses modern contraceptive methods. In mitigating this, Ashaiman Municipal Health Directorate in 2013, identified Adoption option as an unmet need/ neglected that called for redress. Increasing referrals of clients seeking abortion at bigger maturities necessitated the initiative. Again, the uncertainties of the outcomes of such referrals became a key motivating factor. The Adolescent, Comprehensive Abortion Care (CAC) / family planning units collaborated to intensify adoption counselling for such clients with recourse to the benefits as against the risks of abortion at bigger maturities and in cases of infertility. These interactions revealed adoption as an option in CAC service has been on the low side as the focus usually dwelt on abortion services.

Methodology:
All CAC clients 128 in 2013 were first taken through just 3 basic questions. Whether they knew about adoption. If they have considered adoption in the face of unwanted pregnancy/ (probable infertility). If yes /no Explain Why. They were then taken through counselling, highlighting on adoption as an option with all the pros and cons.

Key Findings:
Per the interview questions during 2013 Reproductive Health activities in Ashaiman, out of the total of 128 CAC clients seen, 116 (90%) had no information on adoption so had not considered,13(10%) knew and had considered but were not very sure of the implications. All the CAC clients received adoption counselling amongst others before choice of type of abortion service. In sum, 61 had manual vacuum aspiration (MVA),58 medication, 9 were to be referred. However,4 out of the 9 women counselled on keeping pregnancy accepted, and 3 out of that (2 adolescents and one single mother) delivered for adoption This trend has continued since. Different women and couples keep expressing interest as adoptive families. Pregnant women especially adolescents with consent of guardians accept to deliver for adoption. Currently the Ashaiman Polyclinic Family Planning/ CAC in collaboration with adolescent health unit ensure that adoption processes are initiated whenever the need be with ready adoptive families.

Conclusion:
Whatever circumstance has led a person or couple to family planning and CAC units e.g. whether they are facing an unplanned pregnancy or struggling with infertility choosing adoption must be equally highlighted as other options. Notwithstanding, it takes careful thought,

consideration, research and planning to determine whether adoption is the best choice for each individual. This concept when promoted and accepted widely in the country and beyond will gradually reduce abortion mortalities and the stress of couples with infertility. There will be reduced pressure in the various homes and orphanages as more people with infertility will confidently adopt other people's children Infant/ child abuse and neglect will decrease reducing child morbidity and mortality as adoption will be of mutual benefit to birth and adoptive parents

Recommendation:
There should be an advocacy campaign on Adoption as an option in reproductive care as a critical unmet need Awareness creation on the importance of adoption and the need to demystify it. It is an act of kindness and a gift to the family and not something to be frown upon. Policy makers to reconsider the role of adoption in reproductive health care and the society at large. There is the need for a policy or framework that will make adoption process easier and integrated in reproductive health care in collaboration with all concerned agencies. This will reduce the morbidity/mortality incidence during ANC as well as baby thefts and sales at various levels of health institutions. It is recommended, a counseling unit is set up in all facilities to take care of the socio-medical, psychosocial, traditional and cultural problems as part of preventive reproductive health. This will help the populace manage situations well with least impact on their health.

AE11: The role of the health facility committees in sustaining the free maternal and child healthcare programme of Enugu State, Nigeria.

Authors: Chinyere .C. Okeke, Anne .C. Ndu

Introduction:
Tax-funded free maternal and child healthcare programme (FMCHP) was introduced in December 2007 on the back drop of poor health indices in the state. It was introduced into the publicly owned health facilities, to improve the utilization of primary health care, ensure that households are protected against the financial risk of obtaining essential maternal and child healthcare and reduce maternal and child mortality. User fees for maternal health services contribute to high patronage of faith clinics and traditional medical practitioners increasing the likelihood of avoidable deaths from pregnancy and childbirth. Even when user fees are not impoverishing, financial constraints still significantly limit access to maternal health services in rural Nigeria. The FMCHP policy envisaged two social accountability strategies, namely health facility committees (HFCs) and complaint systems. The HFCs were designed to monitor the delivery of free services, identify eligible users, provide platforms for consultations with citizens, raise awareness about free services, mobilize communities to use public health facilities, manage facility resources and facilitate implementation of the complaint systems including complaint boxes, hotlines, patient exit and vignette surveys in health facilities. This study seeks to answer the question: Are the HFCs instrumental to the sustainability of the programme till date?

Methodology:
A descriptive, qualitative study was carried out between November 2016 and April 2017 at the state ministry of health and in Agwu district, in Enugu state, south east Nigeria. Covers 7,161km2 with population of six million. Data was collected using document review, in-depth interviews and focus-group discussions. A district was selected by simple random sampling from the 7 districts in the state. Information was extracted from 9 policy documents and 28 interviews (10 policymakers, 8 providers, 6 HFC leaders and 4 FGDs with users) were conducted using a semi-structured in-depth interview guide. Data were analysed using thematic analysis.

Key Findings:
This study has contributed by showing the role of social accountability initiatives in the implementation of FMCH program in Enugu State, Nigeria. HFCs were not represented in Steering Committee and so did not participate in fund raising and budgeting for FMCHP. They were weak in enforcing spending rules and so were not involved in fund management decisions. With the coming in of development partners, they advocated for delinking of service entitlement from evidence of tax policy (ETP). HFCs were responsive to service providers by advocating to government to engage volunteer health workers. There exists a good HFC–provider relationship, as the HFCs meetings included FMCHP regularly on their agenda and also provided feedback to users and citizens and made rewards available to deserving staff. They also acted as community connectors by addressing the demand-side barriers to FMCHP by making their phone numbers available and resolving complaints from the women. They increased the awareness of FMCHP and of complaint procedure among users. They helped

community fill service delivery gaps in health facilities by supporting town union/traditional rulers and leading to community ownership of HFCs. They monitor staff attendance from the trainings received from civil society organisations who attracted sponsorships from development partners. They monitor drug-revolving fund and the use of free care funds in health facilities. The HFCs mainly engaged with district-level decision makers, directly or through the HFC Alliance. Key issues presented to policy makers were infrastructure, security and staffing needs to support effective maternal and child health service delivery.

Conclusion:
In all, the HFCs increased women and children's utilization of free care by breaching the healthcare providers' indifference and clients' lack of trust in public health institutions and they also bothered government officials to fill service delivery gaps in health facilities, made sure drugs were available through the drug revolving funds which they monitored and it reduced the cases of drug stocks outs in the facilities. The HFCs strengthened user/citizen–provider relationship by functioning as community connectors, back-up government and general overseers to influence the responsiveness of service providers, leading to improved transparency and accountability in the programme.

Recommendations:
The HFCs should be involved in revenue generation, management of FMCHP funds, payment of providers, designing of benefits and delivery of free services as their usefulness in sustainability of the program has been shown in this study. Social accountability should be ensured with support by policymakers and service users in the form of active engagement of the HFC members in joint problem analysis and planning with other stakeholders in the FMCHP. Such actions will improve transparency and accountability in free healthcare policy implementation and enhance the attainment of universal health coverage goals of service use relative to the need for care. Other states in Nigeria and low-resource countries should emulate the use and empowerment of HFCs in programs pertaining to the good of the whole community.

AE12: Family planning utilization and factors associated among women receiving abortion services in health facilities of central zone towns of Tigray, Northern Ethiopia: A cross sectional Study

Authors: Goshu Hagos, Gurmesa Tura, Gizienesh Kahesay, Kebede Haile, Teklit Grum, Tsige Araya

Introduction:
Abortion remains among the leading causes of maternal death worldwide. Post-abortion contraception is significantly effective in preventing repeat unintended pregnancy and abortion if provided before women leave the health facility. However, the status of post-abortion family planning (PAFP) utilization and the contributing factors are not well studied in Tigray region. So, we conduct study aimed on family planning utilization and factors associated with it among women receiving abortion services.

Methodology:
A facility based cross-sectional study design was conducted among women receiving abortion services, central zone of Tigray, December 2015- February 2016. A total of 409 abortion clients were selected using systematic random sampling technique and women were interviewed at exit. The data were collected by a pre-tested, interviewer administered questionnaire. Data were coded and entered in to Epi info 7 and then exported to SPSS for analysis. Descriptive statistics, frequencies and mean were computed. Bivariate logistic regression was used and variables statistically significant at p0.05 were checked in multivariable logistic regression to identify associated factors.

Key Findings:
A total of 409 abortion clients were included in this study. Majority 290 (70.9%) of study participants utilized contraceptives after abortion. Type of health facility, the decision maker on timing of having child, knowledge that pregnancy can happen soon after abortion and husband's opposition towards contraceptives were significantly associated with Post-abortion family planning utilization.

Conclusion:
About one-third of abortion women failed to receive contraceptive before leaving the facility.

Recommendations:
Private facilities should strengthen the post abortion care service. Health providers should provide counseling on fertility-return following

abortion before abortion women left the facility. Women empowerment through enhancing community's awareness focusing on own decision making in the family planning utilization including the partner should be strengthened

AE13: SMART Couples Working Together to Improve Health Outcomes

Authors: Dorothy Brewster-Lee, Caroline Agalheir, Yahaya Zakou

Introduction:
Despite decades of investments in health, agriculture and household economic strengthening programs, chronic problems, including malnutrition, persist in Sub-Saharan Africa. There is growing recognition that a multi-sectoral, integrated approach that includes healthy timing and spacing of pregnancies (HTSP) is needed to solve these complex problems. Research shows that women spend more on food, education and health care than men. Men, however, control household income. Addressing these challenges will require behavior changes in couple communication and joint decision-making. Catholic Relief Services (CRS) has initiated the SMART Couple (SC) intervention. SC is a peer-led, participatory, 24-hour, skills-building curriculum that provides couples an opportunity to assess and improve the quality and level of equity in their relationship. SC is delivered in small couple groups, followed by support groups for peer accountability and outreach to other couples. The intervention has been incorporated into multi-sector nutrition programs designed to reach 1,223,749 project beneficiaries in Burundi, Ghana, Niger, Uganda, Ethiopia and Rwanda. Through active male partner support and agency of female partners, SC has the potential to 1) increase women's access to program services including HTSP, 2) increase joint management of household assets, and 3) increase women's participation in community decision-making processes and demand for quality community services.

Methodology:
In 2017, 152 pilot project participant couples were interviewed, at baseline and endline, to assess couples' relationship quality and related health behaviors. After the initial formative study, 142 of these couples continued as beneficiaries in a multi-sector nutrition and food security program. After 12 months, 106 couples were available for follow-up interviews. The Couple Functionality Assessment Toolkit was used during this follow-up evaluation, which measures behaviors in five domains of couples' relationships and 8 technical area program-related modules: health including HTSP, GBV& child protection, parenting, savings & internal lending communities, agriculture and livelihoods, household financial managements and nutrition.

Main Outcomes:
At the follow-up interview, the mean Relationship Quality Index (RQI) increased from 71 at endline to 76, indicating sustained level of quality during the year following the pilot. Couple communication was 15.8 (20-point scale). 78% of couples reported discussing child spacing on at least 2 occasions over the previous month. The mean RQI score for overall decision-making was 8.7 at follow-up (20-point scale), indicating improvement from endline (mean 7.3).

45% of responders achieved high RQIs (>80). The women in these unions reported making statistically significant ($p < 0.10$) more decisions about health without involving their male partners.

In all reports of pregnancy, the male partner accompanied his wife to the health center. Comparison of results between participants who reported high and med-low attendance at the SC sessions showed: groups with high attendance were statistically more likely than participants with medium-to-low attendance to have used a birth-spacing method in past month; to have higher RQI ($p < 0.001$) and higher joint decision-making domain score ($p < 0.001$), more joint decision making over household income ($p < 0.05$), health care of children ($p < 0.01$), consumption of nutritious food ($p < 0.05$), agricultural activities ($p < 0.01$), household sanitation ($P < 0.01$), and education for children ($p < 0.10$). Similar analysis for women showed similar significant ($p < 0.05$) positive results for RQI, joint decision-making about income they generated and major purchases, and ability to visit family members. Comparison groups were similar for age, education level, participant gender, and marital type.

Conclusions:
Study results indicate that the SMART Couple intervention is associated with improvements in quality of couples' relationships, communication, and joint decision-making related to maternal and child health. Analysis demonstrated a correlation between participants

that completed all SMART Couple program activities and positive behaviors across multiple technical areas. The follow-up study also demonstrated an increase in joint decision-making in several technical areas that are critical to the acquisition of good nutrition for children. Sustainability is being accomplished through advocacy and training government staff and religious leaders for adoption of "couple strengthening" as an integral part of their health and well-being activities.

Main Recommendations:
Undertaking couple strengthening activities as a foundational gender intervention can encourage positive couple behaviors and skills to be systematically applied across multi-sectoral programs. Improving couples' communication holds potential for increasing the capacity of women to participate in local community institutions and national programs to achieve durable impacts in household-level outcomes. The SC approach empowers couples with the capacity to decide together, plan together in several areas, and work together to realize their dreams.

Randomized control trials have documented positive results of the SMART Couple curriculum in four sub-Saharan countries (Uganda, Cameroun, Ethiopia and Zambia). However, more experience is needed in implementing this methodology in multi-sector programs. Additional modifications will include strengthening implementation, documenting results in technical sectors and cross referrals and contextualizing nutritionally-related messages for couples to further facilitate positive decisions and behaviors. Additional documentation will be required to understand the contribution of SC to health and development outcomes.

AF1: Overcoming the power dynamics between providers and clients with a view to improving social accountability and empowerment in access to, and the quality of, reproductive health services in the communities concerned

Authors: Ghislaine Alinsato, Erin Dumas, Alfred Makavore, Jimmy Nzau

Introduction:
The present crisis in Northern Mali has worsened the health of women and girls within a socio-cultural context of human rights denial, access to Reproductive Health (RH) services including Family Planning (FP), and Post-Abortion Care (PAC). At the commencement of the SAFPAC project in 2013, there were frequent long-term shortages of stocks of contraceptives, low use of services, insufficient qualified personnel and adequate equipment, non-involvement of men and religious leaders, and persistently unfavourable social and gender standards. The theory of change which underlies the intervention of CARE is that the improvement of the attitudes of caregivers will render RH more attractive and simulate their use. With a view to improving credibility and reducing the power dynamics between caregivers and service users, CARE has adapted the Community Score Card CSC ©which implies the citizens' participation in the improvement of service quality. The project demonstrated a continuing improvement in FP and PAC performance for 5 years in 2 regions of Mali.

Methodology:
The CSC was adapted in the Mopti and Ségou regions for 43 health training sessions. It enfolded members of the community, caregivers and local Authorsities in continuing the quality improvement process. It afforded a sure space for negotiation right from data analysis and the gathering of complaints. During these monthly meetings and quarterly reviews, the caregivers and community representatives shared the data and feedbacks as a starting point for the exchanges. Thereafter a joint analysis of the challenges and an action plan were established and monitored.

Outcomes:
Since 2013, 45,057 women and girls from four health districts of the Mopti Region have used FP methods, 56% of whom opted for a long-term method. 2,543 clients underwent treatment for abortion complications and 64% were able to complete the health training session with a contraceptive method. The credibility of the caregivers was enhanced, and they now enjoy the support of the community, thereby reducing the community's complaints. The communities became aware of their influence on health performance. No stock shortages of contraceptives and consumables were reported during the health training sessions in the January-June 2018 half-year. The SAFPAC project led to continuously ensuring the offer of FP services. Among other lessons learnt were: data analysis as a starting point for facilitating communication on the basis of evidence; enhancing trust between the citizens and caregivers; the latter and the leaders must acquire the necessary means for making commitments and abiding by them; the citizens need support to organize themselves; the intervention must

be expressed through activities adapted to the literacy level and the rural communities; the men and adolescents must break some socio-cultural barriers.

Conclusion:
In unstable contexts, lack of available resources to respond to the needs and preferences of citizens was significant. Through the SAFPAC project in Mali, CARE undertook a holistic approach of accountability and local governance based on its approach referred to as Community Score Card which yielded significant outcomes. CARE's experience demonstrated that the commitment of communities and service providers in a process that enhanced respect, trust and mutual responsibilities may have contributed to improving the quality of, and satisfaction for the services provided.

Recommendation

1. We recommend that the social accountability model should not be replicated in toto. Rather, priority should be given context adaptation (e.g., literacy level). An accountability model must be evolved involving the community, the health district/zone and project staff. The model must be included in all project phases from planning to monitoring-evaluation. Building the capacities of all the teams on the approach will ease its ownership and sustainability.

AF2: A model for the adaptation of a successful innovation: From "Academic Leadership" to "Community Leadership" for Behavioural Change in SRHAY (LCC)

Authors: Abdoulaye Ousseini, Ginette Hounkanrin, Laura Lundstrom

Introduction:
In Niger, the youth aged between 10 and 24 account for 32% of the population. Their needs in SRH (Sexual and Reproductive Health) are acknowledged by the government as a priority. Nonetheless, rare are the SRHAY programmes effectively upscaled with a view to producing an impact on the population. One of the reasons for the failure is that conclusive data on the upscaling potential is sufficiently considered during the pilot phases of the project (ExpandNet, 2011). Project E2A, in collaboration with the MPH and the Ministry of Higher Education, has instituted the project "Academic Leadership for Behavioural Change in SRHAY" (LUC) in the University of Niamey aimed at reducing the unsatisfied needs of the youth as far as the SRH/FP is concerned. The pilot phase was conducted with a methodology for planning its upscaling (PAGE). On the basis of the conclusive data generated, a participative process of reflection on the adaptation of the LUC at community level (Community Leadership for Behavioural Change) was embarked upon in the Zinder region. This summary presents the status of the adaptation.

Methodology:
The stages followed with the identification of the adaptation elements of LUC to LCC: 1- Identification of the essential components likely to ensure the successful upscaling of LUC: a. Youth leadership and creation of the request; b. strengthening the offer of services RHC/FP; c. stakeholder commitment to sustainability. 2- Critical analysis of the community context by the strategic actors, especially young community leaders in order to identify the elements for adaptation. 3- Weekly collection and discussion of the perceptions of youth leaders between young academics and young community members for identification of the gaps and recommended solutions.

Outcomes:
The application of the ExpandNet methodology for planning the upscaling of the academic leadership model facilitated the adaptation of this approach within the community environment through the use of conclusive data for knowledge transfer aimed at an enhanced project implementation, improved ownership of the model by the decision-makers and for participative planning of its upscaling. This systematic measure will undoubtedly contribute to changing perceptions and behaviours as far as RHC is concerned and increase the demand for quality FP/SRH services among the youth of Zinder towards an improvement of health and wellbeing.

Conclusion:

The application of the methodology for the systematic planning of the upscaling (PAGE) of the academic and community leadership approach (LUC) demonstrates that the systematic collection of data, documentation and the commitment of stakeholders all through the pilot project facilitated the expansion of the academic leadership model and enabled the identification of the elements for its adaptation in the community environment. Any upscaling is an adaptation to a new context and should be based on the utilization of conclusive data for increasing the chances of success and the upscaling of the tested and successful innovations in the pilot phase.

Recommendation:

- Implementation of the successful upscaled innovations is always a process of adaptation in various contexts. This requires an analysis of the context with a view to ensuring success in the upscaling.
- The frontline actors' perceptions of the intervention count a lot in the success of the latter. It is therefore necessary to put in place mechanisms for the collection of the trends of the stakeholders' opinions in real time with a view to identifying the lapses and providing solutions

AF3: The strategy of itinerant midwives (SAFI)

Authors: Amy MBACKE, Khady SECK

Introduction:

Community health is a major axis for strengthening the health system in Senegal. Two reference documents have been prepared to serve as an intervention framework for the community health sector in Senegal. They are: • National Community Health Policy (PNSC) validated in 2013; • National Community Health Strategic Plan (PSNSC) validated in 2014. Lack of qualified personnel in the community is, among other things, the cause of the low level of health indicators of the maternal, neonatal and infant and adolescent/youth (SRMNIA) at peripheral level (maternal mortality rate, neonatal mortality rate, contraceptive prevalence rate, assisted delivery rate by qualified personnel). In order to address these challenges, a line of action has been described in the PSNSC for improving service offer within the community in the zones of difficult access by qualified health personnel, in this case, midwives. It is within this framework that the pilot project for itinerant midwives (SAFI) was initiated within the community from February 2015 to February 2017 in two regions of Senegal (Matam and Sédhiou).

Methodology:

The Ministry of Health and Social Welfare (MSAS) carried out the coordination and monitoring at all levels. 50 SAFI (21 for Matam and 29 for Sédhiou) are posted to the health post which does not have a midwife. They spend 3 out of the 5 working days of the week for outreaches to the most remote populations; • preparation of a framework document describing the strategy and its implementation; • continuing enhancement of the capacities of the SAFI; • endowment of equipment to the health posts with SAFI; • organization of joint supervisory missions; • organization of periodic reviews.

Outcomes:

6,607 out of 8,385 outreaches undertaken by the SAFI (79%); • 31,284 children vaccinated; • 7,289 CPN carried out (1st contact); • 7,324 HIV tests performed for pregnant women; • 3,803 new family planning (FP) users recruited; • 11,437 children given Vitamin A supplements. The indicators for SRMNIA also increased between 2014 and 2016: • Contraceptive prevalence rate increased at Matam by 4 to 6.9% and Sédhiou from 10 to 12.2%; • assisted delivery cover rate by qualified personnel increased from 41.2% to 55.3% for Matam and 15% to 42% for Sédhiou; • Proportion of completely vaccinated children increased from 64% to 72% for Matam and from 90% to 96% for Sédhiou.

Conclusion:

The SAFI strategy made it possible to strengthen the offer of services at community level in the two pilot regions. In that regard, plans were prepared for sustainability and extension to the level of Matam and Sédhiou.

Recommendation

- Sustainability and extension of the strategy to the two pilot regions; -upscaling of the strategy to other priority regions.

AF4: Towards the implementation of the Maputo Protocol on the right to sexual and reproductive health for the reduction of early and unwanted pregnancies as well as illegal abortions in Burkina Faso

Authors: Cécile Thiombiano Yougbare, Etse Ditri Sallah, Dr Hyppolite Gnamien, Hélène Menard, Béatrice Bama, Sodeha Hien, Dr Joseph Zahiri, Olivier Van Eyll.

Introduction:
Maternal mortality in Burkina is still a matter of concern, also due to non-application of some policies for the prevention of, and care for, unwanted pregnancies. The policies are not known enough and are limited in terms of services offered and targets affected. Although they make it possible to ensure a medicalized abortion in some conditions, due to cumbersome legal, administrative and medical procedures, eligible pregnancies end up in illegal abortions and death. Women therefore, as a result of rape and incest, continue facing death owing to the undesired pregnancies that put their social or professional lives in danger. 10% of the 330 maternal deaths per 100,000 live births are due to unsafe abortions; 65% of women who decide to have abortions are less than 24 years old. The application of sexual and reproductive laws in conformity with national and regional commitments, such as the Maputo Protocol, constitute a decisive factor in reducing maternal mortality concomitant with improvement of the RH service offer and the rise in socio-economic factors. In this reflection, MdM-F and CSO Burkinabé have, since 2015, been conducting advocacy aimed at reforming the laws.

Methodology:
The approaches adopted are as follows: - diagnostic study of the national legislative framework of sexual and reproductive rights; - Creation of alliances with CSOs, parliamentarians and the media; - Building the capacities of institutional partners and civil society; - Review of the laws and transmission of the amendments to decision-makers; - Collection of the consequences of the non-application of the sexual and reproductive rights with SOGOB; - Media work and citizen mobilization for the dissemination of the evidence of work on the ground at Djibo; - Sensitization and lobbying with key decision-makers.

Outcomes:
Results obtained: - Two advocacy coalitions (1 CSO network, and 1 parliamentary network); - The enhancement of knowledge and attitudinal change on abortion regarding 174 key actors and multi-sectoral policy-makers; - Raising the number of allies (CSO, ministerial and parliamentarian sectors) of the programmes and interventions to combat morbidity-mortality related to unwanted pregnancies and to illegal abortions; - Setting up media platforms for the dissemination of unrestricted messages against stigmatization linked to the problem; At legislative level, a number of judicial and administrative bureaucracy was removed from the new penal code, thus limiting the prevention of morbidity-mortality linked to unwanted pregnancies and illegal abortions; For example: -the rise in the period (from 10 to 14 weeks of pregnancy) for the right of abortion in case of rape and incest; - The existence of prevention measures in pregnancies of minors of school-going age; - Sanctions against persons who obstruct access to contraceptive methods for women and girls. Experience demonstrated the importance of the legal environment (national as well as regional) on the reduction of maternal mortality. It enabled: - The regional upscaling of advocacy for challenging the Authorsities to respect the regional and international commitments towards the protection of sexual and reproductive rights. – to gauge the magnitude of the socio-cultural inhibitions on the SRH public policy.

Conclusion:
Sexual and reproductive rights should be respected as enshrined in the Maputo Protocol and the African Charter on Human and Peoples' Rights. Relating to the rights of women is a key means of combating provoked illegal abortions and maternal mortality. It is of prime importance for the commitments engaged by our States to be quickly translated through a harmonization of the national laws with the regional and international conventions in favour of the health of women and girls.

Recommendation
This advocacy on RH rights requires the implementation of recommendations. To MdM-F: - strengthen the capacities of health professionals and the population in general for an enhanced knowledge and application of the laws; - Strengthen the capacities of legal practitioners on the legal framework of sexual and reproductive health; - Ensure the permanent support of the CSOs for the sensitization and education for the health of the populations. To the partners: - disseminate the new legal framework with the progress made for an enhanced knowledge, enhanced application and increased access to the SRH services and rights; To the State: - ensure the harmonization of the national laws in conformity with the regional and international commitment to the promotion and protection of the DRSH; - create mechanisms that foster direct and effective application of the agreements signed and ratified by Burkina – promote new regulations on SRH.

AF5: Enhancement of geographical accessibility to treatment services to women suffering from Obstetric Fistula in Mali: decentralization of the training of fistula surgeons through the mentorship approach

Authors: Demba Traore, Cheick Touré

Introduction:
Obstetric Fistula is a real public health problem in Mali. Indeed, according to the National strategy for combating fistula of the MPHH, 1,804 and 2,405 women run the risk of the onset of obstetric fistula every year. The government's political commitment to the global campaign for the elimination of fistula decreed in 2005 by the United Nations was reflected in the design of a National Strategy for the Prevention and Treatment of Obstetric Fistula in 2009 with the support of its partners including USAID through Fistula Mali executed by IntraHealth International in Mali. One of the priority objectives of the Fistula Mali project is the capacity building of sites to cater for Obstetric Fistula (OF). It is within that framework that the organization developed an approach referred to as mentorship. Mentorship is a technique for training fistula surgeons based on the observation of the learner's skill in his own environment. After the successful pilot experiment in a hospital at Gao, MPHH recommended that it be extended to the other treatment sites with a view to endowing the country with a sufficient number of surgical teams to improve service offer to women who suffer from fistula across the country.

Methodology:
The fistula surgery training process according to the mentorship approach was performed in four principal stages: 1) Development of training models on fistula surgical techniques; 2) Design of grids for the evaluation of the knowledge and skills of fistula surgeons; 3) Organization of campaigns for the surgical treatment of fistula cases and training of fistula surgeons locally; 4) Assessment of the surgeons at each campaign per site through the use of a grid for verifying skills accounting to national standards.

Outcomes:
PRINCIPAL OUTCOMES: Thanks to the mentorship approach, the USAID Fistula Mali project contributed to the training of twenty-five (25) fistula surgeons between June 2014 and July 2018. Appraisal of the skills showed that a 100 % of them were capable of fistula diagnosis by the standards. 52% (13/25) were at level II and 48 % (12/ 25) at level III. All the sites boasting Level III fistula surgeons introduced routine surgery in the respective sites. Prior to the intervention, a situational analysis of the sites had demonstrated that all the specialists present did not possess the skills for conducting an autonomous clinical and/or surgical fistula diagnosis. Furthermore, all the paramedicals involved in the fistula treatment saw their skills enhanced in pre and post-operative nursing skills. The fistula surgical treatment sites of MPHH increased from three (3) in 2013 to seven (7) sites in 2018. In the project's areas of intervention, 94.8% of the confirmed fistula cases underwent surgical intervention between June 2014 and April 2018.

Conclusion:
The mentorship approach availed MPHH with competent human health resources to cater for surgical fistula treatment. The outcomes of the 2nd objective of its anti-obstetric fistula campaign was thus attained.

Recommendation
In all the new strategic plans for a reduction of maternal, neonatal and infant morbidity and mortality, the MPHH recommends the mentorship approach as a key strategy for building the caregivers' capacity in a decentralized area within a context of limited resources.

AF6: Upscaling Family Planning into immediate Post-Partum in three health districts (Adzopé, Agboville and Akoupé) in Côte d'Ivoire

Authors: Ernest K. Yao, Sayon Kone; Ginette Hounkanrin; Katharine Hutchinson, Liliane Winograd

Introduction:
Estimated at 614 per 100 000 live births, Maternal Mortality (MM) ratio in Côte d'Ivoire is among the highest in the world. The Ivorian government has repositioned Family Planning (FP) as a priority strategy for reducing MM. In its bid to reduce the lost occasions of offering contraception, the Ministry of Health experimented FP in Immediate Post-Partum (FPIPP) at the Teaching Hospital of Treichville-Abidjan

from 2013 to 2016. Over the period, the pilot demonstrated the PFIPP's capacity to increase the number of additional FP users. The Ministry of Health therefore decided to extend the FPIPP to national level. Before the Pathfinder intervention, the FPIPP service was not yet available in the Adzopé, Agboville and Akoupé health districts. A basic study in the project site demonstrated that the utilization of modern contraception in the general FP department was 73% injectables, 18% implants, 8% pills and 0% IUDs.

Methodology:
The project aimed to increase the use of contraception by women immediately after delivery, including adolescents and young girls. Thus, Pathfinder intervened in 15 Maternities with the training (contraceptive technology, counselling, IUD insertion, friendly services to adolescents/young girls, clarification of values), equipment, supply of IUDs dedicated to IPP and monitoring. Capacity building was undertaken from September 2017 to February 2018. All the contraceptive methods were offered and recoverable. Health training sessions have been provided monthly reports since March 2018. Simple statistical analyses have been performed and the data classified by age and by method.

Outcomes:
During three months of activity, 3,772 deliveries were recorded in the 15-target Maternity of the project. Among the women, 3,445 (91%) received counselling on contraception in IPP in the delivery wards or immediately after childbirth. The acceptance rate of the contraception in IPP was 63% (2,156 women). However, nursing mothers who accepted to use a method or received a product before leaving the Maternity account for 74% (1,601) of those who accepted the contraception in IPP. Among the methods adopted, MAMA accounted for 87% as against 13% (215) for all the other modern methods. Besides MAMA, the use of modern contraceptive methods was 45% of IUDs, 38% of implants, 9% of injectables, 7% of pills and 0% of condoms. Thus, the IUDs and implants accounted for 83% of the products used in IPP as against 18% in the general FP departments. Adolescents and young women (under 25) accounted for 31% of the users of modern contraception as against 34% in the general FP departments which took account of the health centres dedicated to adolescents and young women. In the project sites, these age groups constituted 38% and 25% respectively of users of implants and IUDs in IPP.

Conclusion:
Our programme made it possible to offer FP in all the Maternities immediately after delivery. After three months implementation, data demonstrated that the strategy was promising; especially for the use of long-term contraceptive methods of action by adolescents and young girls. Nonetheless, there were numerous losses in the cascading of indicators and a wide preference for MAMA. The period from immediate post-partum represented an ideal moment for offering contraception to adolescents, young girls and women.

Recommendation
Although the FPIPP constitutes hope for increasing the use of contraception, several challenges remain and need to be addressed to ensure success of this strategy. It is indispensable to develop the caregivers' capacities on effective interpersonal communication in CPN and in Maternity. The communication should be extended within the community, to the key influencers. Also, the Ivorian Government also instituted free delivery. It will be laudable to include FPIPP in the free package in labour wards. The IUDs dedicated to the IPP was the Copper T 380A, incorporated in a long single-use sterile applicator, and ready for use. In view of these advantages, it will be convenient to include it on the national list of contraceptives for distribution through the central purchasing agency. Investment in FP, specifically FPIPP is ideal for enhancing the objectives of reducing maternal mortality.

AF7: Burkina Faso's experience in task shifting relevant to family planning in two health districts: Dandé and Tougan

Authors: André Yolland Ky, Mathieu Bougma, Dr Boezemwende Ouba/Kabore, M. Bougassè Charles Zoubire, M. Seydou Boudo

Introduction:
The project of task shifting in family planning is the result of fruitful exchanges between the Ministry of Health and its technical and financial partners with a view to resolving the development problems on high fertility. From 7,964,705 in 1985, the Burkina population today is estimated at 20,244,079 inhabitants. This rapid population growth is in contrast with the sustainable development goals in the area of reproductive health: "Ensuring, access for all to sexual and procreative health care services, including for purposes of family

planning…". One of the reasons behind this population growth is the high level of unmet needs of women and young girls in family planning, and inadequate qualified personnel to respond to FP demands. In 2016, therefore, Burkina Faso adopted the task shifting project with a view to encouraging access to family planning services for the populace by building the capacity of community workers and providing services in the neighbouring health centres. One would wonder whether the basis for such an approach were justified or the outcomes encouraging enough for scaling up the approach.

Methodology:
The signing of the Memorandum of Understanding on task shifting led to the preparation of the Concept Note and the monitoring plan. This was followed with the equipment for health training and community-based health workers in contraceptive kits. This started in October 2016 spanning 24 months. A Steering Committee was put in place to coordinate all the activities under the technical coordination of the family Directorate. The decentralized structures of the health ministry ensured coordination in the regions and districts.

Outcomes:
After one year of project implementation, the following results were observed: ▤ 100% of 124 CBHWs were trained and declared suitable for the initial offer of pills and the injectable method at community level (SyanaPress) ▤ 100% of the 79 workers at the health centres were trained and declared suitable to administer the long-term contraceptive methods. ▤ CBHWs carried out a total of 3,744 discussions on FP that concerned 77,263 persons affected; ▤ CBHWs carried out a total of 7,196 counselling sessions which resulted in 11,647 persons affected; ▤ 5,733 injectables were distributed by the CBHWs including 1,657 new users recruited; ▤ 2,054 pill packs distributed by the CBHWs including 399 new users recruited; ▤ 653 IUDs distributed in the CSPS including 394 new users with 104 between 10 and 24 years; ▤ 1,811 distributed implants including 1,245 new users with 619 aged between 10 and 24 years.

Conclusion:
The experience in the pilot project demonstrated that the community-based health workers and the caregivers of the health centres trained in the administration of contraceptive methods were suitable each in the service packet defined to them. Demand for family planning services and the offer of the services thus increased at community level as well as in the health centres.

Recommendation:
In order to ensure a successful implementation of task shifting at national level, the following recommendations prove incontrovertible: (a) the strategies for the involvement of men and young boys in the family planning programmes should be continued, since behavioural change cannot be achieved within a short period; (b) the draft Decree on the "procedures for the delegation of medical acts to State health delegates, nurses, midwives/birth attendants in Burkina Faso's public health centre structures" should be reviewed to include auxiliary midwives, health field workers and community-based health workers (CBHWs); (c) strengthen the motivation of CBHWs defining a proximity payment mechanism and on the basis of simplified supporting documents including a third party proposed by CBHW.

AF8: Mentoring support to caregivers in the health districts of Djibo and Gorom-Gorom (Sahel region in Burkina-Faso) to improve the quality of sexual and reproductive health care (SRH)

Authors: Hyppolite Kouadio Gnamien, Gon Woro ; Guire Moussa ; Cécile Thiombiano Yougbare ; Sodeha Hien ; Joseph Zahiri ; Olivier Van Eyll ; Etse Ditri Sallah (Equipe Médecins Du Monde Burkina Faso)

Introduction:
The Sahel region in Burkina Faso has the most dependable health indicators in SRH and especially family planning (FP). It has since 2016 been confronted with religious radicalism and insecurity characterized by attacks, kidnapping and assassinations. This context of security tension has provoked a considerable mobility of qualified health personnel negatively impacting on the continuity and quality of health care especially as far as sexual and reproductive health is concerned. Regarding support to the Djibo and Gorom-Gorom health districts in the region and faced with a low quality of health care which classic training has not succeeded in improving, the "Doctors of the World" organisation has put in place in agreement with the Management Team in the Districts, the activity of mentoring health caregivers in the health centres with a view to maintaining the quality of SRH care especially family in the populace despite the socio-cultural inhibitions and religious radicalism. Mentoring is an individual support to health personnel at the work place through knowledge sessions and know-how aimed at enhancing knowledge and practices for improving the quality of SRH care.

Methodology:
The mentoring process of the caregivers last 3 days in health training and is conducted by a joint team of Doctors of the World supervisors and sexual and reproductive health (SRH) focal points of the health districts. The teaching techniques used are: ▤ Discussions with the staff on the objectives, motivation and work environment; Direct observations for evaluating the practices to be improved in the offer of SRH care and family planning; ▤ Presentations on staff performance in health care offer; ▤ Demonstrations on anatomical models and practices on actual cases.

Outcomes:
From March and July 2018: ▤ 4 mentorship trips of three days each were fielded to 4 health training sessions for maternity workers (2 Midwives, 1 certified birth attendant and 1 auxiliary midwives). The trips supplemented and reinforced the theoretical training sessions conducted for the sexual and reproductive health and family planning personnel. During the mentoring, the following topics were reviewed: FP counselling, implant insertion and removal techniques, Manual Vacuum Aspiration (MVA) technique Progress in the knowledge and performance of the health personnel on initial and final assessment which rose from • 49% to 82% for FP counselling according to the REDI scale. • 69% to 89% for the implant insertion technique • 57% to 88% the implant removal technique • 57% to 83% for the MVA technique. During discussions the health agents benefitted from: ▤ ample information on the use of Misoprostol, hygiene of the premises and management of medical and technical equipment and SRH medicines. Demonstrations on the techniques and procedures for handling instruments in the delivery rooms and the material for MVA through high-level disinfection. Reinforcement of health skills in the offer of health, and motivation of health personnel, given the security situation of the area and its commitment to practicalize on continual basis the new knowledge in its daily tasks.

Conclusion:
Mentoring is a mechanism centred on health personnel with the aim of strengthening the quality of health practices and esteem. It constitutes an appreciable aid and draws its efficacy in its inclusion in the daily activities of the caregiver. It complements and reinforces the knowledge acquired during the training sessions organized away from the health structures. These classic training sessions have demonstrated their limitation in the improvement of the quality of SRH care indicators, especially in family planning in the areas where supervision is not regular in regions such as the Sahel.

Recommendation
Mentoring is a learning process not an audit, and so the relation must be based on mutual trust and founded on the confidentiality of the exchanges. It is recommended to: organize it for health personnel when the multiple classic training sessions do not allow for an improvement in the quality of care offered to the populace; organize it when difficulties of the context hinder the implementation of regular formative supervisions; Broaden the learning to other SRH acts such as providing care for haemorrhaging at delivery (Mama Natalie), insertion of PPIUD (Mama-U); Reprogramming follow-up of the achievement of mentoring after 6 months.

AF9: Health tribune for the youth and adolescents: a platform for enhancing youth access to information and services, through social media

Authors: Tao Oumar, Tarnadga Geneviève; Ba Youssouf; Ouedraogo Boureihiman

Introduction:
The social media affords an opportunity for discussions, education, response to youth concerns for information on sexual and reproductive health and even reference for service offer; It is within this context that the IPPF supports the Youth Action Movement for the implementation of this innovative project referred to as Youth connect initiative. It is a project that focuses on the development of a platform on networks with a view to disseminating multimedia content to enhance youth knowledge on the sexual and reproductive rights of adolescents and youth. Thanks to the project, a platform referred to as Health tribune for the youth and adolescents was set up on the various social networks. The objective is to provide space for dialogue, discussions on sexual and reproductive health rights (SRHR) of adolescents and the youth, to conduct advocacy for the promotion and support of SRHR issues, sensitize their peers on the various topics related to contraception. The platform is also used for referring to the youth who use social media towards the association of youth centres and any health centre.

Methodology:
Training the youth in social media, capturing images (filming), video and radio programmes editing, and blogging. Production of videos, radio micro-programmes, articles on various SRHAY subjects. Establishment of a mentorship system to support the youth during the project. National project cover, but also a wider geographical cover (international) due to the opportunities offered by the internet. Convening periodic meetings between the members of the project's Steering Committee to appraise the attainment of the objectives, meetings and mutual support between the youth engaged in the realization of activities.

Outcomes:
The following results were obtained: • 24 900 youth affected by the various sexual health and reproduction topics as against 15 000 expected; • 15 articles produced on the various SRHAY topics; • 02 radio micro-programmes produced and broadcast; • 05 videos produced on topics such as abortion- linked stigmatisation; • 10 WhatsApp chat and tweet-ups with the participation of the youth (at least, 100 youth per session); • skills of 20 youth enhanced in blogging, presence in the media; • Recognition on the role of youth leadership of the youth action movement which has succeeded in developing and implementing innovative project; • Making the youth understand the challenges relating to their sexual and reproductive (SRH) during tweet ups and WhatsApp chats. • Further empowering the youth in the conduct of projects; • Strengthening youth capacities on the production of multimedia micro-programme contents: radio, amateur video for sensitization; • Strengthening youth skills in the production of sensitization articles which has led to developing and sustaining/arousing among the youth the taste for writing, journalistic vocations; • Organizing and producing tweet-ups which was not common in Burkina Faso before the project began; • Obtaining blogging skills and online sensitization; • Advising and directing the youth with sexual and reproductive needs; • Holding online conferences.

Conclusion:
The project mainly enabled: • The use of the social networks to enhance information, youth sensitization and references towards health centres of the association; • Strengthen the visibility of the association's activities (ABBEF) and those implemented by the youth; • strengthen the frameworks for advocacy with decision-makers through the various tweet-ups; • Ensure the involvement of young activist in sexual and reproductive health.

Recommendation

- Create a web tele with young activist involved in the SRHAY to produce and disseminate the contents in relation with the problems affecting adolescents and the youth;
- Organize sexual education courses online to help reinforce the capacities of adolescents and the youth; - Enhance youth training in the use of the social media.

AF10: Experiences from the documentation and upscaling of the social network approach of Tékponon Jikuagou (TJ) for reducing the unmet needs (BNS) in family planning (FP) relating to socio-cultural barriers.

Authors: Mariam Diakité, Susan Igras, Rebecka Lungren

Introduction:
The FP programmes conducted in Benin led to an enhancement of the knowledge of sexually active men and women, on the modern methods of family planning. However, from 1996 to 2012, the number of unmet needs (BNS) in FP increased from 28% to 33% and the prevalence of the use of modern contraceptives from 3% to 8% (EDS, 2011-2012). Admittedly, the number of unmet needs BNS does not account for the demand for contraceptive methods and does not provide a flow of programming likely to translate the sustained use of FP.

What prevents women and men with unmet needs (BNS) in FP from using a contraceptive method?
The outcomes of the formative research of TJ showed the following social barriers of FP: disapproval, lack of discussion and false information on FP (in the base study, 36% of women have declared that it was acceptable to talk about FP in public.).

Also, there was strong influence from family members and the community. (e.g. mothers-in-law, partners), on the choice of persons regarding health, the men were neither well-informed on FP discussions.

Methodology:
TJ engaged a few groups and socially influential persons in the reflective dialogues on the social barriers relating to FP and the dissemination of new ideas in the social media. After this successful, TJ was used, in 2015 and 2016 by four NGOs, including three local, in 88 villages of *Couffo and Ouémé,* in Benin. It was included in Nutrition, Literacy, Water, Hygiene and Sanitation, and Savings and Credit projects. Many quantitative and qualitative methods are applied for evaluating its effectiveness in the context of upscaling and the effects on integrative projects.

Outcomes:
The four NGOs fully implemented the TJ intervention package and the changes were noted in the outcomes of the various evaluations. The integrative projects noted improvements in their principal deliverable products in addition to the expected outcomes for TJ. The personnel certified that the use of TJ facilitated their own reflection and the change of their attitude (in relation to FP, gender, etc.) and that their capacity improved in the implementation of the TJ approach, collection and use of data.

Furthermore, in the integrative project intervention communities, the use of the TJ packet led to changes in attitude, behaviour in relation *to gender and the use of an FP method. During interviews on the most significant changes, a male respondent testified that "At last this change also impacted positively on my own household . . . 3 of my wives . . . were able with my understanding to adopt a method their choice".* In the Findings of the household enquiries the use of modern FP methods rose from 38.5% to 59.4% among the women and the perception of satisfied needs with the men reduced from 45.7% to 7%.

During a study on the sustainability of the TJ effects, almost unanimously, the respondents emphasized that after TJ, the people discussed FP with more ease in the communities and between couples. They confirmed that the people had changed their attitude and behaviour towards the use of Family Planning.

Conclusion:
The TJ package was used by NGOs in various socio-cultural with the same expected results. The practice is effective for breaking the socio-cultural barriers with a view to encouraging the use of FP. With a simple adaptation and support of the IRH, at the moment, the approach has been upscaled in Mali by three NGOs in the area of girl's education, food resilience and security and sexual and reproductive health of adolescents and the youth. A religious leader has encouraged the practice for, instead of imposing a change of norms and behaviour, it makes people embark on reflection, discussion and decision.

Recommendation :

- The TJ social network approach urged us to reflect differently on the creation of demand for FP. It consequently encourages social comparison and a flow of new ideas and attitudes through the networks instead of reaching persons with static information.
- Our outcomes therefore prove that, a light but constant approach to individual behavioural changed through the change of social and gender norms is a precious programming option that must be extended to a larger number of communities.
- Although TJ prioritizes the reduction of unmet needs (BNS) in FP rather than an increase in contraceptive prevalence, among the men in the intervention group, the current use of a modern method and the needs met have reduced but the intention to use FP methods has increased as opposed to the control groups. These responses are sharply different from the responses from the responses of the women and deserve more indepth exploration.

AF11: Improvement in sexual and reproductive health of adolescents and the youth in family planning in Niger through the introduction of sexuality in comprehensive education in college and high school curricula in Niger

Authors: Ali Halima Moumoni, Lucien Marcel Omar

Introduction:
Demographic health indicators in Niger, are alarming. According to the Demographic and 2012 Health Study report in Niger, with 51.7% of the population under 15 years, the average age of initial marriage is 15.8 years for girls and 24.3 years for boys, with high fertility of an average of 7.6 children per woman. The fertility rate of girls aged between 15 and 19 is 201 per 1 000 births, and 68% attain motherhood as early as at age 19. The average age for initial marriage 15.8 years for girls and 24.3 years for boys. The maternal mortality rate in that country is 535 maternal deaths per 100 000 births and the adolescents contribute to 14%. The HIV prevalence rate of the youth is 0.5% and 63% of children in Niger undergo at least one type of violence.

In the face of this situation, Niger with the support of UNFPA has embarked on the inclusion of Comprehensive Sexual Education (CSE) in the secondary education curricula in Basic science (SVT), Family Economics and Geography, and two years after implementation an evaluation of the programme content and achievements of the students was undertaken.

Methodology:
A two-stage pilot phase: Peer education in 10 schools (1) Adaptation of generic modules; (2) Elaboration of data collection tools; (3) Training of peer educators and nurses; (4) Production of communication media; (5) Launch of the pilot programme; (6) Monthly data collection (7) Quarterly Reviews (8) Experience sharing and subsequently Extension to SVT and EF teachers.

Phase of including CSE in the secondary school curricula after advocacy with the stakeholders; Review of the modules; (3) training and monitoring, (4) Content evaluation and educational achievements.

Outcomes:
Pilot phase: 80 peer educators and 60 teachers trained for a target of 15,079. 1280 sessions held during 8 months, 9 681 adolescents and youth affected. 459 monthly consultations including 607 cases of STI, 11 seropositive and over 5000 contraception offered.
In 2014 inclusion of CSE in the curricula with over 57 % teachers trained. This contributed to developing empowerment of the adolescents and youth and led to reduction of the training cost and a rise in RH knowledge.

A control of the educational achievements of the students was successful for at least for half of the Items: 81.1% 6th; 84% 5th; 73% 4th; 88% 3rd; 93% second; 50% first A; 69.1% first C/D; 75.1% terminal A and 75.1% in terminal C/D.

Outcomes questionnaire to teachers:
57% have derived considerable benefit from the training, especially those of Family and Social Economy topped the list (69.7%) against 30% for History and Geography as against 37.5% which had difficulties.

Outcomes questionnaire "pedagogical supervision"
41.4% derived considerable benefit from the training to better supervise teachers and 48.3% said they noted an improvement. On the other hand 41.4% said they found out that the teachers trained had difficulties.

Outcomes of the CSE programme evaluation by the SERAT tool
Evaluation by the SERAT tool, bore on the CSE Programme objectives and principles of the in Niger, Programme contents, Programme implementation, Inclusion in the curricula, Teacher training, Monitoring-Evaluation and Institutional context.

The outcomes showed 53% of the strong elements, 35% low or average and 12% of Non-applicable.

Conclusion:
Including the CSE in the curricula is a good practice to promote in the countries where the knowledge level in RH/HIV and the family

planning request remains low. It highly increased the creation of demand as well as the use of RH services. It also contributed to the reduction of discrimination and judgement of the adolescents and youth by the service providers of the school clinics during the offer of the services. Furthermore, the evaluation of the students' school achievements and the contents included in the disciplines helped identify the strengths and weaknesses of the programme, therefore recommended the elaboration of additional modules.

Recommendations

- A high commitment of the State and all decision-makers should be advocated:
- All the stakeholders should be involved at all levels;
- A coherent upscale plan should be prepared and implemented;
- A Multisectoral Committee should be set up to monitor the measures to be undertaken;
- Technical and financial support of the partners must be ensured;
- Permanent availability must be ensured for the product as well as proper stock management;
- A dependable data collection system must be put in place for product offer and consumption in order to gauge the advisability of the intervention;
- There must be a periodic organization of the offer and RH/PF services supervision for adolescents and the youth;
- The outcomes of the offer to the various actors should be periodically shared with the actors working in the area.
- The intervention outcomes must be documented.

AF12: Family Planning and Reproductive Health for First-Time Parents: A combined approach to behavioural change at Zinder, Niger

Authors: Assani Osseni Akim, Ousseini Abdoulaye, Claire Moodie

Introduction:

The high demographic growth in Niger is the result of a long period of high fertility with an average of 7.6 children per woman and with 51.7% of the population aged below 15 years. The fertility rate of girls between 15 and 19 is 201 per 1,000 births and, at 19 years, 68% attain motherhood1. At national level, the average age of initial marriage is 15.8 years for girls and 24.3 for boys2. In their homes, the married adolescents without proper information on sexual and reproductive health face social pressure for early and frequent motherhood. This situation is the main cause of an extremely high maternal and child mortality and morbidity rate. In Niger, in 2015, the maternal mortality ratio was 520 for 100,000 LBs and that of infant mortality 126‰ LBs 3. In that context, Pathfinder International, in collaboration with government and local partners, implemented the family planning and reproductive health project for First-Time Parents (FTP) in Niger intended for married young women (up to 24 years) who are pregnant or have had a first delivery, and their partners.

Methodology:

The approach is set out in an additional intervention package of social and behavioural change and following the 3 levels of socio-ecological models, i.e.: personal, social and structural. Consequently, at individual level, home visits and small group meetings were organized to sensitize adolescents and support them in health training. At social level, small group meetings and community activities were conducted for husbands, co-wives, mothers-in-law and community leaders with a view to creating a conducive environment for FP. Structurally, the project included services suited to the needs of the youth.

Outcomes:

Individual/Couple level

- 288 community relays trained;
- 6,200 home visits conducted;
- 4,300 small group discussions held;
- Over 1,950 young FTP couples involved;
- Over 1,000 young women referees at the health centres;

Social/community level

- Over 8,200 contacts with mothers-in-law, fathers-in-law, co-wives and other influential persons through home visits;
- Almost 150 forum theatres conducted in 48 intervention villages (12,000 participants);
- 15 radio spots produced in three languages (Hausa, Kanouri, Fulfulde) and broadcast over 850 times;
- Over 120 religious heads trained in family planning;
  - Progress noticed in communication among couples and an increase in joint decision-making;
  - Wider involvement of husbands in heavy household chores;
  - More support from husbands to enable their young wives use the health services;

Structural/System level

- Over 50 health workers to offer services suitable services for the youth;
- Over 350 mobile clinics organized in collaboration with IMPACT in Niger to cover FTP project villages.
- On 16 health centres sustained by the project:
  - 1,845 ANC at Q4 2017 (266 ANC at Q4 2016).
  - 12,695 women have adopted family planning methods (including 60% below age 24).

Conclusion:
In order to encourage effective change in social norms the measures must be conducted in combined fashion at many levels of the socio-environmental system of the targets. The combination of home visits (VAD), small group discussions and community dialogues were measures which did not affect young married girls alone at personal level but equally their close circles (husbands, influencers, etc.). All this must be sustained through a permanent enhancement of the quality of health services to meet the demand thus created.

Recommendation

- Account should be taken of vital needs not met in sexual and reproductive health of the married adolescents and especially first-time parents in the health programmes by combining many successful approaches of the socio-ecological model to enable an effective response thereto in West Africa;
- Account should be taken of factors linked to the close circles of young first-time mothers, which sometimes constitutes an impediment to the quest for information and health services in the process.
- Measures should be taken to get the key influencers to generate a conducive environment for expressing and enjoying the rights inherent in sexual and reproductive health for the married adolescent.

AF13: Funding Family Planning interventions by local communities

Authors: ZEKPA Apoté Tovinyéawu, N'GANI Simtokina

Introduction:
By way of repositioning Family Planning (FP) with the aim of reducing maternal mortality and benefiting from demographic dividends, Togo has made ambitious commitments at national and international levels.

Between 2016 and 2020, Togo must include 141,000 additional users in the modern contraception programme. It will thus contribute about 6.40% of the outcome of the Ouagadougou Partnership which is to recruit 2.2 million additional users and 1,200 000 for FP 2020 in 2020.

One of the impediments identified in health funding is the low financing allocated to Family Planning on the national budget and the budget of the communes and the special delegations of the prefectures, including securitizing the FP products.
As forecast for the 2018 Budget Management, the Network of Champions for Adequate Health Financing in Togo (RCFPAS- Togo) with technical and financial support in the account of the Opportunity Fund has proposed pursuing advocacy with the Togo communes for them to earmark 5% of their budget to Family Planning.

Methodology:
This initiative took off with the effective involvement of the Ministry of Health and Social Protection and the Togolese Union of Communes. Prior to the public signing of the Mayor's commitment, the advocacy was conducted through the presentation of RAPID Togo 2014 (Resources for analyzing the Population and its impact on Development) for the Directors of the Communes as well as the other stakeholders (decision-makers, health caregivers, civil societies involved in health, partners, religious leaders, beneficiaries, guarantors from the US and customs, women groups, men's local development committees, media).

Outcomes:

- 420 commune directors and other stakeholders (decision-makers, health caregivers, civil societies involved in health, partners, religious leaders, beneficiaries, guarantors from the US and customs, women groups, men's local development committees, media) were involved in the advocacy;
- 19 out of 21 communes signed the commitment to allocate 5% of their annual budget to Family Planning as from 2018;
- Each commune has a work plan based on activities regarding the creation of the demand;
- 17 out of 21 communes have actually allocated CFAF 36,229,828 for Family Planning for 2018;
- 79 commune stakeholders have built their capacity on resource mobilization based on the AFP SAMRT approach.

Conclusion:
Family Planning is a strategy that enables couples to undertake frank and sincere dialogue on ideal birth spacing, to discuss the repercussions of gender-based conjugal violence and on women's right to RH; FP also enables the avoidance of a high number of pregnancies, excessive closeness of undesired pregnancies which lead to illegal abortions leading to deaths among adolescents and the youth. The increase in the funding of the local communities for the FP interventions will impact positively on their community by ensuring the availability of the quality services offered.

Recommendations:

- The actors should be trained on the AFP SMART tool and the advantages of Family Planning funding.
- The networks and CSOs working in the Reproductive Health and Family Planning sector should be involved.
- An efficient mechanism should be put in place to evaluate and monitor Family Planning interventions
- Respect must be ensured of the commitment made by the communes towards Family Planning.
- The network/CSO partnership working in the Reproductive Health and Family Planning sector should be maintained, the health district and communes should guarantee the effectiveness of the outcomes in terms of significant improvement of the indicators relating to Family Planning in Togo

AF14: Facebook page 'Entre Nous', a promising channel for improving knowledge and attitudes in Sexual and Reproductive Health (SRH) for adolescents and youth in Côte d'Ivoire.

Authors: Marie Fedra Baptiste, Adou Kouablana Arsene, Gaby Kasongo

Introduction:
In Côte d'Ivoire, those aged between 10 and 24 account for 21.3% of the population (RGPH 2014). In 2012, the modern contraceptive prevalence rate (TPCm) was 11.9% (15-19 years) and 16.9% (20-24 years) while the unmet needs in contraception were estimated at 60% for the two brackets (EDS-CI 2011-2012).

Aware of the low access to healthcare services by the youth population, the Ministry of Public Health and Hygiene (MPHH) instituted a National Programme for School and University Health (PNSSU) which enfolds 77 (SSSU) School and University Health Services at national level for the youth.

In that context, the project Ignite, funded by The Netherlands and implemented by Population Services International (PSI), supported MPHH's efforts for improving the SRH for the youth. The programme's main objective was to create a demand for contraceptives, and it is within that framework that the PSI alongside the youth created the 'Entre Nous' Facebook page, by leaning on a media most often used by the latter. The objective was to create the demand in SRH products and services for adolescents and young girls while improving access to relevant, motivating and suitable information.

Methodology:
The approach adopted was inspired by a human-centred design, which consisted in designing the page, together with the target population, after a 'phase of immersion' with a view to an improved understanding of their realities. During discussions on the procedure, the PSI team understood the aspirations and expectations of the participants, their interest in terms of health, and their needs in terms of counselling on contraception.

The information gathered was used in creating the Facebook page "Entre Nous", whose objective was to create a community of youth who, in all trust, shared their preoccupations on sexuality and contraception and had access to a source of dependable information.

Outcomes:
So far, (after 5 months of existence), ''Entre Nous" enfolds a community of 29,792 subscribers exposed to messages of awareness on contraception through Facebook. Statistics reveal that we registered 4,417 subscribers in March 2018, 5,605 in May that same year, as well as 4,572 in June 2018, and 8,521 in July respectively. Since August, 6,677 new subscribers have been registered.
Daily publications come out from Monday to Friday, with 2 to 3 postings per day bearing on:

- SRH: 2 to 3 times a week;
- beauty: 2 to 3 times a week;
- contraception: 2 to 3 times a week.

The flagship column is "La sage-femme Gabi" ("Gabi the Midwife") appears on Tuesdays. The section affords subscribers the opportunity to directly express their concerns to an SRH expert. The maiden session was launched on 29 May 2018 and reached 6,700 users, attracting 481 followers.

We were able to establish that 98% of our subscribers were women with 53% in the 18-24 age bracket, 16% from 13-17 years and 28% from 25-34 years. Over 96% of the subscribers live in Côte d'Ivoire. The commonest issues from those under 25 years were related to the menstrual cycle, the calculation of the menstrual cycle, and the impacts of contraception methods on fertility. For those over 25 years, the issues were linked to desires of motherhood, pregnancy and the side effects of contraceptive methods.

Conclusion:
The most important growth of the Facebook page "Entre Nous" demonstrated that conception efforts and their operationalization paid off. The youth needed an interactive platform capable of creating close cooperation among the youth themselves, for they shared the same concerns as well as between the subscribers and the creators of the page, for the youth often had the impression that the existing structures did not allow for dialogue and the space for free discussion without inhibitions. That is why the page "Entre Nous" is the spearhead of the 'communication' dimension of the programme Ignite.

Recommendations

- Account should be taken of the subscribers' comments regarding an improvement of the page's contents;
- Creativity and innovation should be constantly introduced into the manner of communicating and interacting with the subscribers. That will prevent the latter from becoming bored with the items and ending up disinterested in them. For instance, contests could be created, or photos published that come from the formal context of the page with a view to strengthening

closeness with their subscribers. Tabs could also be created to personalize the page;

- Watch out on Facebook and observe the "competitors". As a matter of fact, it is important to seek information or even take a cue from the techniques used by them;
- Open up to other platforms (WhatsApp, Instagram) to capture part of the youth who use them;
- Draw up a chart for the use of social networks for PSICI employees with a view to drawing them in with the strategy.

AF15: Feasibility of Obstetric Fistula surgery at Level 1 of Mali's health pyramid (reference health centres): Pilot experiment CSRéf at Koulikoro

Authorss: D. Traoré 1, C.O. TOURE1, M. Keita1, R. Fomba; S. Diakité 2; S. Guindo 2

Introduction:

Mali is a West African country in which it is estimated that the number of women running the risk of Obstetric Fistula (OF) is between 1,804 and 2,405 per year. Obstetric Fistula is an acquired disease between the vagina and the surrounding organs, which occurs during delivery, resulting in permanent loss of urine and/or faecal matter through the vagina. Women affected encounter social isolation in addition to physical pain.

To tackle this predicament, Mali's Ministry of Health with the support of its technical and financial partners, including USAID, has since 2009, devised a National Strategy for the Prevention of, and Care for Obstetric Fistula. USAID support to MPHH in the implementation of this strategy was carried out through two projects: Fistula Care (2008-2013) and Fistula Mali (2014-2019).

With a view to bringing the Fistula care services to most of the women affected and reducing treatment cost, the USAID/Fistula Mali project, in collaboration with the National Health Directorate, conducted an operational research which consisted in steering the feasibility of the OF surgery in the Reference Health Centres (CSRéf), which are closer to the populace but do not carry out that operation according to the National strategy.

The CSRéf in Koulikoro was selected to conduct that pilot experiment because it is one of the regional capitals of Mali that are not endowed with a second reference public hospital establishment. In addition, it is a matter of being a project intervention zone where the national OF Prevention and Care strategy has not yet been implemented.

Methods:

The methodology for the execution of this approach on the Koulikoro site was performed in four stages centred on client needs:

1) Situational analysis of the care site for identifying the needs of the CSRef in skills and equipment for enhanced client services.
2) Strengthening the capacities of the site through the following measures: caregiver training counselling and nursing care of the fistula client; prevention of infections and management of obstetric emergencies; introduction of the PQO approach (Optimization of Performance and Quality); endowment in medico-surgical materials and equipment, arrangement of reception and hospitalization framework.
3) Creation of a conducive environment for combatting fistula based on the involvement of the political and administrative Authorsities, health programme managers and civil society organizations.
4) Organization of campaigns with two objectives: ensuring surgical treatment for obstetric fistula cases and training healthcare teams to cater for the clients.

Outcomes:

The project reinforced the capacities of the Koulikoro CSRéf, after which it organized six campaigns that enabled catering for 151 women OF victims from May 2015 to March 2018. Furthermore, the clients were the oldest in relation to the other sites, which was likely to make the surgical prognosis difficult. Despite these inadequate conditions, 60.2 % (91/151) of the fistulae were closed and dried. This outcome is even better than some 2nd and 3rd reference hospitals, which have more resources and skills as indicated in figure 1 below.

The approach strengthened the capacities of five local surgeons in the treatment of Obstetric Fistula, which made it possible to put in place a mechanism for starting routine surgery at the Koulikoro site. This new service broadened the scope of care provided to the population, for during the basic evaluation, the site did not have any fistula surgeon certified by the Ministry of Health.

In addition to the training of surgeons, the site had human resources (midwives, nurses, nursing care assistants, anaesthetists, etc.) competent and motivated enough to ensure all the pre and post-operative care, as well as psychosocial support for clients and their families.

Conclusion and Recommendations:
Surgical treatment for OF in the CSRéf is feasible thanks to this approach based on three intervention axes, namely, building the site's capacities, involving all local stakeholders and informing the communities on the availability of treatment services. Thanks to the encouraging aspects of the approach, the MHPH retained it as one of the key approaches for the implementation of its new Strategic Plan for the elimination of obstetric fistula (2018-2022). The principal recommendations formulated at the workshop for sharing the outcomes of this approach are:

- Fistula surgery should be extended to all CSRéfs of the country with human resources in specialized care (gynae-obstetricians, general surgeons, urologists) for enhanced geographical accessibility to fistula victims.
- The technical plateaux of the health structures should be strengthened at the level of the health pyramid with a view to reducing the cost of reference evaluation and/or curative care.
- The approach should be extended to the other components of maternal and infant care.

AP1: Health planning and best practices: analysis of the availability and readiness of maternal and newborn, infant, adolescent and youth health services in Bissau and Biombo

Authorss: André Beja, Vany Moreira, Augusta Biai, Agostinho N'Dumbá, Clotilde Neves, Marta Temido, Paulo Ferrinho

Introduction:
The health system of the Republic of Guinea-Bissau (RGB) faces shortages that negatively affect the access to care and health indicators, namely mother and newborn, infant, adolescent and youth health (MNIAYH) 1-4. This led to the proposal (for the creation) of a hospital complex in Bissau (HCB) that would concentrate resources and the installed capacity in public sector units and conventions (non-governmental non-profit organizations, religious entities). In 2017, the hospitalization capacity of the units in the autonomous sector of Bissau and the region of Biombo - an area concentrating one third of the population and the majority of the RGB2 reference hospital infrastructures – were assessed. The methodology developed by the WHO, the Service Availability and Readiness Assessment (SARA), to collect consistent and standardized information on health services and regular monitoring of their availability and readiness, essential to support the planning processes, universal coverage reform and the sustainable development goals5-7, was used for the assessment. In this article, we present and discuss the main study results, describing an overview of these health facilities and the availability and readiness of MNIAYH services.

Methodology:
The health system of the Republic of Guinea-Bissau (RGB) faces shortages that negatively affect the access to care and health indicators, namely mother and newborn, infant, adolescent and youth health (MNIAYH) 1-4. This led to the proposal (for the creation) of a hospital complex in Bissau (HCB) that would concentrate resources and the installed capacity in public sector units and conventions (non-governmental non-profit organizations, religious entities). In 2017, the hospitalization capacity of the units in the autonomous sector of Bissau and the region of Biombo - an area concentrating one third of the population and the majority of the RGB2 reference hospital infrastructures – were assessed. The methodology developed by the WHO, the Service Availability and Readiness Assessment (SARA), to collect consistent and standardized information on health services and regular monitoring of their availability and readiness, essential to support the planning processes, universal coverage reform and the sustainable development goals5-7, was used for the assessment. In this article, we present and discuss the main study results, describing an overview of these health facilities and the availability and readiness of MNIAYH services.

Results:
The overall availability of services analysis was limited by the lack of data on the reference population of these services and their use, and by the fragility of common information systems in the African region8. The data collected showed a majority of workers (77.4%), hospital

beds (73.59%) and maternity beds (79.89%) concentrated in the public sector (23% of units). Units operated by religious organizations (23% of units) showed an increased operational capacity (76% on readiness index), followed by NGOs (73%), the public sector (59%) and the private sector (56%). The general availability of services is mainly affected by the low availability of drugs and basic resources to ensure diagnostic capacity. At the level of the MNIAYH, the availability and readiness of the following services were analyzed: family planning; prenatal health; basic and advanced obstetric services; childhood immunization; child health (prevention and cure) and adolescent health. Only the public sector provides all these services. In all units, none of the services had a preparedness level above 63% (basic obstetric services), with adolescent health services being the least prepared (22%). The lack of trained staff and guidelines contribute to the current preparedness indexes. Moreover, it was seen that private units have lower readiness as compared to public ones. The average availability of essential drugs for mothers (36%) and children (34%) was low and none of the units provided the 13 Life-Saving Commodities defined as essential by the UN 9.

Conclusion:
In line with other descriptions of the RGB health network, the results show a shortage of equipment, infrastructure and resources, a predominance of the public sector and the growth of the conventional and private sectors, and imbalances in the supply and availability of services. In addition to strengthening the relevance of creating an integrated, rational and adequate response to the challenges faced in the country in terms of maternal, newborn, child, adolescent and youth health, these data will be fundamental, in line with the recommendations and good practices in health planning, to support a reorganization of the health network according to objectives of the health system.

Recommendation
Articulate the already defined MNIAYH objectives and strategies with those of the objectives of the Campaign for the Accelerated Reduction of Maternal Mortality in Africa in a National Reproductive Health Program; Reorganize and strengthen the availability and preparedness of MNIAYH services, seeking to ensure and promote a more effective access for adolescents, youth and women of all ages; Adoption of common guidelines to all units, strengthening the use of existing guidelines or, if necessary, welcoming existing and appropriate guidelines; Strengthen the training and education of MNIAYH professionals, in line with recruitment, professional development and retention strategies for health human resources. Adoption of regular monitoring of the availability and readiness of RGB health services, with particular attention to the MNIAYH.

ABSTRACTS - ORAL PRESENTATIONS

Public Private Partnership and ICT in improving Maternal, Newborn, Child and Adolescent and Youth Health (MNCAYH)

BE1: How and why frontline health workers in a low resource setting used a multifaceted mHealth intervention to support primary care maternal and neonatal health decision-making

Authors: Hannah Brown Amoakoh, Kerstin Klipstein-Grobusch, Evelyn K Ansah, Diederick E. Grobbee, Lucy Yevoo, Irene Akua Agyepong

Introduction:

Despite increasing use of mHealth interventions, there remains limited documentation of 'how and why' they are used to produce observed effects. We explored 'how and why' an m-Health intervention to support clinical decision-making by frontline providers of maternal and neonatal healthcare services in a low-resource setting was used. The intervention consisted of phone calls (voice calls), text messaging (SMS), internet access (data) and access to emergency obstetric and neonatal protocols via short code (Unstructured Supplementary Service Data or USSD); delivered through individual-use and shared facility mobile phones with unique Subscriber Identification Module

(SIM) cards networked in a Closed User Group.

Methodology:
The study design was a single case study with multiple embedded sub-units of analysis within the context of a cluster randomized controlled trial (CRCT) of the impact of the intervention on neonatal health outcomes in the Eastern Region of Ghana. We analyzed SIM card activity data for voice calls, SMS, data and USSD use. We also conducted key informant interviews and focus group discussions with users of the intervention. SIM card activity data was analyzed in Stata and qualitative data was analyzed manually for themes.

Key Findings:
Voice calls were used most followed by data, SMS and USSD in that order. Over time, use of all 4 intervention components declined. There was little closed user group (CUG) communication between members of the CUG. Shared-use phones and phones designated to remotely located health facilities utilized the intervention less often than individual-use phones or phones designated to non-remotely located health facilities. Individual health worker factors (demographics, personal and work-related needs, perceived timeliness of intervention, tacit knowledge, and utility of CUG), organizational factors (resource availability, information flow, availability and phone ownership), technological factors (attrition of phones, and network quality) and client perception of health worker intervention usage explain the observed pattern of use of the intervention.

Conclusion:
How and why m-Health interventions are used (or not) goes beyond the technology itself and are influenced by individual and context specific factors. These must be taken into account in the design of such interventions to optimize effectiveness.

Recommendations
★ Clinical decision-making support mHealth interventions that are based on voice calls and use of the internet to access protocols and advice are more likely to be effective in the study context. ★ Designing clinical decision-making mHealth support interventions such that frontline health workers can have access to these interventions with their personal phones can potentially ensure that all health workers have equal access at all times. ★ mHealth interventions must have incorporated into their design, features that provide continuous awareness and capacity building in the use of the intervention and its components among its current and future users.

BE2: Multi-systems approach in improving maternal and newborn health outcomes: A case study of Saving Mothers Giving Life Initiative (SMGL) in Cross River state, Nigeria

Authors: Kazeem Arogundade, Oluwayemisi Femi-Pius, Eberechukwu Eke, Sulaiman Gbadamosi, Olayiwola Jaiyeola, Farouk Jega

Introduction:
The World Health Organization estimates that about 830 women die every day from childbirth or pregnancy related complications with 99 percent of the deaths occurring in developing countries.

Yearly, 3.3 million stillbirths and over 4 million newborns die within the first 28 days of life. Nigeria ranks as the second highest in the world with 576 maternal deaths per 100,000 live births and Neonatal Mortality Rate (NMR) is 37 deaths per 1000 live births. In Cross River state, the Saving Mothers Giving Life (SMGL) Initiative assessed 812 health facilities to identify their readiness to provide comprehensive and integrated maternal and newborn health services while identifying gaps that require interventions in order to reduce MMR and NMR. Findings from the health facility assessment revealed a MMR of 872/100,000 live births and NMR of 160/1000 live births. Using the health facility assessment data, 97 health facilities (Public, Private and Faith Based) were selected to implement the project based on an inclusion criteria consisting of delivery data, geographical spread and availability of skilled birth attendants. The baseline data collected from the 97 SMGL facilities revealed MMR of 313/100,000 live births and pre-discharged perinatal death of 58/1,000 live births.

Methodology:
SMGL Initiative capacitated over 400 health care workers on in public and private health facilities on emergency obstetric and newborn care services

(EmONC) including the use partograph, strengthened the collaboration between public and private health sector through activation of cluster model referral network across and electronic referral system (CommCare) and digital health messages. Furthermore, the initiative institutionalized Maternal and Perinatal Death surveillance response and data review meetings and facilitated the setting up of community driven emergency transportation systems (ETS) in 63 wards across the state to address the delay contributing to maternal mortality.

Results/Key Findings:
Since inception of emergency transportation services (ETS) and referral network systems in Cross River state, over 1000 women in labour and or with complications during delivery have been transported by ETS services and referred from communities to health facilities and across health facilities (public, private, primary and secondary) for timely obstetric care This resulted in positive maternal and newborn outcomes in over 95% of cases. As a result of improved capacity of over 400 health care workers on evidence based MNH interventions the rate of partograph use in monitoring labour and delivery is currently 78% compared to baseline of 15% in the year 2015. This has helped in identifying promptly cases of prolonged/obstructed labour and providing timely surgical interventions to save lives of mothers and avert stillbirths. The digital health interventions (HelloMama and CommCare) and safe delivery kits helped increase institutional delivery by 24% from baseline figure. Within 3 years of SMGL implementation in Cross River state, the initiative achieved 28% (225) and 24% (44) institutional reduction in Maternal Mortality Ratio and Peri-natal mortality rate from institutional baseline of 313/100,000 and 58/1,000 respectively.

Conclusion:
From the foregoing, it is obvious that improving maternal and newborn health outcomes requires a strong synergy of systems such as demand creation activities at the community level, capacity building for health care workers, functional emergency transportation systems, collaboration with professional bodies (obstetricians and neonatologists), infrastructural upgrade including provision of maternal and newborn health equipment, referral network systems across facilities (Public and private), data review meetings, MPDSR and timely surgical intervention (including cesarean section).

Recommendations
To sustain the early gains of maternal and perinatal death reduction, it is imperative for partners and government stakeholders to mobilize community members in the planning and implementation of health intervention programs for sustainability sake. Continuous collaboration between public and private health sector, primary and secondary health facilities and professional bodies such as Society of Obstetrician and Gynecology of Nigeria (SOGON) and Nigerian Society of Neonatal Medicine (NISONM) are key to improving the quality of maternal and newborn care services. Adequate skilled birth attendance should be provided for health facilities and regular Maternal and Perinatal Death Surveillance Response and data review meetings should be ensured at facility and state level. The digital health interventions (HelloMama and CommCare) should be scaled up by the government to improve uptake of maternity services at the health facilities

BF1: Mobile health contribution to the dissemination of health information for pregnant women and mothers of children under five years.

Authors: Hamidou Sanou, Ali Sié, Maurice Yé, Moubassira Kagoné

Introduction:
The practice is in the framework of the Mobile health project, Mobile santé (MOS@N) being implemented in the Nouna Health Research Centre for 3 years now. The project provided sponsors selected in the 26 villages and the 5 CSPS with mobile phones to sensitize the pregnant women and mothers of children under 5 years through the voice function. Indeed, the sensitization messages prepared by the Ministry of Health were transcribed into 5 local languages (bwamu, peulh, dafing, bobo, moaga) and French and were incorporated in the phones. The sponsors were also provided with bicycles to facilitate their movements in the villages and were financially motivated in the amount of CFAF 5,000 per month. At the level of the CSPS, computers were offered to enable the recordings of patients' data in an electronic file. The data was transmitted to a central server which transferred the reminders of the consultation dates to the mobile phones of the sponsors and enabled them to listen to sensitization messages. All the telephones were incorporated into a prepaid fleet and shortcuts were made to facilitate their use by the sponsors.

Methodology:
The methodology for best practice identification is based on a combined analysis (qualitative and quantitative) comprising data collected thanks to a crosscutting and descriptive study of the MOS@N project. The different documents (articles, expansion notes for upscaling

the MOS@N, report of the national monitoring committee meeting) as well as cyber-strategy documents of the Ministry of Health were collated.

Outcomes:
The best practice identified was implemented in the Nouna health district, in a rural area, from 2014-2016. It facilitated access to sensitization messages and strengthened the capacities of community stakeholders. In the framework of MOS@N, it facilitated the monitoring of 2,161 pregnant women in ANC by the sponsors and digitized for 2,897 access to the contents of sensitization (ANC, vaccination and PLWHIV) despite the challenges linked to the telephone network. It enabled them to obtain a 12.6% gain in ANC4 (58.07 test zone vs 45.47 control zone), a 3.5% polio and BCG increase and a gain of over 46 points in the reference of high-risk pregnancies. It was declined as follows: it is aimed at providing the community-based health workers with mobile phones and memory cards containing voice messages of sensitization in the local languages of Burkina (moore, dioula, fulfuldé, dafing, bwaba) and in French. Upscaling proved easy because the voice messages were available, and the Ministry of Health already had a cyberhealth directorate. It will suffice to conduct advocacy with this directorate which was part of the MOS@N project monitoring committee meeting for the coordination of the practice at national level. In terms of financial implications, it is worth saying that the expansion of the practice proved simple because it did not require too many inputs as it did in the initial MOS@N project, more so as the community-based health workers were already included in the health system and the practice needed neither a prepaid fleet nor a telephone network to function. It will suffice to purchase mobile phones and memory cards and involve the health districts in the implementation of the practice.

Conclusion:
All notwithstanding, the practice proves effective and relevant, because it responded to the challenges of the people's access to health information. It can be replicated and sustainable because it is based on the stakeholders of the health system and falls within the logic of the national cyberhealth policy.

Recommendation
Prior to any practical implementation, the local languages in which beneficiaries may best understand the voice messages must first be identified by minimizing the problem linked to the linguistic dialects. Subsequently, it will be based on the participatory method of the populations in the choice of community relays who would work with the technological tools in case they are not State community health workers who will operate them. Finally, it is also to accompany the telephone with solar recharge systems because in the rural area, the challenges of electricity remain a problem.

BF2: ICTs and social media, motor for the promotion of RH/FP by the Young Ambassadors

Authors: Emilienne Adibone Assama, Moctar Diallo, Baba Coulibaly, Cheick Oumar Toure, Mamoutou Diabate, Soumaïla Moro, Ilyasse Bore, Sorofing Traoré, Khoudiedi Camara, Ibrahima Fall, Jonas Haba (Alliance Of Young Ambassadors Rh/Fp)

Introduction:
The Ouagadougou Conference and that of Sally in 2011 committed the French-speaking West African countries to embark on family planning as a priority in development policies. Hence the Civil Society Initiative for Family Planning Plus (CS4FP Plus) covering the 09 partner countries of the Ouagadougou Partnership (Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, Togo). Funded by the William and Flora Hewlett Foundation and the Kingdom of the Netherlands, it lays emphasis on the youth, as the most vulnerable stratum, to enable it have access to suitable sexual and reproductive health programmes guaranteeing their rights. CS4FP Plus ensures that the governments take due account of the youth needs in the preparation and monitoring of National Plans of Action with Budgets (PANBs) for FP, respect their commitments for speeding up the use of FP by the youth. CS4FP Plus has initiated the strategy "Young Ambassadors RH/FP (YAs/RH/FP)". Recruited from within the CSO members of FP coalitions, the YAs RH/FP are trained in the use of Information and Communication Technologies (ICTs) and social media to enable innovation in the sensitization of the peers in the use of Reproductive Health Adapted to the Youth (RHAY).

Methodology:
• Recruitment and training of YAs of the 09 countries by using ICT (Internet, websites, Skype, content creation), Blogging and social media

management (Facebook, Twitter, WhatsApp, Viber, Instagram) by a specialized digital agency; • Training of YAs in Reproductive Health/FP including HIV/AIDS for enhancing contents quality; • Content production and dissemination for sensitizing peers on the Facebook pages, Internet, Twitter, WhatsApp groups, and blogs; • Promotion of YA activities, coalitions and partnerships on Facebook pages, Internet, Twitter, WhatsApp groups, and blogs.

Outcomes:
The use of ICT and social media by YAs enabled the recording of the following principal outcomes:
• 364 YAs trained in social media content presentation, in ICT, and in blogging for the promotion of RHAY, in the 09 Ouagadougou Partnership countries; • 34 RHFP blogs were regularly animated by the YAs;• 73 articles on family planning published in the blogs; • 337,987 feedbacks (with 55% of young girls) registered on the social networks in the second quarter of 2018 against 285,285 feedbacks in 2017 and 5,503 in 2015; • 02 WhatsApp content presentation platforms "Responsible Sexuality" and "Youth and Sexuality", with 46 topics discussed and 300 participants; • 20 Tweet Ups organized on RHAY topics in the 09 countries of the Ouagadougou Partnership;• 28 "Saint Valentine without pregnancy" campaigns and disseminated on Facebook, Twitter, WhatsApp, blogs and the web site www.mafamilleplanifiee.org; • 01 Youth sensitization campaign on the adverse effects of tobacco use organized on the social networks by the YAs in Benin • 01 awareness campaign on obstetric fistula organized on the social networks by the YAs in Mali; • The promotion of actions and activities of YAs on the international digital platforms (K4Health, Le Monde, RFI, Youth for Family Planning, FP2020, www.partenariatouaga.org); • Dissemination of the FP promotional video clip relayed by social media on: http://mafamilleplanifiee.org/clip-jeunes-ambassadeurs-planification-familiale-pays-po/.

Conclusion:
The use of ICT and social media by the YAs enabled the enhancement: - Advocacy for resource mobilization with youth contribution to the implementation of the PANBs for Family Planning; - Youth exhibition with sensitization messages on RH/FP and HIV/AIDS through the implementation of synchronized communication; - Visibility of the contribution of CSO/FP coalitions to the implementation of PANBs - The YAs are henceforth the key stakeholders sought after by the Ouagadougou Partnership players.

Recommendation
The CS4FP Plus initiative recommended: - Increasing the number of strategies addressing the youth in the PANBs; - Continuing the strengthening of the youth ICT and social media; – Enhancing communication for the social mobilization and behavioural change of the youth; and - Increasing resources for the implementation of efficient strategies for the youth.

BF3: Computerized Management of Human Resource for Health, a tool for aiding decision-making for the improvement of health care delivery: The Mali experience.

Authors: Mamadou M'Bo, Djénèba Togora Touré, Jeanne TESSOUGUE, Hamidou CISSE, Cheick Touré

Introduction:
One of the major strategies for speeding up the reduction of maternal, neonatal and infant mortality, is based on strengthening human resource policies. Mali is one of the 57 countries in the resource management crisis according to the World Health Organization. To address this situation, the Ministry of Public Health and Hygiene (MPHH) formulated a national human resource management strategy in 2007 one of whose strategic axes is the computerization of the human resource health management system (SI-GRH). The implementation of this axis benefitted from the support of USAID partners across the Capacity Plus and Human Resources for Health (HRH) project. As a reminder, Mali's Ministry of Health had very little up-to-date information on its human resources and was using the method of paper archiving. The aim of the implementation of the SI-GRH was to provide MPHH, with a comprehensive, dependable human resources database for REASONED decision-making (recruitment, training, deployment).

Methodology:
The implementation process of the SI - GRH was characterized by five main stages • iHRIS software customization which consists in the adaptation of the software to the context of Mali's health system; • procurement of IT equipment and materials and office equipment; • design and validation of tools for the collection and recording of human resource data;• training human resource management stakeholders

at various levels of the health pyramid; • data collection and entry; • data verification and analysis for decision-making, a process of monitoring and supervision and facilitation at all stages.

Outcomes:
The SI-GRH was acknowledged by the Malian Government as a national reference tool in the HR management for the three components of the health sector (Health, social development and promotion of women). It is used as an instrument for planning short- and long-term recruitment, HR and deployment of providers in relation to the needs. It is also a tool in advocacy for technical and financial partners. The utilization of SI- GRH data enables MPHH to know the trend of health personnel ratio per 10,000 inhabitants in relation to WHO standards (23/10,000 inhabitants). Thus from 2014 to 2017, the national ratio increased from 4 to 6/10,000, with extremes between 3 and 23 respectively at Mopti and at Bamako in 2017. The SI-GRH enabled the production of a yearly statistical directory and the establishment of a human resource map per gender, qualification and sources of funding. To this must be added their distribution, type of health structure, as well as in rural and urban areas. The Human Resource Directorate utilizes the database as a daily decision-making tool for managing career plans. Sharing the outcomes from the utilization of the SI-GRH data base helped strengthen the HRD leadership. Indeed, it ensured the coordination of the partnerships and synergy of the interventions relating to the problem of RHS in the country.

Conclusion:
The computerization of the human resource management for reasoned decision-making is a reality in Mali due to the high Authorsities' commitment to the country and support from the partners including USAID. Actually, timely information on the RHS and its decentralized management should keep improving the planning and advocacy mechanisms for a management suited to the local context for improving healthcare services.

Recommendation:
To better enhance the SI-GRH, the following recommendations have been formulated by the stakeholders concerned: • Advocacy must be conducted with the decision-makers for SI – GRH's interoperability with DHIS2 and the other platforms for the information for mHero; mHealth service providers; • Extension of decentralized management to health districts; • Human resource management capacities should be reinforced at the different levels of the health pyramid; • The private sector should be involved in the SI-GRH execution process.

BF4: Improving the Integrated Management of Childhood Illnesses (IMCI), family planning and monitoring of new-borns and pregnancies: Case of the implementation of the CommCare application in Benin

Authors: Gbadébô Aude-Elvis Odeloui, Eunice Pedro, Marius Awonon

Introduction:
These past years, the analysis and diagnosis of the maternal and neonatal mortality situation in Benin demonstrates that considerable efforts have been made. However, despite those efforts, maternal mortality remains high with a rate that has since 2014 stagnated around 350 deaths per a hundred thousand live births (RGPH4 2013). This dysfunction is characterized by the following three delays: (i) taking a decision to recourse to health services; (ii) delay in conveyance to an appropriate health service; (iii) delay in caregiving after arrival in the health services. How, can Information Communication Technologies (ICT) improve the treatment of the Mother, New-born and Child, with a view to eliminating this dysfunction?

In its support to the Government of Benin, USAID, launched an initiative "CommCare" through the programme for the improvement of reproductive health, new-borns and children, (ANCRE), in 2015 in the Communes of Tchaourou and Bassila. CommCare enables assistance for Community Relays in the application of the Protocol of the Integrated Management of Childhood Illnesses (IMCI), family planning, stock monitoring, of the pregnant woman and new-borns, as well as monitoring case contacts of the Ebola Virus Disease (EVD).

Methodology:
The pilot phase of the project commenced in August 2015 in the health zones of Tchaourou and Bassila. The initial modules were developed to assist the Community Relays in the Integrated Management of Childhood Illnesses (IMICI) and family planning. In 2016, there was

another stock monitoring module and yet another, for pregnant women and new-borns. The stages of the design and implementation were: programme design, management guided collected data, training in the use and maintenance of telephones.

Outcomes:
In July 2017, 235 Community Health Workers (CHWs) and 29 heads of post in the two zones used the demand, which accounted for 100% of the CHW in the two zones. On average, 500 forms were submitted every month in 2016, demonstrating that the users were technically capable of using the mobile application. The pilot phase of CommCare enabled the CR to use Android mobile phones for resolving health problems within the community. The application also enabled risks of error to be reduced in the management of sick children as well as giving FP advice for the well-being of the community. A few illustrative outcomes obtained since the establishment of CommCare as a decision-making tool are:

- In 2016, 195 women were counselled in FP against 505 counselled in 2017, i.e., a 259% progression of women reached;
- The number of women who accepted the FP methods increased from 54 to 222 between 2016 and 2017.
- Out of 5,853 children received by the CR, 350 were referred to CP for general signs of danger, i.e., 6% (Jan-Dec. 2017).

Out of 4,804 positive Rapid Diagnostic Tests (RDT+), 4,727 cases were treated by the CR with a Artemisinin-based combination therapy on (ACT), i.e., 98% child home treatment and 2% referred to health centres (Jan-Dec. 2017).

Conclusion:
CommCare is a mobile solution interoperable with the DHIS2.
Thanks to automatized control included in this solution and in partnership with MTN mobile, decision-making in the healthcare of children between 0 and 5 years improved in the rural communities that benefitted from the project. Moreover, an increased contraceptive prevalence and a positive trend in performance indicators were observed. Another positive result was the improvement of the reference, the reduction of maternal and neonatal deaths. The solution may be sustainable. It was retained in the national cyberhealth strategy.
Recommendations

- CommCare/DHIS2 integration should be continued;
- Partnership with GSM operators should be strengthened to ensure data transmission of populations difficult to reach;
- Telephones should be maintained, and technical ownership and supervision of the solution ensured;
- Adherence of the locally elected officers should be strengthened, and CR motivation ensured;
- CommCare experience at the coordination instances should be documented and shared for an enhanced capitalization of the attainment;
- The economic model that supports the solution must be defined;
- The m-Health projects of the national Cyberhealth strategy prepared and validated by Benin must be implemented;
- Scaling up of the solution must be ensured.

BF5: Use of Information and Communication Technologies (ICT) for continuing education of health professionals on Emergency Obstetric and Neonatal Care (EmONC): case of the "safe delivery" application

Authors: Adegnika Spouse Bangbola Karamatou Ognilola, Zannou F. Robert, Tossou Boco Thierry, Kohoun Rodríguez

Introduction:
Maternal and neonatal mortality is still a public health problem in Benin notwithstanding the numerous efforts at reducing the indicator. The maternal mortality ratio is 347 deaths per 100,000 live births and the neonatal mortality rate is 38 per 1,000 live births (LB)according to the 2014 MICS investigation. After an analysis of the situation, competence in SONU and the availability of workers at the post were the two important determinants for improving quality of care with a view to reducing the deaths. During formal training on EmONC, the providers did not have enough time for practicals on mannequins but additionally did not have any occasion to practise on the living during the clinical sessions at the hospital. The "Safe Delivery" application afforded the opportunity of continuing reinforcing capacities in EmONC of the health professionals while maintaining them at their work post. It is in that perspective that the Ministry of Health, through the Directorate of the Mother and Child Health care, opted for the "safe Delivery" experiment by a pilot project referred to as "Maternity Project" with the financial backing of BornFonden.

Methodology:
The project was implemented from March to October 2017 in 8 communes in Benin. The intervention strategy was focalized on the capacity building of 100 health workers of localities targeted respectively on the EmONC and the signs of danger in pregnant women, women who had just delivered and new-borns.
The implementation of the project was characterized by:

- Ownership and validation of the Application;
- Training of trainers and service providers of 88 maternities in the use of the application installed on smartphones; Monitoring of the users' performances and their perception.

Outcomes:
After six months of implementation, field monitoring, mid-term review and final assessment the project yielded the following results:

- 92% and 95% of application users improved their level of knowledge of basic EmONC after 4 to 6 months respectively.
- 74% improved their level of knowledge of AMIU;
- 73% improved their level of knowledge for the management of high blood pressure;
- 73% improved their knowledge level for prolonged work management;
- 75% improved their knowledge of the usual healthcare for new-borns;
- 78% improved their knowledge level of post-partum haemorrhage management;
- 71% improved their knowledge level in the prevention of infections.
- In terms of the contribution of the use of the application for improving quality care,
- the statistics revealed, among other things, that:

i) the number of vacuum-assisted deliveries rose from 112 in 2015 to 211 in 2017;
ii) the number of resuscitated new-borns dwindled from 375 in 2015 to 247 in 2017.

Lessons learnt:

- Good use of the application contributed to strengthening the post with professional health skills;
  Use of the application contributed to improving confidence in the health professionals' management of cases.

Conclusion:
The "Safe Delivery" application is a real tool for continuing on-site training, memory aid and knowledge assessment for health professionals. The creation of a "WhatsApp" forum led to the capitalization on the experiences and facilitation of exchanges between the application users.

Recommendation:
In a bid to maintain the attainments of the experimental phase of the "Maternity project" and improve on them, the following recommendations must be observed:

- Monitoring of the performance of the application must be pursued;
- A workshop on sharing the outcomes of the "Maternity Project" with the key stakeholders must be convened;
- The use of the "safe delivery" application must be upscaled.

The use of ICT for reinforcing the skills of healthcare givers must be extended to other high-impact interventions on maternal and neonatal health.

ABSTRACTS - ORAL PRESENTATIONS

Non Communicable Diseases and Maternal, Newborn, Child and Adolescent and Youth Health (MNCAYH)

DE1: Prevention of Non Communicable Disease in High Risk Adolescents and Young Adults: An Intervention Study in Northern Senegal

Auteur: Sidy Mohamed Seck, Ismaila Thiam, Amamdou Diop Dia, Diatou Gueye Dia

Introduction

Non-communicable diseases (NCDs) represent an important health issue for young people, for now and for the future. Two thirds of premature deaths in adults are associated with childhood conditions and behaviours. In addition the control of NCDs is part of the Scaling Up Nutrition (1000 days), adopted by all ECOWAS countries. Global trends show that NCD-related behaviors are on the rise among young people, and that they establish patterns of behavior that persist throughout life and are often hard to change. Like in other continents, the most common NCD risk factors in young Africans are tobacco and alcohol use, sedentarity, unhealthy diet and overweight. Community-based interventions have been identified as key research priorities for efficient and sustainable management of NCDs particularly where resources are limited. However, these types of research programs are lacking in African region. Moreover, NCDs are expensive for households and have a negative economic impact in low and middle-income countries. This study aimed to assess feasibility and effectiveness of a community-based intervention on BP and blood glucose control in Senegalese adolescents and young adults with high cardiometabolic risk profile.

Methodology

We performed a cluster-randomized study including adolescents and young adults aged with high cardio-metabolic risk from urban and rural communities in Saint-Louis and Gueoul (northern Senegal). Participants were assigned to either the intervention group which received intensive health coaching delivered by a health workers team, or the control group which received standard care. Primary outcomes were body mass index (BMI), waist circumference, fasting blood glucose (FBG), HbA1C and blood pressure (BP). Clinical and biological variables were compared between groups using independent t-test, Mann Whitney test or chi-square test as appropriate. A significance level of <0.05 were considered for all tests.

Main outcomes :

Of the 4 out 21 urban and 5 out of 36 rural communities, we included 276 participants (144 from urban and 132 from rural) with a mean age of 20.6 years (range 18-25 years). After a 5-year period of follow-up, those in the intervention group showed a significant reduction in BMI (-3.28 cm ; ranges -1.66 to -6.57, $p<0.01$), FBG (-0.39 g/l ; ranges -0.11 to -0.79, $p<0.05$), HbA1C (-0.53 % ; ranges -0.26 to -0.65, $p=0.01$), systolic (-15.1 mm Hg ; ranges -8.15 to -23.48, $p<0.01$) and diastolic BP (-6.30 mm Hg ; ranges-2.73 to -10.21, $p<0.01$) compared to those in control group. There was no difference between urban and rural participants.

Significant improvements were also found in serum total cholesterol, LDL and HDL cholesterol of adolescents and young adults in the intervention group. At the end of follow-up, a higher proportion of participants from the intervention group shifted from high risk to a moderate/low risk profile in comparison to the initial screening (33% versus 10%).

Conclusion

This study demonstrates that community-based interventions delivered by field health workers may be an interesting solution for prevention and management of NCDs in adolescents and young adults in under-resourced urban setting. Further larger studies are needed to evaluate the effectiveness of community-based interventions for prevention of NCDs in Senegalese adolescents and young adults.

Main Recommendations

Low and middle-income countries suffer the most from the NCDs rising health and economic matters. Lack of human and financial resources are challenges to decrease the high rates currently observed. These are part of the reason NCDs control are in place in the Senegalese

health priorities. In order to achieve that, development of policy papers is a high priority. However this should not be an obstacle to implement innovative community-based interventions for the control of the behavioural risk factors as well as the management of cases. Our study points out the need to scale up and to strengthen the intervention in order to contribute significantly the prevalence observed. Beyond that, the lack of financial resources in most of our countries is a limiting factor to facilitate such initiatives.

DF1: Psycho-cognitive stimulation and Kinesitherapy for stimulating malnourished children

Authors: Bagnoa Tuenwa Clément, Caroline Boltz , Rafik Bedoui, Uta Prehl

Introduction:
The food and nutrition crisis in the Sahel is today worsened by the erosion of the populations' resilience due to a rapid succession of crises, the insufficiency of basic services and the ramifications of conflicts raging in the region. Malnutrition further constitutes a real Public Health problem whose repercussions resound negatively especially on the most vulnerable populations, namely, women and children under 5 years.

Although the treatment of acute malnutrition is effective today and standardized, the stimulation and the accompanying psychosocial aspect remains difficult to apply. Many studies show the correlation between the deep nutritional and cognitive deficits in the lives of young children the consequences of which may be invalidating, or even fatal in the case of acute severe malnutrition. It is within this framework that Humanity & Inclusion have implemented with nutritional services and its partners, various interventions to respond holistically to the specific needs of malnourished children and their families in three health districts in Burkina, Mali and Niger. The project comprises three aspects:

- Psycho-cognitive stimulation
- Stimulation physiotherapy
- Psychosocial and community support

The best practice described in this document relates to the first two aspects.

Methodology:
Between 2015 and 2017, the project implemented psycho-cognitive stimulation activities with a view to helping children rectify their development retardation. The treatment began with an appraisal of the state of development of the child with the help of a specific tool bearing on 7 skills: fine motor skills, gross motor skills, language, hearing, vision, personal hygiene and social skills. Where a retardation was detected, individual or collective stimulation was proposed. A stimulation kit comprising modern and traditional games was used in each health training session and the child received a minimum of five sessions over a period of about 5 weeks.

Outcomes:
Through the stimulation sessions, about 90% of the malnourished children were able to rectify the retardation observed. The psychomotor exercises fostered an enhanced muscular reinforcement; interaction between the children and their guardians enabled an enhancement of mother-child bonding. According to the project data the stimulation physiotherapy enabled an improvement of psychomotor recuperation scores and the development of the children:

- In Burkina Faso, 379 children improved their development score after evaluation, out of a total 429 children who received physiotherapy stimulation care, i.e., an improvement of 88%.
- In Mali, 517 out of 621 children under treatment improved their development score, i.e., 83.2% of the rate of recuperation.
- In Niger, 803 children were treated 740 of whom improved their score, i.e., 92% of the rate of recuperation.

One of the unexpected changes generated by the stimulation activity is doubtlessly the enhancement of socialization and development of interpersonal relations among mothers of the malnourished children. They were able to communicate among themselves during collective stimulation sessions. The children undergoing physiotherapy benefitted from a good social integration into their community.

Regarding capacity strengthening, different modules were developed and dispensed to 233 socio-health workers: early childhood development, early stimulation, the importance of parental education, care for the development of the young child, anomalies of development and stimulation physiotherapy, nutrition, communication techniques and psychosocial support.

Conclusion:
Through the project, Humanity & Inclusion, positions itself as a technical resource on the psycho-cognitive and physical stimulation of malnourished children. This experience demonstrated the possibility of organizing in the nutritional services, emotional and physical, collective and individual stimulation sessions in the presence of the mother. In the course of time, the health professionals working in the health training sessions showed interest in the practice of stimulation activities. Physiotherapy stimulation improved the physical and motor development of malnourished children. However, putting this in practice runs counter to the availability of physiotherapy in our countries.

Recommendations:
The successful implementation of psycho cognitive stimulation in the nutritional recovery units requires beforehand:

- Training and supervision of the socio-health workers in stimulation;
- Opening or rehabilitation of stimulation areas in the nutritional care units;
- Identification, referrals, child assessment, and the organization of individual and collective stimulation sessions within the nutrition departments;

Sensitization of doctors and other paramedics on the care for children under physiotherapy stimulation sessions: the offer of "paediatric physiotherapy care linked to nutrition" was not in existence in the health structures of the intervention zones. For optimal implementation of the physiotherapy aspect in the integrated care of malnutrition, it is necessary to promote awareness on the approach of paediatric physiotherapy and on the diagnosis of motor retardation to facilitate referencing.

DF2: Facilitating family planning services for female mental patients.

Authors: Amy Sakho,

Introduction:
In Senegal, no mention is made in family planning services for female mental patients nor is there any provision to take account of them. Their families often abandon them to themselves even when they are exposed to high-risk pregnancies. That is why the Boutique de Droit de l'Association des Juristes Sénégalaises initiated in a suburb in Dakar, a series of education sessions for taking care of female mental patients to afford them easy access to family planning services. The sessions aim to make the patients' parents aware of the need to ensure their right to adequate healthcare services and family planning. It is also aimed at telling the health personnel that they are duty-bound to provide them with family planning services without any discrimination. That the State is equally duty-bound to put in place family planning and reproductive health services to ensure respect and promotion of women's rights to health, including sexual and reproductive health in consonance with sub-paragraph 1 of Article 14 of the Maputo Protocol.

Methodology:
The intervention consisted in identifying the families concerned through focal groups with the support of neighbourhood sponsors and the involvement of health districts. Once identified, the sponsors refer them to the health services.
The aim of our approach is to prevent the consequences of rape and sexual aggression.
In this very perspective Article 13 (3) of the law on comprehensive reproductive health stipulates that: "The State and local communities shall be obliged to ensure, safeguard, promotion and protection of the reproductive health of individuals…"

Outcomes:
This enabled the selection of 10 out of the 15 female mental patients targeted, aged between 15 and 34, living in deprived and uneducated

families. The mental patients benefitted from family planning services for unwanted and high-risk pregnancies of which the latter were frequently victim. In such cases, the parents did not hesitate in finding the means at their disposal to commit unsafe abortions. According to a study conducted in 2012 by the Guttmacher Institute, 51,500 provoked abortions were perpetrated in Senegal with 16,700 women entailing post-abortion complications.

Since the realization of this activity, which was largely popularized in the community media and during the community awareness programmes it became a best practice that was extremely valued by the families with a view to preventing undesired risky pregnancies

Conclusion:
What motivated us to adopt this best practice was firstly the concern to prevent the mental patients from undesired and high-risk pregnancies as well as campaign against illegal and forced abortions that might constitute remedies for their families. Through this best practice we also wanted to demonstrate that it is necessary to enforce the provisions of the Maputo Protocol ratified by our country since 2005, but which has not been applied in all its measures especially regarding the right to reproductive health.

Recommendations:
By way of recommendations, we suggest a network of the national territory to replicate this best practice to enable all mental patients in Senegal to benefit from it as well as to forewarn the services at the level of family planning regarding the offer of family planning services. Lastly, a special programme must be designed for the best practice through its institutionalization.

DF3: Community approach for improving the treatment of snake bites in a rural community in guinea "Experience of the Centre Médical Associatif (CMA) of Timbi Madina"
Authors: Abdoulaye Aguibou Barry

Introduction:
Timbi-Madina is one of the rural communities of the Prefecture of Pita, situated 25km away from the Prefecture and 425km from Conakry, capital of the Republic of Guinea. With a surface area of 300km2, the population is estimated at 60,000 inhabitants spread over 14 districts. Essentially agro-pastoral, it has a few forest galleries, low lands, and developed agricultural plains.

A snake bite is a wound caused by a snake, which generally results in the penetration of the fangs that causes poisoning.
It is difficult to estimate the frequency of snake bites due to the fact that it is not obligatory to report them in many regions of the world. Nonetheless, it is globally estimated that 5.4 million people are bitten by snakes including 2.5 million poisonings with 125,000 deaths.
In Timbi-Madina, several poisonous snake species can be found. Snake bites are frequent and constitute a medical emergency with an extremely high lethal rate. There is virtually no help, and the situation therefore becomes a serious health problem in that area. It is within this context that the CMA of Timbi-Madina, put up a first-line health structure, and initiated a community approach to respond to this concern of the people of this community.

Methodology:
- a community dialogue was organized on snake bites;
- the Institut Pasteur in Kindia was requested to brief the Authorsities and caregivers on the problem of snake bites in Guinea;
- financial resources were mobilized by the community through contributions from the 14 districts;
- a Management Committee was put in place;
- a mechanism for the treatment of cases of snake bites was defined;

Constraints and solutions:
- Funding of the process/it is handled by the CMA
- Non-commitment of the Authorsities/information and sensitization of the Authorsities.

Outcomes:

1 - On 04 November 2016, the following was observed through community dialogue:
- frequency of snake bites: 19 cases with 10 current deaths as at 2015 (52.63);
- lack of AVS (anti-venom serum) in the health centres, referral hospitals and dispensaries;
- lack of training of health personnel on the treatment of poisonings

2 - On 06 May 2016, the Head of the Department of Venerology of the Institut Pasteur in Kindia travelled to brief the different stakeholders on the poisonings in Guinea, i.e., the availability and accessibility of AVS and training of health workers;
- the cost of AVS is GF 1,200,000 (CFAF 75,000), which is not accessible to the rural population;
- 16 health workers were trained on the treatment of poisonings;

3 - On 10 May 2016, fixing of the contributions among the districts:
- the contribution per district was defined and varied according to population size: GF 1,000,000 (less than 1,000 inhabitants), GF 1,500,000 (1,500 at 2,000 inhabitants), GF 2,000,000 (more than 2,000 inhabitants);
- GF 13,000,000 was mobilized by the community;
- a 4-member Steering Committee was set up;

4 - On 31 May 2016, GF 1,350,000 of contributions was paid, out of an estimate of GF 29,500,000. 10 vials of AVS were purchased, and the management procedures defined.

5 - From 1 June 2016 to 31 May 2017, i.e., 19 months, 41 cases of snake bites including 16 cases of poisoning, and 3 deaths were recorded. The lethality rate was 7.32 deaths per bite, and poisonings, 5.33

Conclusion:

Snake bites constitute a public health problem in Timbi-Madina. This scourge identified by a first-line health structure and shared with the community led to putting in place a mechanism for adequate treatment, thanks to participatory funding by the community.
This action therefore led to a reduction of the lethality rate from 52.62 to 7.2.

The Authorsities' commitment contributed considerably to the success of the project as well as to the specialist's intervention, which demonstrates the interdisciplinary nature of the activity conducted.

At the moment, the community approach remains the permanent tool for a community to resolve its health problems.

Recommendations:

- Community dialogue must be organized with the involvement of the relevant stakeholders at the end of each year on the activities of the health Centre;
- The local Authorsities must be trained on good health governance;
- The health workers must be trained on the community health approach.

ABSTRACTS - ORAL PRESENTATIONS

Contribution of Traditional Medicine in improving Maternal, Newborn, Child and Adolescent and Youth Health (MNCAYH)

CF1: Intervention Approach of Community-Based Traditional Medicine Practitioners for Improving Mother and Child Health Care Indicators

Authors: Kroa Ehoulé, Toure L.D.T.; Ble Bk; Amessan Bm.,

Introduction:
The Ministry of Public Health and Hygiene (MPHH), with the technical and financial support of the United Nations Children's Fund (UNICEF) of the Côte d'Ivoire Office, is developing activities for improving the health of children and women. The activities are also being conducted in the health structures, community structures, as well as even within the community, going as far as to homes. They have led to a general improvement in child survival. The National Mother and Child Health Programme (PNSME) and the National Programme for the Promotion of Traditional Medicine (PNTMP) with technical and financial support of UNICEF, have been implementing since 2016, an initiative including Traditional Medicine Practitioners (TMP) in a national strategy of Integrated Management of Child illnesses (IMCI) through the sensitization of their peers and patients, Essential Family Practices (EFP) and through household management for the adoption of EFP for survival and development of the young child (Community IMCI).

Methodology:
Training of 74 TMP leaders identified by the Departmental Health Directors and local associations of TMP of the 41 Health Districts targeted on the EFP with particular emphasis on case references (EFP targets) in the conventional health structures, the supervision of TMPs implementing the EFP outreach activities by the HS with special attention on the quality of the data collected by TMPs.

Outcomes:
1,113 sensitization sessions organized by the TMPs involved in the EFP outreach (902 individual discussions and 211 group discussions) on the vaccination timetable, ANCs, exclusive breastfeeding, Child feeding, signs of danger with pregnant woman and the child, the importance of LLINs, hand washing, and birth declaration. A total 4,585 persons were sensitized including 1,315 TMPs sensitized on the adoption of EFPs and their popularization with their peers, their patients and households, 3,270 persons (family heads, households, guardians) sensitization on the EFP. An adoption was observed with 2,851 of them for the EFP to which they are eligible, 263 pregnant women referred for delivery haemorrhaging, assisted delivery in hospital environment, pregnancy diagnosis, antenatal consultation, vaccination, suspected diabetes and hypertension, acute malaria, 308 children under five referred for vaccination, acute malaria, bleeding from the umbilical cord, anaemia, convulsions, body rashes, vomiting, diarrhoea, high fever, etc.

Conclusion:
Involvement of traditional medicine practitioners in the EFP and AEN outreach activities and in community surveillance MPE organized by the Directorate General of Health through the PNTMP, the PNSME and the PNN, supervised by the HS and supported by UNICEF enabled: - the strengthening of the Ivorian health cover in qualified personnel; - improving collaboration in conventional and traditional medicine; - fight against nefarious traditional practices against mother and child health; - improving health offer in the survival of the mother and child within the community. The strategy for the collection of data from TMP activities must be improved and the monitoring of TMP by the HS should be sustained and strengthened.

Recommendations
- The TMPs should be involved in the promotional and preventive activities relating to mother and child health; – A framework for collaboration between the Health Districts and the TMPs should put in place; - Doctors, Nurses and Midwives should be sensitized to TMP activities; - Data from traditional medicine should be included in the reports on the health situation of National Health Information Systems (NHIS).

CF2: Involvement of Traditional Birth Attendants in the Emergency Obstetric Management System in Mali

Authors: Rokia Sanogo, Sergio Giani

Introduction:
Since the Eighties, many recycling experiences of Traditional Birth Attendants (TBA) have been supported by the Ministry of Health and International Cooperation bodies. The outcomes on the reduction of maternal and infant mortality have been beyond expectation. From 1990, serious effort was made for the design and implementation of an emergency obstetric system. CSRef and CSCom human and technical resources were thus strengthened. A cost sharing system led to collective catering for the cost of evacuation and surgical intervention. In 2005, free Data from traditional medicine included in the reports on the health situation of National Health Information Systems was to be part of the collective efforts. In this new context, access to the system and its impact on maternal and neonatal mortality remained unsatisfactory. Rates were 368 maternal deaths per 100,000 live births and 34 child deaths per 1,000 births respectively. The assumption of our intervention was that taking due account of the TBAs with adequate approaches and methodologies may help break the barriers between women at risk and the CSCom, leading to a fairer and enlarged access to antenatal and postnatal monitoring services and emergency obstetric care.

Methodology:
The aim was to develop effective collaboration between the traditional system of assistance to pregnancy and delivery which are the responsibilities of the birth attendants (TBA) and the conventional system of emergency obstetric care. The aim was the detection and timely referral of critical cases. Instead of classic training, it was a matter of facilitating intercultural exchanges, sharing information and experience and strengthening skills, through the organization of informational and organizational workshops with the participation of the TBAs, the socio-health sector and other local stakeholders. A local system of data collection and assisted self-assessment was put in place.

Outcomes:
From 1999 to 2009, the organization and monitoring activities of the TBAs conducted by Aidemet Ong, in partnership with the State's technical structures, led to the involvement of 390 TBAs from 195 villages in 13 health zones which comprised about 325,000 inhabitants in the Health Districts of Kolokani, Kadiolo, Sikasso, Bandiagara and Kati. A work on capitalization was published in 2009. From 2012 to 2015, the activities of the HURAPRIM project, funded by the EU, enabled the involvement of 45 TBAs from 3 health zones in the Health Districts of Kolokani and Sikasso. An analysis of the collected data confirmed the Findings of the previous experiment: the TBAs may well be considered as human resources for maternal and neonatal health as part of a collaboration organized and evaluated with the social and health personnel of the conventional system. While comparing the outcomes of the year before and after the intervention, we observed in Kolokani an increase in antenatal consultations, assisted deliveries and emergency obstetric referrals. The differences were almost always statistically significant. The increase in the cover in Polio 0 vaccination was significant, too, in the HURAPRIM project zone. The outcomes were confirmed by the international document review on the role of the TBAs in the chain to save the lives of mothers and new-borns. An intervention on more sites or for a longer duration would enable more statistically significant outcomes on the maternal and neonatal mortality data.

Conclusion:
The approach of TBA involvement may contribute to reducing the first two out of four delays which could prevent women at risk from receiving the necessary care to save their lives as well as that of the new-borns. In the villages, the rapid detection of danger signs and rapid decision regarding the referral of women in obstetric distress must be supported by adequate means of transportation. For the efficiency of the system, a good quality rapid response, at affordable price at different levels of the conventional health pyramid is finally indispensable.

Recommendation:
To the health Authorsities and partners: (i) Due account should be taken of the need to strengthen collaboration between TBAs and socio-health sector personnel, to improve maternal and infant health; (ii) Means of adequate transportation between the villages and the CSCom should be made available; (iii) The capacities of the socio-health sector personnel should be reinforced on the approach with a view to upscaling it to use this best practice; (iv) Due account should be taken of TBA activities organized and informed in the SLIS; (iv) Best practices should be replicated on a broader number of areas for a longer period so as to obtain the statistically significant data necessary for validating the strategy for the involvement of the TBAs on the basis of factual data; (v) The process should be supported by a vast advocacy campaign and policy dialogue to take due account of the TBAs in the fight against maternal and neonatal mortality.

Ankasa Conservation Area, Western Region. Ankasa is the only area in the Wet Evergreen Forest Zoo in Ghana. It covers about 500km^2 .

ABSTRACTS
POSTER PRESENTATIONS

ABSTRACTS – POSTER PRESENTATIONS

Good Governance and accountability for the Maternal, Newborn, Child, Adolescent and Youth Health (MNCAYH)

AE14: Refurbishing skills labs in nursing and midwifery training colleges to improve teaching and learning of skills in Ghana

Authors : Amos Asiedu, Martha Serwaa Appiagyei, Karen Caldwell, Etta Forson Addo, Patience Darko, Dora Agbodza

Introduction:
This study aimed to evaluate the effects of the specific interventions implemented by the USAID-funded Maternal and Child Survival Program (MCSP) on the core competencies of students graduating with certificates from selected community health nursing training schools in Ghana. The interventions include establishing/strengthening skills laboratories to improve the knowledge and skills of students and better prepare them for practice in the workforce.

Methodology:
Knowledge tests and objective structured clinical examinations have been conducted twice using a successive independent samples design: baseline and one- years after project support begins. Each sample was drawn from that year's final year certificate students. Midline assessments were conducted in Fomena, Winneba, Tamale, and Navrongo Community Health Nurse Training Schools that had data from a baseline assessment. Theme areas assesses were: malaria, respectful maternity care, breastfeeding practices, newborn sepsis, HIV and family planning. Ethical approval were obtained from NMIMR IRB and JHSPH IRB.

Key Finding:
The proportion of students who explained procedures to client increased from Midline (63%) to 97% at endline. Hand washing increased from midline (47%) to 100% at endline and arrangement of necessary items needed for performing the task increased from 45% to 78% at midline. Furthermore, for breastfeeding counseling, baby held to breast with fingers in C shape increased from midline (50%) to 86% at endline. In addition, counseling on selected FP methods which matches client desire for timing and birth spacing from midline (40%) to 87% at endline. Correct interpretation and documentation of results increased from midline (20%) to 100% at endline and a few documented their Findings, thus, from 0% to 47% at endline.

Conclusion:
Improving skills labs at NMTCs can help contribute to improved provider knowledge and skill in the areas of maternal health, newborn health, malaria and family planning. When reviewing resources, stakeholders should consider improving pre-service education institutions because improving student skills will have a direct effect on client health outcomes.

Recommendation
To improve health care of children and women, nursing and midwifery training schools should be well equipped with skills labs and eLearning platform to enhance teaching and learning of skills and knowledge.

AE16: Labour pain management practices in two tertiary hospitals, South west Nigeria

Authors: Akinmade Adekunle Adepoju, Oluseyi Isaiah Odelola, Adebayo Adekunle Akadri

Introduction:
Childbirth is a joyful event, but it exposes the mother to one of the severest forms of pain reported. Many hospitals in Nigeria have no protocol for labour pain relief, hence obstetric analgesia is underutilized. This study was designed to assess the Labour pain management practices in two tertiary hospitals in south west Nigeria.

Methodology:
This was a cross-sectional study involving 132 pregnant women who had vaginal delivery. A structured questionnaire was administered to women within 24 hours of delivery to record details of labour and delivery; and the form of labour analgesia administered. Labour pain perception was assessed using the Visual Analogue Score (VAS). Data analysis was done using IBM–SPSS Statistics for Windows version 21.0 (IBM Corp., Armonk, NY, USA).

Key Findings:
The mean age of the parturients was 30.6±4.8years. Sixty-six (50%) women rated labour pain to be severe (VAS 7.1).Thirty eight women (28.8%) did not receive any pain relief method. Non-pharmacological pain management practices such as back massage, breathing exercises and companionship were administered to 45(34.1%), 79 (59.8%), and 45 (34.1%) women respectively. Only 9 women (6.8%) received pain medications for labour analgesia. Back massage method had the highest proportion of women who were satisfied with pain relief (82.2%). The odds of perceiving labour pain as severe were 2.1, 1.2, 1.4 and 2.1 in women who requested for back massage, breathing exercise, companionship and pain medications respectively. Majority of the respondents 114(86.4%) expressed desire for more effective pain management techniques in their future pregnancies.

Conclusion:
Labour pain management in South west Nigeria commonly involves use of non-pharmacological methods with only occasional use of pain medications. There is need for development of organized obstetric analgesia services to cater for the large proportion of women who desire more effective methods of labour analgesia.

Recommendation:
The Findings of this study will contribute to achieving the Sustainable Development objective of ensuring universal access to sexual and reproductive health care services, including information and education and the integration of reproductive health into national strategies and programmes.

AE17: Improving Access to Maternal, New born, and Child Health Service at Community Level; Role of Maternal and Child Health Promoters and Introduction of 5S method in Ghana

Authors: Shoko Enomoto

Introduction:
Challenges faced by community people in Ghana is the limited access to basic health services and it has become a barrier in improving maternal, newborn and child health from the viewpoint of continuum of care. In the target area of this project, Kwahu East District, Eastern Region, the access to health facilities is limited and there is a risk of endangering pregnant women's health by not responding to pregnancy related complications or limited number of health personnel resulting in low figure of skilled birth attendance. The need for access to better quality maternal, newborn and child health services is high and the support for bringing about understanding of community people on the importance of utilizing maternal health services, increasing access to health services by more outreach services and strengthening a partnership between health facilities and communities are crucial in responding to the current situation. Supported by Japan International Cooperation Agency and private sector in Japan, the project has implemented at the project site in Ghana from 2017 to 2019 with the aim to improve access to Maternal, Newborn and Child Health (MCH) services for women, newborn and children.

Methodology:
The project undertook the following activities: improved MCH by utilizing the existing system of community health volunteers in Ghana and introducing the Maternal and Child Health Promoters (hereinafter referred to as MCH promoter) system originated in Japan; trained community health volunteers and community people as an MCH promoters who do activities to care about the health of mothers and children in the community; developed of MCH promoters kits; Conducted health education through group/individual discussions by MCH promoters; provided training of health personnel in client-friendly service (customer care) and 5S (workplace organization method); and enhanced MCH activities at the community level.

Key Findings:
So far, 5 trainings of MCH promoters in the project site have been conducted to build capacity of health education at community level and referral support to health facilities for Pregnant and nursing women and children under 2 years of age. As a result, 150 MCH promoters have been trained with average 92.79% for post-test while average of pre-test was 73 %. MCH Promoters has been doing their activities at their communities and one of the area spontaneously started "Pregnant women's class" by health staff and MCH Promoters at a health facility. The training of health personnel in client-friendly service and "5S-KAIZEN-TQM" has been conducted for 90 staff. 5S is the principles of work environment improvement and focus on effective work place organization starting from physical environment and gradually to functional aspects, which are influential to 5S simplifies a work environment, reduces waste and non-value activity while improving quality efficiency and safety. 5S Principles are reliable instruments to make a break-through in improving a work environment and staff attending various types of jobs in health facilities. This is not only a concept but also a set of actions which have to be conducted systematically with the full participation of staff serving at facilities. 5S implementation by trainees are practiced in a real participatory movement to improve the quality of both the facility environment and service contents delivered to clients at health facilities in the project area.

Conclusion:
MCH promoters are expected to contribute to providing MCH information and referring clients to facilities at community level. As promoters work closely to the community, they could gain community's confidence and it makes their activity more effective. The implementation of 5S at the health facilities could improve their environment and provided promptly health services for clients. As a result of improvement at both communities and facilities at the same time, access to Maternal, Newborn, and Child Health service could be improved for pregnant and nursing women and children under 2 years of age.

Recommendation:
At community level, MCH promoters seem to take a role of first line health information providers regarding Maternal, Newborn, and Child Health. Key points for meaningful encouragement of MCH promoters are collaboration with health service providers, trainings including refresher one, supportive supervision, logistical support, and resource mobilization for community activity. For these key points, it is essential to cooperate with the national and local government, community leaders, influential people in communities, local NGO, international organizations, etc. In addition, it will become more efficient volunteer system if the several systems of existing community health volunteer in Ghana could integrate into one system. 5S method could be effective method to improve facility environment at both hospital and CHPS levels. Therefore, it should be scale-up to regional and national level. Key points for 5S implementation are proper training for health personnel and other related staff at health facilities (logistic staff, security staff, accounting staff, etc), shearing information and good practices of 5S implementation, establishment monitoring mechanism, continuous positive commitment, etc.

AE18: Integration of Traditional Birth Attendants (TBAs) into the Primary Healthcare System in Lagos State: A sustainable positive action for Maternal and Child Health Outcomes

Authors: Onyemelukwe, Akaoma, Ibironke Dada, Sumbo Makinde

Introduction:
With 545 per 1000 births maternal mortality rate and a 30% hospital based delivery rate, the challenges of improving maternal and child healthcare outcomes is an imperative for saving lives, achieving health outcomes and sustainable development goals. Available evidence shows that Lagos State has over 5000 traditional medicine practitioners who provide various health services for the communities in various areas of health. In maternal and child health has over 2800 traditional birth attendants across the state.

Traditional birth attendants (TBA) annually records about 19,000 deliveries, showing the preference of the community. The potential for negative maternal and child health outcomes are high. This demands urgency for MNCH interventions and integration in the primary healthcare system. Regulation is required to ensure traditional birth attendant operate within the remit of the law but the institutional capacity of the traditional medicine board is weak.
Strengthening primary healthcare system to deliver quality healthcare by ensuring that women and child are preserved is essential for greater reach and universal health coverage. The integration of the informal health sector is required to deepen the accessibility and availability of health care services to the communities and facilitate collaboration and partnership with the aim of reducing maternal mortality.

Methodology:
A mapping was done using a locator map; TBAs are within densely populated locations with the poor and vulnerable. Technical assistance to Traditional Medicine Board (TMB) for the collection and collation of delivery reports from traditional birth attendants and registration. A process of partnership with the college of health technology commenced. A TBA curriculum was developed and adapted. The TBAs were trained on the basic MNCH, family planning and reproductive health. Each TBA home was linked to PHC or private hospital where investigations are done for pregnant women and nurses visit to carry out immunization, data collection and support infection controls efforts.

Main Result:
Evidence of deliveries was produced with TBA accounting for approximately 18000 deliveries while the public sector collectively accounts for 22100. The evidence was disseminated showing the need for integration. Advocacy for integration was conducted. Integration was established with PHCB instituting monthly data meeting with TBA across the Local government areas (LGAs). LGA based orientations were facilitated to mobilize the communities and more TBAs. Over 500 TBAs were trained and converted to community birth attendants to support other community level actions. Collaboration and partnership between the formal and informal sector was established. This increased the quality of care received by women and children. It reduced the potential for negative MNCH outcomes. Referral barriers were broken as TBA referred cases for clinical investigation especially for women who may have complications. A database was developed with over 800 TBA captured with about 790 TBA taking deliveries in communities.

Conclusion:
The integration of the traditional birth attendants into the primary health care system provided an opportunity to reach more women with better health care services through mutual collaboration to facilitate timely referral, the greater utilization of investigation and expert advice, ensuring TBA operates within the remit of the law and have save more lives of women and child. It provided an opportunity to develop knowledge and skills of the TBA on basic health topics such as family planning, reproductive health and maternal and child healthcare. TBA trained are currently supporting other community level interventions in Lagos State.

Recommendation:
Traditional Medicine Boards should be constituted in other states to support the regulation of the traditional birth attendants
The Curriculum should be adopted for national use and scaled up States should facilitate the integration of traditional birth attendants into the primary health care system to reach more women with services and save more lives. Linkages and network should be established with TBA homes to ensure data collection, support for infection control, immunization Develop, maintain and updated list of traditional birth attendants operating in the states.

AE19: Integrated eDiagnosis Approach: Assessing the Quality of the Management of Children Illnesses in Burkina Faso

Authors: Some Satouro Arsene, Blanchet Karl, Somda A. Serge, Lewis James, Sarrassat Sophie, Cousens Simon

Introduction:
In Burkina Faso the high mortality rate of children under five (89/1000) is mostly explained by the low adherence (15%) of Integrated Management of Childhood Illnesses (IMCI)-trained health workers to IMCI guidelines which provide a standardized, integrated approach for children care. The use of the Integrated eDiagnosis Appraoch (IeDA), a package of several interventions, is aimed to improve the quality of child health care in health centers to ultimately decrease child morbidity and mortality. After piloting IeDA in 3 districts of two health regions of Burkina Faso, it has been extended to 4 other districts of the same regions based on the improvement of health indicators collected routinely in the pilot districts during three years. To evaluate the quality of disease management for under-five children using IeDA in primary health care centres in Burkina Faso we conducted a study with the following methodology.

Methodology:
We conducted four steps of the stepped-wedge trial from September 2014 to October 2016 in 10 randomly-selected primary health care centers in each of the 8 districts of two regions of Burkina Faso (Boucle du Mouhoun and Nord) using IeDA which included: REC: the IMCI protocol translated into a computer-based tool aimed to guide nurses during consultations; The training of nurses on IMCI and REC; A

quality assurance mechanism; A supervision system; A health information system based on data collected through the REC. Data on 1,805 child consultations were collected through direct observation of consultations. The same children were then reexamined by an IMCI expert to obtain a "gold standard" assessment of the child's IMCI classifications and treatment. Results of the two consultations were compared for analysis.

Key Findings:
Among the 53 children identified by the expert as having at least one danger sign, 38 children were identified by the healthcare workers (75% in intervention districts versus 71% in control districts). Among 100 children needing referral or hospitalization, according to the health worker's classification, only 58 (58%) were referred or hospitalized with a slightly higher proportion of correct referrals in intervention districts (67% vs. 55%). Overall adherence to the IMCI protocol for clinical assessment (pneumonia, malaria, diarrhea, malnutrition and anemia) was lower in control districts (48% vs. 68%). Overall, 47% of children were correctly classified with a better performance in intervention districts (54% versus 46%). Health care workers made prescriptions consistent with their own classifications for 69% of children with marginally better performance in intervention districts compare to control districts (71% vs. 69%). Health care workers made prescriptions consistent with the expert's classifications in 57% of cases with slightly better performance in intervention districts (61% versus 57%).

Conclusion:
There are some early indications of improvements in the overall quality of the management of children illnesses following the implementation of IeDA. We suggest that this is the result of the guidance giving by the REC, of the capacity building through the training of nurses on IMCI and REC, of the support provided to health centres during the supervision, and finally of the enhancement of the practice of nurses through the finding of appropriate solutions in response to primary healthcare's local needs thanks to the quality assurance mechanism.

Recommendation:
The above results suggested the pursuing of the study and the final results will lead to the writing of a policy brief for the scaling up of the package of the interventions as a whole.

AE20: Reducing premature child mortality in Northern Togo: an evaluation of the integrated community-based health systems strengthening initiative

Authors: Komlan Kenkou ,Kevin Fiori, Molly Lauria , Jennifer Schechter, Sesso Gbeleou, Sandra Braganza, Sebabe Agoro

Introduction:
In 2014, the under-5 mortality rate (U5M) in Togo was 80/1000 live births. The main causes of premature mortality are birth complications, pneumonia, diarrhea, malaria and malnutrition. Although 62% of the population lives within 5 km of the public health clinic, only 30% utilizes these facilities. In 2014, we launched a three-year Integrated Community Health Systems Strengthening Initiative (ICBHSS) in communities covered by four public sector clinics in collaboration with the Ministry of Health. The ICBHSS model includes the following package of evidence-based interventions: (1) user fee elimination, (2) pro-active case management using community health workers (CHWs), (3) clinical mentoring and enhanced supervision, (4) supply chain management. As part of the model, all public sectors had site assessments completed and when appropriate capital investments were made. The overall study aim is to assess the ICBHSS initiative implementation using an adapted RE-AIM implementation science evaluation framework.

Methodology:
Setting: Four communities in Northern Togo with an estimated maternal and child catchment population of 5,843 and baseline average health facility utilization rate of 27% (range 12-40%) in 2013.

Design: We organized program data by respective RE-AIM domains: reach, effectiveness, adoption, and implementation. Using population weighted sampling we conducted an interrupted time series design utilizing household surveys to estimate annual mortality rates. We performed a return on investment analysis using the Community Health Planning and Costing and Lives Saved Tool. Next, we tabulated program data to summarize process indicators.

Results/ Key Findings:
We have summarized selected indicators organized by RE-AIM framework domains of ICBHSS initiative implementation in Northern Togo, from August 2015 to August 2017.

Reach: There were 23,181 pediatric consultations for the first year and 22,053 for the second year. Regarding pre- and post-natal consultations there were 2,712 for the first year and 4,087 for the second year.

Effectiveness: Baseline under-five mortality rate was observed to be 70 (per 1000 live births) and 36/1000 and 25/1000 at 1 and 2 years post intervention, respectively. The Return on Investment estimate was approximately 10:1 with total cost/capita for the intervention at 7.74 USD.

Adoption: Health facility based deliveries was observed to be 67% to 75% at year 1 and 2 post intervention, respectively.
Implementation: Pediatric cases (0-5 years) assessed within 72 hours of symptom(s) onset was 76% the first year and 86% the second. Average CHW adherence to protocol was 97% the first year and 98% the second.

Conclusion:
Preliminary results suggest that the ICBHSS initiative is associated with reductions in premature mortality through increased healthcare coverage, differences in health seeking behaviors, and improvement in quality. Due to study design limitations, one cannot definitively attribute mortality reduction to intervention. Though there are few alternative factors that could explain reduction. Initial discussions with MOH and field staff suggest that the observed decreases in pediatric consultations from year 1 to 2 could be due to decrease demand due to effectiveness of CHWs. Increases in maternal care are likely associated to improvements in quality of care and elimination of user fees.

Key Recommendations:
These promising initial results may represent an opportunity to prevent child mortality in resource limited settings. From our preliminary 24 months data, we posit the following recommendations:

- Integrate CHW programs within public sector health infrastructure to optimize impact and build health sector capacity
- Invest in a CHW workforce that includes training, supervision and salary to maximize positive return on investment
- Utilize a "pro-active" case finding approach for CHWs to increase timeline of care
- Increase access to health services by focusing on improvements in quality of care including investing in clinical mentorship, physical infrastructure, and management practices

Eliminate user fees associated with essential clinical care services in impoverish areas to address financial barriers to access, promote preventative and early presentation for care, and reduce administrative costs.

AF16. Reproductive health project and sexual rights (DEBO ALAFIA) in 2 communes of Tenenkou health district in Mopti region

Authors: Diaby Abasse, Mossa Yattara, Abdoul Abass Koina, Safiatou Doucoure

Introduction:
Indicators regarding adverse traditional practices reveal the amplification of these practices (excision, forced and early marriage, fattening/forced feeding, etc.). This densification mainly draws its source of wealth from the history of this region which, since the 16th century, has been the crossroads of Islam and especially the different kingdoms (Dina de Sékou Amadou) which have exerted unprecedented influence on the development of Koranic teaching. Poor interpretation of Islamic knowledge by some people, lack of education (51% of the TBS), the weight of the habits and customs are such that, in our days a large part of the population think that these practices are opposed to the Koranic provisions of our ancestors.
Development indicators linked to the topics of the programme (sexual and reproductive health, gender-based violence and adverse traditional practice against girls and women) places the Mopti region in a situation of vulnerability and justifies Mopti as the choice site for project implementation.

Methodology:
The Consortium's methodological approach is based on the effective and responsible involvement of the beneficiaries in a framework of fruitful partnership. The participatory approach is aimed at:

Valorizing and strengthening the well-being and know-how of the target groups for responsible participation of the local stakeholders. The latter will participate actively in all stages of project implementation, namely, the identification of measures, planning, implementation and monitoring/evaluation of the measures identified. All the measures to be carried out under the project should contribute to improving the use of reproductive health services and the people's access to quality contraceptive products, increase in the level of decision-making by the youth and their ownership of their reproductive health and reduction or even the abandonment of nefarious traditional practices (excision, early marriage and other violent acts perpetrated on women and girls). Ensure the sustainability of the measures undertaken by the people after the withdrawal of the Consortium through their training, their organization and their empowerment;

Outcomes:
A series of training sessions on the topics have been delivered concerning 82 relays including 62 men and 20 women, 24 peer educators including 22 men and 2 women, 28 elected community leaders including 27 men and 1 woman, 14 excisors, 10 traditional midwives and 6 health agents including 3 men and 3 women, 12 teachers including 8 men and 4 women.

During that period, the PMO team conducted the CIP activities comprising radio broadcasts, educational discussions and video projections. During that period, the PMO team carried out: 144 educational discussions on family planning; 1,034 FP home visits, 144 discussions on nefarious traditional practices (Early marriage and excision), 144 educational discussions on sexual education, 96 video projections on PTN (Early marriage and excision), 22 radio broadcasts on RH/PTN and the signing of six agreements on the abandonment of nefarious traditional practices

Conclusion:
The activities conducted during the fourth quarter enabled the conscientization especially through the video projection of a large number of persons within the community who continue to clamour for the abandonment of nefarious traditional practices owing to the complications they entail.

Furthermore, we observed an increase in the rate of utilization of family planning services, especially with the organization of the family planning campaign during the quarter. The ultimate aim of capacity reinforcement is project ownership with a view to the sustainability of the attainments and sustaining long-standing results for the measures undertaken by the people after the withdrawal of the Consortium through their training, their organization and their empowerment;

The ACD AMAC Consortium ensured the signing of five conventions for the abandonment of nefarious traditional practices.
It must be pointed out that the sensitization activities tremendously impacted on the outcomes of the signatures and that the monitoring of these achievements by the PMO and the defence committees remain the guarantor of the sustainability of the measures conducted.

Recommendations
The rate of family planning in the two intervention communes must be increased. Agreements should be signed for the reduction and/or abandonment of the nefarious traditional practices. The youth should take ownership of their sexual rights

AF17: Community level-task shifting in relation to family planning: "Strategy for reducing unwanted pregnancies and unsafe abortions"

Authors: Ouedraogo Boureihiman, SORE Idrissa

Introduction:
Community-based health workers are Authorsized solely for the supply and distribution of pills at community level. The intervention had the main aim of demonstrating by the practice that community-based health workers could, with appropriate capacity building, initially

prescribe the pill and offer injectables within the community.
Women of childbearing age and young girls are the primary targets with men and boys being secondary targets.

Methodology:

- A monitoring plan with project indicators was prepared with the participation of all stakeholders.

- The CBHWs were provided with data collection tools following the indicators we found in the monitoring plan. Basic data collection, including a report sheet of undesirable events used for identifying potential cases of injury to clients or to the CBHW during the offer of injectable contraceptives as well as the complications likely to occur. The sheet will be completed and transmitted for each undesirable event and/or complication. This information should also be included in the monthly activity reports of the CBHWs.
- Data was collected on a daily basis by the CBHWs and compiled monthly with the support of supervisor facilitators.
- The monthly data was transmitted to the CSPS.
- A meeting for data verification was organized by the head nurse with the involvement of the CBHW supervisor facilitator.
- The validated and consolidated data was transmitted to the district level to be captured into the national health information system.
- A quarterly data validation meeting was organized at district level with the involvement of the national and regional project coordination.
- At this stage, the outcomes were shared with the regional level, national level and with the partners.
- Produce and disseminate the defined pace of the report on the progress achieved.
  Dissemination of outcomes;

Outcomes:

- The two hundred and twenty-four (224) community-based health workers were from the community and have primary level education and can read and write. They were selected by the management of health promotion and education in collaboration with the health districts and administrative Authorsities
- They were trained in the initial prescription of pills and administration of injectables Sayana Press for 10 days (i.e., 5 days of theory and 5 days of practical in health training sessions) for a total cost of about CFAF twenty-five million;
- After their training, they underwent a 3 month-probation in their health training under the supervision of head nurses. Each CBHW should administer (05) injectables according to the prescribed standards before being declared suitable;
- Apart from the three who dropped out, the 221 CBHWs were suitable and initially offered pills and administered the injectables within the community;
- Up till now, no incidents nor complications have been recorded or alerted in the appropriate support;
- Many users of the contraceptive methods in the concerned zone have increased;
- The decongestion of the health centres was effective;
- Bringing the health services close to the beneficiaries is a reality;

The number of unwanted pregnancies and unsafe abortions have reduced.

Conclusion:

Task shifting is an innovative practice with several advantages:

- Bringing the services to the community
- Contribution to the resolution of the problem of inadequate number of health personnel
- Decongestion of the CSPS
- Improvement of access to FP services
- Contribution to the reduction of unwanted pregnancies and recourse to unsafe abortions

Contribution to the acceleration of the capture of the demographic dividend.

Recommendation:
A sufficient resource allocation, an impact study and the quality of life in terms of improvement of access to health services are recommended for successful scaling up.

AF18: Community-based access of family planning products and services (ABCP/FP) including injectables: Introduction of the sub-cutaneous injectable contraceptive Sayana Press (SP) in Benin

Authors: Adegnika Karamatou Ognilola Bangbola, Zannou F. Robert:, Tossou Boco Thierry, Ahounou D. Gaston, Affo A. Jean, Djihoun Ahouangassi Florence, Tossou Justin

Introduction:
Family Planning (FP) represents the first pillar of reduction in maternal mortality (RMM) for without pregnancy, there is no maternal death. It is an efficient strategy for RMM. In Benin, the Maternal Mortality ratio is still high, 347/100,000 live births (MICS 2014), unmet needs in FP are high (33%); modern contraceptive prevalence (CP) is 7.9% (EDS 2011). Injectables account for 25% of CP.

Improvement in access to modern contraceptive methods through community-based distribution is deemed in many countries as a strategic response to the potential demand. The strategy of the replenishment of oral contraceptives and the offer of condoms by the Community Relays (CR) have been tested with success and upscaled at community level (CL). In order to broaden the range of contraceptive methods and contribute to the increase, the CP rate from 12.5% (MICS 2014) to 20% by the end of 2018, the DSME with the support of UNFPA and USAID, through the ACP project and the ABMS, has begun introducing SP sub-cutaneous injectables in the community. The development of this approach should help improve the offer of FP services within the community.

Methodology:
The pilot phase of implementation was started in May 2017 in 10 Health Zones (HZ). The procedure consisted in conducting a series of activities such as:

- The adaptation of training/communication/monitoring-evaluation tools;
- The elaboration of surveillance tools/undesirable effects;
- Training of journalists

In each HZ:

- advocacy with political, administrative and religious leaders
- training midwives/nurses,
- training CRs (at least 5th grade level of instruction) in 3 days followed by validation in 2-5 weeks; supervising the latter on a monthly and quarterly basis; -coordinating all the activities relating to health.

Outcomes:
The service providers (Midwives/maternity nurses) are the trainers/direct supervisors of the CR. A team of 15 Master-Trainers exist at national level.

- 713 religious/traditional leaders, 536 locally-elected officials and 115 journalists have been sensitized,
- 15 Master-trainers have been initiated in this approach. In ten HZs, they have trained 242 trainers who themselves have in turn trained 817 CRs including 417 who have successfully validated their training, i.e., a validation rate of 50.67% under the supervision of DSME.
- The training of the CRs was validated in accordance with very precise criteria. After 3 days of training, they must pursue the practicals for 2-5 weeks to validate their training after 5 successful injections under the supervision of the trainers. Cost: about $80 000/CR
- 172 maternity caregivers underwent orientation.

At 30 June 2018, 17,684 clients were received in the community for counselling including 5,232 who agreed to Sayana Press. The CRs have effectively administered the Sayana Press to the 5,232 clients.

Total number of new acceptors:

- Monitoring post-training of the CRs 6 weeks after training
- Joint supervision six weeks after post-training monitoring
- No post-injection complication recorded during the period.

Lessons learnt:

- CR involvement in this approach increased the number of NA considerably;
- According to the clients, the adoption of an MC fostered peace in the home.
- Access to quality community FP is a practice with high impact that is accepted as a global standard for reaching vulnerable/marginalized populations.

Conclusion:

The ABCPF enabled the rapprochement of the population's FP services and hence enabled them to take that opportunity to benefit from their income-generating activities. The permanent availability of the caregivers and inputs was a measure of the success of the approach. The involvement of journalists, religious leaders and local representatives fostered adherence to the community. Very few of the side effects were reported. The upscaling plan prepared took account of social marketing to ensure the provision of the products in the private health structures and cover all the HZs.

Recommendations:

- A team must be put in place to monitor FP activities in the EEZS
- The monthly reports must be validated at CODIR as well as the SNIGS reports to ensure the sustainability of the activities.
- Availability of FP products should be monitored in the health centres;
- SFE/nurses should be supervised in their management of side effects and rumours;
- All implemented FP activities must be documented (discussions, advanced strategies, inputs, monitoring meeting);
- The CRs must be strengthened on the animation techniques;
- Close supervision must be strengthened for the CRs;
- All FP products must be made available in all the health centres;
- All the range of the community's FP products must be made available to the CRs;
- The heads of the centres should be urged to regularly supervise the CRs.

AF19: A multi-component approach to the improvement of maternal breastfeeding in a region in Burkina Faso

Authors: Jenny A Cresswell, Rasmané Ganaba, Fodié Maguiraga, Sophie Sarrassat, Henri Somé, Abdoulaye Hama Diallo, Simon Cousens, Veronique Filippi

Introduction:
In Burkina Faso one out of five children suffers from retarded growth and 27 out of 1,000 children die in the 30 days following birth. Early initiation of breastfeeding (IPA) and exclusive maternal breastfeeding (AME) are effective practices for reducing neonatal and infant morbidity and mortality and promoting an optimal development of the child. Since 2014, the Alive & Thrive initiative (A&T) has supported the Burkina Faso Government in the implementation of the National Upscaling Plan of the promotion of the feeding practices of Infant and Young Child (IYCF). In the region of Boucle du Mouhoun, A&T with its implementation partners, namely, Mwangaza Action and Entraide Universitaire Mondiale of Canada have tested the feasibility of the promotion of AME by allying Interpersonal Communication (IPC) and Community Mobilization (CM). The intervention comprised the training of health workers to make the IPC high-quality in the health centres and train the community workers to undertake home visits, the implementation of a system and formative supervision of the workers, and the group facilitation sessions and exchange meeting in the villages.

Methodology:
The impact evaluation of the intervention randomized 19 communes to serve as control zones and 18 communes as intervention zones. Two representative crosscutting enquiries of the population were conducted: and a basic enquiry in July 2015 (N = 2 288) and a final enquiry in July 2017 (N = 2 253). The sample was of mothers with infants under 12 months. The principal indicator of the evaluation was the AME practice defined as the proportion of infants under 6 months that had received maternal milk during the day and the night preceding the enquiry.

Outcomes:
The main analysis was based on a binomial regression model adjusted to individual data level with standard and robust errors that enabled an intragroup correlation. Data at the cluster level were analyzed with the difference in difference methods. The prevalence of AME in the intervention group increased by 42 percentage points in relation to the control group (risk differential: 42.1%, 95% IC: 33.1%, 51.1%, p <0,001). The mothers of the intervention group were more likely to declare an early initiation of maternal breast feeding (risk differential: 22.4%, 95% IC: 4.2%, 30.6%, p <0.001); give colostrum at birth (risk differential: 21.6%, 95% CI: 15.0%, 28.2%, p <0.001); and no pre-milked feeding (risk differential: 9.9%, 95% IC: 5.8%, 13.9%, p <0.001). The mothers of the intervention group had better knowledge and were more likely to agree with the positive affirmations concerning maternal breastfeeding.

A biological validation study compared the maternal declarations to the deuterium oxide renewal technique in the study zone in 2016. As compared to the prevalence of AME measured with the help of the deuterium technique, the declarations of the mothers overestimated the AME's. This over-declaration was more serious in the intervention group than in the control group. In 2016, when the validation study was undertaken, the intervention had begun but had not yet been completely deployed. It was possible therefore that their responses had been influenced by a bias for social desirability.

Conclusion:
The packet including the interpersonal communication and social mobilization was an efficient approach that enabled a significant improvement in the breastfeeding practices according to the declaration of the mothers at Boucle du Mouhoun. The high involvement of the regional health directorate as well as of the community was an important factor in the success of the intervention. It is plausible that changes in the knowledge and the social desirability preceding an actual change of behaviour accounted for the outcomes of the validation study. This approach could be adapted and upscaled by the government of Burkina Faso.

Recommendations:
The following recommendations make it possible to ensure the success of the replication or upscaling of this intervention. In the first place, a contextual analysis with the Ministry of Health and key partners enabled a consensual choice of the intervention zone. In the second place, implementation and monitoring should involve the regional health structures through the routine and national activities through a frequent share of the outcomes of the process and final outcomes of evaluation. Thirdly, the proposed intervention must be

accepted by the community and respond to the actual need of the community. Finally, the use of the data collected during implementation by monitoring the routine and enquiries, (the process or evaluation) must be shared with all the stakeholders involved in the process with a view to guaranteeing the ownership and sustainability of the outcomes.

AF20: Issue of unwanted pregnancies in school environments in the Sahel region in Burkina Faso
Authors: Managawindin Sandrine Bénédicte Konsimbo, Sidwaya Hamed Ouedraogo, André Yolland Ky, Ahmed Kabore

Introduction:
Since 2017, the Burkina Faso Ministry of Health in collaboration with the Ministry of National Education and the support of UNFPA embarked on the reduction of unwanted pregnancies in the school environment which represents a serious public health problem. The study was aimed at examining the issue of unwanted pregnancies in the Sahel region.

Methods:
This was a joint cross-cutting approach combining a descriptive quantitative aspect based on data analysis collected from 3,578 students in 10 secondary establishments and a qualitative aspect with individual and focus group conversations with 106 people comprising teachers, health workers, students and their parents, including ten out of eleven establishments. Over the period from 1 January to 30 June 2018, quantitative data was collected with a questionnaire and qualitative data by semi-structured interviews. A reasoned choice was made to retain the people for the interview.

Outcomes:
Among the girls surveyed, 3.2% of them had already had a pregnancy. What is more, 15.1% were under 18 years and 75% under 25. In 51 % of the cases, those responsible for the pregnancies in a school environment did not acknowledge nor own up to the pregnancies. A low proportion of 13.21% of the pregnant girls were seen for the fourth ante-natal consultation. For school results, 16.98% of the girls with a child or pregnancy were successful in their school year. It was however reported that, 73.58% of the girls who had had a pregnancy lived with a partner. The study reported that the main people responsible for the pregnancies of the girls in school environments were officials, drivers, traders, small-scale miners, informal-sector youth and, above all, students. The most frequent reported consequences during our study were the complications of pregnancy and delivery, loss of self-esteem, destruction of life projects, reduced educational output of the young girls, school drop-outs, early and forced marriages and provoked unsafe abortions, were emphasized.

Conclusion:
Our results demonstrated the persistence of unwanted pregnancies in the school environment with several consequences of unwanted pregnancies. This constitutes a public health problem that calls for resource mobilization for sexual and reproductive health, but also strengthening the collaboration between the educational services, social services and that of health for the actual protection of girls.

Main recommendations:

1) Collaboration should be strengthened between the educational and health services for enhanced access to, and utilization by girls, of prenatal services.

2) Advocacy must be conducted for the inclusion of teenager and youth Sexual and Reproductive Health in teaching curricula.

3) Resources must be mobilized as well as activities funded for the promotion of Sexual and Reproductive Health for teenagers and youth.

4) Involvement of health services in the organization of officials of school groupings must be strengthened (with a view to taking due account of communication activities in Sexual and Reproductive Health)

AF21: Community involvement in the fight against stigmatization related to unwanted pregnancies and abortion: from refusal to tolerance

Authors: Tarnagda Ganda Génévième Clémentine, Ba Youssouf ; Ouedraogo Boureihman

Introduction:
Stigmatization is a major obstacle to youth access to sexual and reproductive health services. This leads to a higher number of STIs, unwanted pregnancies and unsafe abortions even in countries where that is Authorsized. ABBEF has implemented with the support of IPPF a project to combat stigmatization from the period 2016 to 2018. The project aims to enable young women to know and enforce their right to safe abortion by reducing abortion-related stigmatization. ABBEF has conducted specific interventions to combat individual, community and organizational stigmatization, through community dialogues, information, education, communication and service offer. The target population is women aged between 15 and 24. According to a study commissioned by Guttmacher Institute it is estimated that in 2008 at least 25 pregnancy terminations per 1,000 women aged between 15 and 49 would be carried out. This rate is 23 per 1,000 in the rural areas and 28 per 1,000 in Ouagadougou. According to the same study, women most likely to have recently terminated their pregnancies were those aged from 15 to 24.

Methodology:
The methodology used for project implementation, identification, training of peer educators in the school environment and non-students to conduct IEC/BCC activities and references, of two youth champions for advocacy activities, preparation of articles on issues related to stigmatization, service providers, community leaders, parents of students, heads of institutions, youth in clarification of values in abortion with a view to changing their attitudes on the subject by canvassing for the move from refusal to tolerance; Conduct satisfactory surveys in all the sites for the reduction of any phenomenon of stigmatization

Outcomes:
The project enabled a reduction in the level of stigmatization in the intervention areas.
We therefore moved from 38% of the stigmatization rate in 2004 to 18% in 2016 and subsequently to 5% in 2017. The outcomes were measured by carrying out the SABAS enquiry which was a questionnaire used for collecting data within the community
In addition, it enabled behavioural change in the various actors. The intervention led to sustaining the ABBEF global programme, especially through:

- The existence of a benchmark for the fight against stigmatization linked to abortion (by means of satisfactory enquiries, a collection of testimonies from the various actors);
- Support to the interventions of post-abortion care services after its implementation within the association's clinics;
- The identification of Young Champions engaged in the fight against abortion-related stigmatization;
- Youth involvement in the anti-stigmatization campaign;
- Increasing youth digital presence on the social networks to combat stigmatization.

Conclusion:
The outcomes of the enquiry demonstrated that there is hope in attitudinal change and perceptions of the populations vis-à-vis women who resort to abortion. This was demonstrated by the comparison of the outcomes from those who participated in the project activities and those who did not. This draws attention to the fact that mentalities on issues as sensitive as abortion cannot be changed overnight. The Stigma project should still support the offer of abortion services by laying emphasis on the most effective communication and conscientization activities.

Recommendation
The SRHAY Young Champions should be committed to passing the messages on to the youth.
An appeal should be made to popular musicians and youth to pass on the messages in their music.
Comprehensive sexual education should be included in school programmes with a view to combatting unwanted pregnancies and illegal abortions, and abortion-related stigmatization.

The topic of abortion and unwanted pregnancy stigmatization should be included in public educational programmes with a view to bringing about attitudinal change.

AF22: National family planning week (NFPW), A window of opportunity for satisfying FP clients: The Burkina Faso Experience

Authors: Ouoba/Kabore Boezemwendé, Ky André Yolland, Bougma S Mathieu, Dadjoari Moussa, Sanon Djéneba, Nassa Michel, Dialla M, Ouedraogo A, Nacro A, Zotin C

Introduction:
As part of the reduction in maternal mortality in Burkina Faso, Family Planning (FP) was adopted as one of the major strategies. The country has been endowed with a national plan for speeding up family planning (PNA/FP) for the period 2017-2020 whose objective is to increase modern contraceptive prevalence from 22.5% (EMDS2015) to 32% in 2020, corresponding to the recruitment of 452,095 additional users in four years. As part of the implementation of the plan, the continuation of the holding of the national family planning week (NFPW) instituted in 2012 by the Ministry of Health with the technical and financial support of the United Nations Population Fund (UNFPA) was retained. The first NFPW of the 2018 edition was held from 14 to 20 May 2018. That week through the free offer of FP services was the opportunity to cover numerous unmet needs.

Methodology:
The organization and realization of the week was marked by three high points, namely, the preparation of the week, implementation of the week's activities with the free offer of contraception methods to clients and the appraisal of the NFPW. The main activities of the NFPW was the week's launching ceremony, social mobilization activities (conferences high schools and colleges, competitive games on the FP, presentations to the wide public and stands, projection of films and forum theatres, radio broadcasts and educational discussions), free FP service provision (counselling and free offer of all the contraceptives methods) and exit monitoring of activities. The NFPW was collected and transmitted on a daily basis to the DSF. The data was validated at the health districts and regions prior to presentation and validation at national level during the evaluation meeting of the NFPW.

Outcomes:
Overall, 1,535,259 persons were affected by the sensitization activities. The activities further concerned women (60%) as well as men (40%). The radio broadcast was the channel that enabled it to reach more people (62%) followed by discussions (27.41%). Satisfied FP clients were 117,499 clients including 62,062 new users, which accounted for 53% of the satisfied clients. It is worth noting that the implants, as well as the jadelle and the injectables (Depo Provera) were the methods most used during the Week respectively 42% and 41%. The objective for the 1st edition of NFPW 2018 was attained. Out of 51,843 new users expected, 62,062 were recruited, i.e., an additional number of 10,219 new users. The results showed that almost all the regions largely exceeded their targets with a national average of 119%. 63.2% of new users were the youth aged between 10 and 24. That first week of the year 2018 led to obtaining 231,849 CAP.

The funding of the 1st edition of NFPW 2018 was mainly ensured by UNFPA which contributed CFAF 214,374,260. In addition to the funds, Burkinabè State, WAHO, WHO and the NGO/Associations such as Jhpiego, Pathfinder, Marie Stopes, Burkina as well as local partners and management committees of health training (COGES) equally contributed to the realization of that edition.

Conclusion:
The first NFPW 2018 was a success at country level and certified the results attained with the recruitment of 62,062 new users, i.e., 53.5% of the 2018 objective of the PANFP (116,097 additional users). That became possible, thanks to the involvement of the national, regional and local Authorsities in favour of the FP and the large-scale social mobilization. The week afforded a window of opportunity for covering numerous unmet needs. The outcomes were highly appreciable and even better results could be obtained if the recommendations were implemented.

Recommendations:
The Ministry of National Education and Literacy (MENA) should also be involved through training, conferences for SVT teachers in order to better tool them on sexual and reproductive health issues and family planning; the daily data collection sheet of NFPW should be reviewed to lighten it, adapt it, include the NGO/associations data at district and regional levels during district and evaluation meetings and make the inputs available, at least one month before the beginning of the Week.

AF23: Task shifting in family planning in Burkina Faso: quality of services offered by delegated official in the health district of Tougan

Authors: Souleymane KABORE, Robert. Karama, Roland Sanou, Boureima. Baillou, Isabelle. Zongo, Alidou Zongo, Elizabeth Konde, Ramatou.W. Sawadogo, George Coulibaly

Introduction:
Over 300,000 women in the world die every year, owing to pregnancy and childbirth problems. Nearly 99% of the maternal deaths occur in developing countries including over half of Sub-Saharan Africa. A quarter of the deaths can be avoided if the women had access to contraception.

Burkina Faso is marked by extremely alarming unmet needs in contraception (19.4%). In addition, the standards and guidance paper on reproductive health in Burkina do not Authorsize first-line health workers (FHW) to offer long duration methods of action (IUD and implants), nor injectables.

To improve accessibility of contraceptive methods, a pilot project was initiated for skills transfer (task shifting) of the offer of contraceptive methods to low-level workers in 20 health centres of Tougan. It experiments with the offer of IUDs, implants by FHW as well as the offer of injectables by the community health workers (CHW).
This study was aimed at appraising the quality of family planning services (FP) offered by the delegated official (FHW and CHW).

Methodology:
A crosscutting type of study with a descriptive and analytical scope was conducted. Data collection spread from 13 to 17 December 2017 and a combination of quantitative and qualitative methods were used. It related to all the 20 health centres in the project intervention area and all the 54 caregivers involved in offering contraceptive products (delegators and delegates). Nineteen (19) beneficiaries including 10 new users of a contraceptive method were investigated.

The collection techniques comprised observations from FP caregiver services and the work environment, document review, and individual discussions. The data was analyzed with the aid of the Epi info 7 and Open Epi version 3.01 software. The test of the Chi square and the t test of Student were used in determining whether there was a significant difference between the FP services offered by the delegated officials (Registered nurses and midwives) and that of the delegates. The signification threshold of 5% was used. A multivariate analysis was also carried out to eliminate any possible bias of confusion. Similarly, the data collected from the caregivers were triangulated with those collected from the beneficiaries.

Outcomes:
The study bore on 54 health workers (35 FHW, 19 registered midwives and nurses) and 35 community health workers. The average age of those investigated was 34 ($\pm$5.3), their Sex ratio was 1.5 in favour of men. For the study level, 63% of the delegators had secondary level education, as against 47% of FHWs. Over 70% of CHWs had primary level education.

For the users investigated, 11 had benefitted from contraceptive methods from community workers and 8 from FHW. The average age of the beneficiaries was 33.7 years. Nine (9) of the beneficiaries used long-term methods, 6 used the injectable method and 4 an oral contraceptive method.

The FP quality service general score was 73% for the delegates as against 69% for the delegators. There was no scientifically significant difference between the scores. The FP services were included in the local health system. As far as contraception was concerned, the delegates benefitted from other health demands.

"It was during the weigh-in of my children that we were informed of family planning. They told us to take good care of the children and, if we wanted to give them food to eat, to wash the plates else, if the plates were dirty, the children would get diarrhoea. They told us to go on contraception so as to space out childbearing for between 2 and 3 years or 5 years to enable us rest" (34-year-old woman under the injectable method).

However, there was a significant statistical difference between the quality score of community health workers (75.8 %) and that of the delegators (87.5 %) in counselling ($P < 0.05$). The same went for the quality score regarding the determination of the criteria for eligibility of the implants where the quality of the FHWs appeared higher than that of the delegators: 79% for the delegates, and 64% for the delegators.

Four errors were committed by the delegates in determining the new or former status of users (3 for the community health workers and 1 for the FHWs).

Conclusion:
In a context of rare qualified human resources, the restriction of the offer of long-term contraceptive methods to State midwives, doctors and nurses, as stipulated in the policy documents and reproductive health standards of most of our countries today, highly reduces the accessibility and adherence of women to these methods. This restriction also calls into question the principle of voluntary and independent choice of contraceptive method by users.

This task delegation experience of (skills transfer) in the area of family planning has the advantage of improving the geographical cover of the offer of long-term contraceptive methods. It equally ensures respect for women's rights.

Nonetheless, its implementation recommends maintaining a level of quality and security of irreproachable FP services as recommended by WHO.

Notwithstanding the limitations of the study, it gives us an idea of the quality of the FP services offered, as well as the delegates' capacity to provide contraceptive the methods whose offer was not Authorsized. Under some conditions (capacity building, monitoring, coaching), it is quite possible to extend the offer of long-duration contraceptive methods to first-line workers as well as injectables to community health workers as recommended by WHO.

AF24: Strategy for enhancing the comprehensive treatment of Seasonal Malaria Chemoprevention (SMC) of children aged between 3 and 120 months in the Goudomp District (Senegal): 3-day Directly Observed Treatment (DOT) Initiative performed by relays in six health posts

Authors: Malick Anne, Ibrahima Mamby Keita, Abdel K Dieye, Mamadou Coulibaly, Doudou Sene, Youssoupha Ndiaye

Introduction:
According to the World Health Organization (WHO), in 2016, 212 million cases of malaria and 429,000 deaths were reported globally. In 2015, 90% of malaria cases and 92% of deaths caused by that disease occurred in the region. 76% of malaria cases and 75% of deaths were recorded in 13 countries – mainly in Africa South of the Sahara. In regions with intense malaria transmission, over two-thirds (70%) of deaths as a result of malaria occurred among children under five years.

Indeed, in the sub-region of the Sahel, mortality and morbidity caused by malaria among children during the rainy season continue to be a matter of concern to the States. During that period, the administration, at appropriate intervals, of a comprehensive treatment, with effective anti-malarial medication prevented infant morbidity and mortality.
It is within this framework that Senegal introduced this intervention into its policy of malaria prevention and treatment.

Since 2014, the intervention has been conducted in the district of Goudomp during high transmission periods.

Methodology

Description of the launch of a Seasonal Malaria Chemoprevention campaign in six health structures of the District of Goudomp in September 2017. Indicator: Number of children aged between 3 and 120 months that benefitted from doses of D1, D2 and D3 under DOT
The choice of health structures was made by taking due account of criteria of population size and accessibility.
Prior training of community stakeholders;

The same relays returned three consecutive days to the same household to perform the administration of the medication under DOT.

Outcomes:

The D1, D2 and D3 doses were administered under DOT. Thus, for a target of 16,912 children aged between 3 and 120 months, 15,304 received their comprehensive treatment under DOT, i.e., a performance of 90.5%. Only the newly created post in Kaour from the Goudomp centre recorded a 46.6% performance through overestimation of its target. The HP of Kaour 46.6% and the Goudomp health centre 119.8% had an 83.2% performance of children under DOT. 41 cases of side effects were notified and treated with a good clinical evolution. During the campaign 3,375 households were visited and messages delivered to the parents on the importance of SMC .

Average cost of the 3-day DOT treatment strategy in comparison with the 1-day DOT was, moving from the first to the third passage, CFAF 989, CFAF 809 and CFAF 812 respectively as against CFAF 823, CFAF 646 and CFAF 732.

The cost-effective ratio (CER) was CFAF 379,468 per avoided case for the comprehensive treatment strategy as against CFAF 814,426 per avoided case for the 1-day DOT, making the 3-day DOT strategy the most cost effective.

Conclusion:

The implementation of the comprehensive treatment strategy under DOT during the SMC enabled the treatment of 15,304 children with a correct completion of the cards. It made it possible to ensure observance and strengthened the surveillance of undesirable effects. Community participation, commitment of the stakeholders, the technical and financial partners were decisive for the success of this important activity.

Recommendations:

It must be ensured that the strategy is extended to all the health posts;

All the stakeholders should be trained on the new strategy;

Comprehensive treatment must be ensured for all the target children of the SMC;

Community involvement must be strengthened in the resolution of health problems;

Social mobilization and management of refusals must be put in place at each health post;

Communication to mothers and guardians of children must be enhanced;

Surveillance of side effects must be strengthened;

Inputs for the treatment of side effects must be made available;

Replenishment of management tools must be ensured by community stakeholders;

A complete provision of inputs must be ensured during the activities;

A campaign plan must be prepared;

Outcomes must be shared with the people through fora.

AF25: Improving access to SRH services for the teenagers of the Sahel through the mobility of bespoke services.

Authors: Emmanuel Diop (Sahel Youth Lead, Marie Stopes International), Georgina Page, Bama Barthelemy , Hedwige Hounon , Edouard Keita and Maimouna Ba,

Introduction:
Almost two-thirds of the population of the Sahel are under 20 years old. In the coming years, the number of young women of childbearing age in the region will equally increase and, consequently, there will be an increase in needs for sexual and reproductive health services (SRH). In the region as a whole, SRH services for teenagers are taboos and, so far, only a few significant investments have been made. Existing literature suggests that the key impediments to teenagers to RH/FP services are firstly the parents who are unaware of the benefits derived from FP methods but equally the discretion of some caregivers, who are sometimes reticent in offering FP to girls and unmarried young women. This situation of vulnerability is often exacerbated by lack of confidentiality and the indiscretions of adults who cast aspersions on the sexuality of girls who visit health services.

Marie Stopes International (MSI) began her operations in the Sahel in 2009 in Burkina Faso and Mali, followed in Senegal in 2011 and Niger in 2014. In a bid to increase access to SRH services to teenagers (15-19 years of age) in the 4 countries. MSI implemented strategies in two mobile services delivery channels (mobile teams Marie Stopes Ladies/Mens) based on an effective segmentation of teenagers according to their needs and locations, on a service offer well-suited to their needs and on the development of partnerships to create a favourable environment for improving access to services of the target.

Methodology:
From January 2017 to June 2018, two sources of data enabled MSI to monitor the success of strategies for enhanced reach to teenagers across the 4 countries:

- The routine data of the service provision days follow the demographic characteristics of the clients, the use of previous contraceptives and the services received during the visit.
- The annual outreach discussion held during the visits aimed at evaluating the level of satisfaction of the clients in relation to the service received and the quality of counselling received by clients accessing the services, as well as the socio-demographic profiles of the latter.

Outcomes:
Between 2017 and 2018 the mobile teams (MTs) and the Marie Stopes Ladies/Mens (MSL/M) received about 69,000 client visits (-19 years) for quality SRH services. Thus, thanks to the implementation of this innovative approach, the percentage of adolescent clients who had access to our family planning services increased from 14% of the MTs and MSL/M in 2017 to 17% MTs and 18% for the MSL/M in 2018. Morever, data from outreach discussions showed that the adolescent clients had a positive experience from the services received from MSI. The majority recommended our MSI services to a friend, or to a family member (96% in Burkina Faso, 100% in Niger, 97% in Mali and 94% in Senegal). They equally showed that the counselling received by the adolescent clients was of the same quality as that received from the other clients. The majority (80% or more) of the adolescent clients of each country benefitted from a counselling meeting the criteria of the FP 2020 method information index (which determined the extent to which the women and young girls received specific information when they were given family planning services).

Conclusion:
MSI made structural changes and significant investments to place the teenagers at the centre of our work. Our results show that, although there were no miraculous solutions for reaching the teenagers, with adequate resources, a visibility on the key indicators, collective will, organizational commitment, as well as an undertaking to document and share the lessons learnt, it is possible to carry out an original and innovative to enhance the reach of teenagers on a large scale.

Recommendations:
In the Sahel, in the desire to improve accessibility to SRH services for teenagers and ensure the quality of the services, it is important, above all, to recourse to multi-dimensional approaches. Through the various strategies used by the mobile teams and the Marie Stopes

Ladies/Mens of MSI many key lessons emerge:

- Research was essential for understanding the needs and behaviours of the teenagers in the four countries of the Sahel, and steering and readjusting the strategies for service delivery and social and behavioural change;
- The existing channels for service delivery may be adjusted by concentrating service offer where it is most needed to reach more teenagers.

Intervention partnerships at national and district levels are important for reaching some adolescent segments and creating a favourable environment.

AP2: Title: Maternal and infant health in the Republic of Guinea-Bissau - From strategic planning to indicators

Authorss: Cátia Sá Guerreiro, Paulo Ferrinho, Patrícia Carvalho, Zulmira Hartz

Introduction:
Considered the 16th most fragile country in the world in 2018, the Republic of Guinea-Bissau (RGB) is a state marked by political and institutional instability with a fragile economy that is dependent on the international community. About 90% of the health sector is financed by cooperation partners. Despite the unfavorable performance by most health indicators, GB showed significant progress in reducing neonatal, infant and child mortality in relation to other comparable countries in West Africa, sub-Saharan Africa or low-income countries. Strategic Health Planning (PES) is a reality in RGB and the National Health Development Plan III (PNDSIII-2018-2022), which defines the country's national health strategy, is in force. POPEN has been the strategic/guiding document for maternal and child health (MCH) stakeholders in RGB and initiatives such as PIMI and Programa H4+ derive from it. Plan and program implementation evaluation reports are available. Our objective was to understand the evolution of MCH indicators in a framework of State fragility, relating them to the support received from partners and with the growing emphasis on evaluation as a PES strategy useful for decision-making.

Methodology:
First, we analyzed the 1998 RGB PES documents, from 1998 to date, and conducted a meta-evaluation of the PNDS using the content analysis of PNDS II and III and of the documents evaluating the implementation of PNDS I and II, while verifying the data evaluation use in subsequent planning processes. In the same vein, MCH's strategic documents and their implementation reports were analyzed. We conducted eleven semi-structured interviews with key PES and MCH stakeholders in GB, analyzing the content of the data obtained and allowing a contextual reading of the meta-evaluation results.

Results:
We found that the PNDS implementation evaluation results are used in sequential planning. But in 2017, several MCH initiatives were launched, many programs were created, and a vast network of stakeholders interacted with each other and with the Ministry of Public Health of GB. There was tension with regard to MCH funding policy - between vertical programs and the attempt to have a national strategy. We found that the PNDS III drafting process was based on data evaluating the implementation of the previous PNDS and the contextualization/analysis of the current health situation in the country. The new plan reflects an alignment with international health guidelines and funding partners strategies. Vertical programs and priority programs are included. The evolution of MCH indicators seems to reflect internal adaptation mechanisms, highlighting the resilience and social capital of Guinean society. As resilience is a transformative process based on the innate strength of individuals, communities and institutions to prevent and reduce impacts, as well as to learn from experience, it can lead to commitment, for example, to health promotion/dissemination. Social capital appears to have fostered the development of social networks that have contributed to the population's health needs making it a starting point for the development of healthier spaces and environments, fostering community development with impact on MCH.

Conclusion:
Evaluations, although motivated by donor requests, has proven to be an important strategy in the PES process. PNDS III is an example of best practice in the political-strategic field as it reflects an attempt to adapt the agendas of the Program funders and of the Government, leading to health gains. This convergence attempt is being felt in the current implementation phase of PIMI II. Resilient adaptive processes and social capital will be linked to the favorable evolution of MCH indicators and should be taken into account when talking about development.

Recommendations
In the implementation of MCH programs/projects, we recommend increased efforts for adaption to the PNDS III, as allowed by the convergence of agendas with constant emphasis on health gains. We recommend shorter PES/implementation cycles and decentralization along with intensive monitoring to allow for the emergence of the government's coordination and leadership, even despite high external dependence. Promote the adoption/correction of strategies/guidelines that better meet the country's MCH needs. When implementing MCH programs/projects, we suggest that cultural characteristics and strategic relevance to individuals/institutions be taken into account, without ever compromising the influence of context on health gains. Finally, we encourage the practice of evaluating the implementation of programs/projects in MCH, considering evaluations as complex endeavors deeply influenced by context that improve the use of evaluation results to inform decisions and/or promote actions.

ABSTRACTS – POSTER PRESENTATIONS

Public Private Partnership and ICT in Maternal, Newborn, Child, Adolescent and Youth Health (MNCAYH)

BE3: Partnerships and Systems Strengthening to reduce early Newborn deaths - The Saving Mothers Giving Life Experience

Authors: Oluwayemisi Femi-Pius

Introduction:
Globally, 3.3 million stillbirths occur and over 4 million newborns die within the first 28 days of life every year. Cross River state (CRS) in Nigeria has an estimated Neonatal mortality rate of 120 per 1000 live births. This figure is much higher than the national average of 37 per 1000 live births. The Saving Mothers Giving Life (SMGL) Initiative assessed 812 health facilities in CRS to identify the health facilities' readiness to provide comprehensive and integrated maternal and newborn health services including emergency obstetric and newborn care (EmONC) services. Findings from the health facility assessment revealed a MMR of 872/100,000 live births and NMR of 160/1000 live births. Only four percent of health facilities surveyed performed all basic emergency obstetric and neonatal care signal functions. Sixty percent of staffs were skilled birth attendants and majority lack the capacity to provide full scale of EmONC services including neonatal resuscitation. Less than 5% of the assessed facilities had functional newborn resuscitation equipment. The baseline data collected from the 97 SMGL supported facilities revealed pre-discharged perinatal death of 58/1,000 live births

Methodology:
SMGL Initiative in CRS is partnering with multiple stakeholders to improve maternal and newborn health outcomes. There is collaboration with CRS Ministry of Health and CRS Primary Health Care Development Agency to coordinate MNH interventions and conduct regular facility supportive supervision. There is partnership with Nigerian Society of Neonatal Medicine (NISONM) to train health care providers on essential newborn care including helping babies breathe. The initiative also partners with community-based organizations to generate demand by sensitizing community stakeholders on birth preparedness & complication readiness. There are regular review meetings to evaluate the results of these various partnerships.

Key Findings:
There is improved state government ownership and coordination of MNH activities in the state as evidenced by the CRSMOH re-activating the partners forum meetings and Core Technical Committee on RMNCH in the state. The partnership has also lead to establishment of state and facility level maternal and perinatal death surveillance response (MPDSR) committees to review preventable maternal and perinatal deaths with the state creating a budget line for its sustainability. The Nigerian Society of Neonatal Medicine, CRS Chapter currently provided volunteer neonatologists to support the quality of care at the state facilities. The CRSMOH is in the process of signing of MoU with society to use state facilities as rural posting sites for residents. Community level partnerships has resulted in community-driven emergency transport system for pregnant women with over 700 pregnant women transferred to health facilities by volunteer drivers. Due to improved capacity of over 300 health care workers on Emergency Obstetric services and Essential Newborn Care Services in Cross

River state, the rate of partograph use in monitoring labour and delivery is currently 78% compared to baseline of 15% in the year 2015. This has helped in identifying promptly cases of prolonged/obstructed labour and providing timely surgical interventions to save lives of mothers and avert stillbirths. All supported facilities have functional neonatal bag & mask and 98% of asphyxiated newborns are successfully resuscitated at birth compared to 15% at baseline. Within 3 years,the initiative achieved 24% (44) reduction in institutional pre-discharge Peri-natal mortality rate from institutional baseline of 58/1,000.

Conclusion:
The SMGL initiative has demonstrated that collaboration and partnership with all relevant stakeholders in maternal and new born health as well as health system strengthening are critical to preventing early newborn deaths. There is the need to for intra- as well as inter-sectoral collaboration to improve newborn outcomes. The role of government in coordinating all the related partnerships also promotes ownership as well as sustainability. It is also pertinent that regular review to monitor and evaluate the results of various partnerships will allow for feedbacks and further strengthening of ongoing partnerships.
This is evidenced by CRSMOH initiating the process of signing an MoU with the University of Calabar Teaching Hospital to use the State Hospitals as rural posting sites for resident pediatricians including neonatologists.

Recommendation:
In order to sustain the positive outcomes of these partnerships, there is the need for the cross river state government to continue strong coordination of all relevant stakeholders. The need to ensure that both the demand and supply side of newborn health services are continuously strengthened cannot be over - emphasized. Partnerships with professional bodies such as NISONM are vital in ensuring quality of care at facility level especially as there currently exists significant human resource for health gaps in CRS health facilities. There should be ongoing efforts to explore other related partnerships within and without the health sector to further improve the newborn health outcomes. Regular reviews to monitor and evaluate data and results will inform sound decision to promote new born health outcomes.

BE4: A Private-Public Partnership for Integrated Programming: Pfizer and CARE

Authors: Jimmy Nzau, Ghislaine Alinsato, Dora Curry, Erin Dumas Alfred Makavore

Introduction:
Effective integration of family planning (FP) and routine immunization services has shown the potential to strengthen the delivery and utilization of both family planning and immunization services , but more evidence is needed to fully understand the impact of the integration approach. Commonly, immunization services are used to refer women to FP services during routine immunization visits for children. Efforts to increase uptake of FP services are aimed mainly at women in the extended post-partum period. While closely spaced pregnancies increase morbidity and mortality risks for mother and child, research has shown that in developing countries two-thirds of women in this group have an unmet need for FP (Guttmacher 2001). It is also true that women in the extended post-partum period come into more frequent contact with the health system for post-natal and infant care, opening up opportunities for intervention. This abstract explores how the integrated service delivery model impacts uptake and quality of service provision. It goes further to identify those elements within the health system that facilitate or hinder the success of the service integration, using our results on quality of counseling, completion of referrals and provider perceptions, as well as outcomes in immunization and use of FP.

Methodology:
CARE Benin/Togo currently implements the Pfizer Foundation-funded VIVO! Project in 20 health facilities in Southeast Benin in collaboration with health Authorsities. The project refers women to co-located, same-day FP visits during children's routine immunization visits. The approach consists of group educational messaging, followed by systematic, standardized, individual referrals using educational materials and job aids. In-depth training on FP provision and the integration process strengthens the supply side while community engagement supports increased demand. By addressing both supply and demand barriers, CARE and Pfizer are improving accessibility of contraception and immunization in Benin and building the evidence base for integrated approaches.

Key Findings:
To help create a supportive environment, CARE Benin through the VIVO project trained facilitators and convened group dialogue sessions

where community members, community leaders, and health providers could ask questions among themselves, identify challenges and opportunities for collaboration and build trust while dispelling myths and misconceptions about contraceptive use or immunizations. This has resulted in making FP / Immunization integration feasible in the project area, using a time-intensive participatory process that actively involves stakeholders - with potentially competing priorities - at all levels. In addition, the developed Integration model also resulted in increased FP uptake and a greater proportion of referrals from immunizations among new FP users without negatively influencing immunization services. Since the inception of the project to-date, more than 50,000 children have been vaccinated and over 32,000 women exposed to contraceptive information through counseling. The number of new FP users more than doubled, with over 6,000 women starting a new modern FP method. Most women chose highly effective and long-acting reversible methods, which had been difficult or impossible to access in the past. The project sites experienced a strong increase in the proportion of new FP users who stated immunization services as their referral source.

Conclusion:

The HIN NOU VIVO! Project's integration model has proven feasible in the project area in southeast Benin. Since the majority of women attending childhood immunization services are women in the extended post-partum period, it appears that the integration model reaches this vulnerable population - which often experiences particularly high levels of unmet need for contraception - with FP messaging and services largely than FP provision alone. While these initial results are encouraging, to date it has been difficult to monitor the accuracy of referral tracking, which appears to be underreporting referrals to FP services.

Recommendation:

Although there is already compelling evidence showing marked increase in the uptake of FP with a greater proportion of referrals from immunizations among new FP users without negatively impacting immunization services, yet it has still be challenging for the project to effectively monitor the accuracy of referral tracking, which appears to be underreporting referrals to FP services. In recognition of this fact, it is recommended to undertake further research to critically assess the fidelity of the integration model on the ground, as well as the contribution of different project elements to the results. By so doing, a clear understanding will be established on what models and components of this approach work in different low-resource settings.

BF6: YouthConnect

Authors: Denise Epiphanie Haba, Cécé Jonas Haba

Introduction:

In a bid to promote Sexual and Reproductive Health Rights a new initiative referred to as YouthConnect has been put in place by the Regional Executive Council of the International Planned Parenthood Federation, Africa to promote social media use by the youth in Africa. While taking due account of the recommendations of the Regional Executive Council, YouthConnect mainly supported the efforts of replicating and improving the existing experiences of the promotion of Sexual and Reproductive Health Rights (SRHR) through social media.

In conformity with the recommendation, YouthConnect supported only Projects that are aimed at replicating and improving part, or all of the practices presented, while contributing to the objectives of the above initiatives.

In that regard, Youth Action Movement (YAM) of Guinea prepared a project for the participation in the call for project, while taking care to mention the coordinates of the YAM member leader in the implementation of the YAM focal point to provide more ample information on the project.

While implementing the project, YAM of Guinea made innovations on social media.

Methodology:

The project management team was made up solely of youth with the definition of roles and responsibilities clearly defined. A communication plan was prepared on a monthly basis for determining discussion topics for each period and each platform. We trained

the youth on Sexual and Reproductive Health Rights and the use of the social media for administering two discussion groups: WhatsApp, Facebook and Tweeter set up through several activities described in the project, and monthly meetings were organized to evaluate the activities.

Main outcomes:

Many results were obtained in project implementation:

- 20,000 adolescents and youth received messages on Sexual and Reproductive Health Rights (SRHR) through the social media networks and that increased the number of youth frequently visiting the BlueEcoute youth centre of the BlueZone of Kaloum through references made during discussions and contacts on the publications;
- One Facebook and 2 WhatsApp groups were set up and 2,000 people were added for discussions and debates based on many topics on SRHR as from 20:00 every day, which enabled us during the discussions to understand and identify the problems of information confronting the youth through the plethora of questions posed during the debates;
- A Twitter account was opened with 1,000 followers for publications and retweets of the YAM activities, of the Guinean Association for Family Welfare (AGBEF), the International Planned Parenthood Federation and Youth Action Movement (YAM), Africa on family planning, STI/HIV/AIDS, Female Genital Mutilations, early marriage, personal hygiene, early sex …
- 10 youth were selected and trained in SRHR and the use of social media (WhatsApp, Facebook and twitter account set up) to constitute the project team and administer the WhatsApp, Facebook and Twitter accounts;
- 3 online advocacy campaigns for free sexual and reproductive health services and family planning for decision-makers and which, played a major role in the commitment made by the Ministry of Health to undertake the process of free contraceptive products during the 6th annual Meeting of the Ouagadougou Partnership;
- 6 tweet-ups were organized for questions and answers on the SRHR topics and the messages published on activities of YAM, of the Guinean Association for Family Well-being (AGBEF) and participation in the activities of the International Planned Parenthood Federation and Youth Action Movement (YAM), Africa;

Facebook:

- YAM Facebook Page: https://www.facebook.com/groups/1885411888398714/?ref=bookmarks
- AGBEF Facebook Page: https://www.facebook.com/agbeippfra/?ref=aymt_homepage_panel

WhatsApp discussion Group:

- Infos Santé Ados-jeunes: https://chat.whatsapp.com/GhGsoooFOaH3mSDh6BTZiS
- Responsible Sexuality: https://chat.whatsapp.com/3a28Nf0gyj183IEynYiukt

Tweeter:

- YAM Tweeter account: https://twitter.com/majguinee_ssr
- AGBEF Tweeter account: https://twitter.com/agbef_pf

Conclusion:

In conclusion, discussions on our WhatsApp groups were considered successful. They were held from 20:00 to 22:00h.
In the discussions on the WhatsApp group we had one discussant every day who spoke statement on the topic. They were young leaders often from other countries. They made statements as if in a conference, and, they embarked on discussions, which were extremely interesting. The following day, we launched a topic without any invitee which we referred to as free antenna where anyone could give his opinion, in other words, one day for an invitee and then free antenna the following day.

Main recommendations:

At the implementation of this project, we recommend that:

- The project be made sustainable and be upscaled to reach many more youth;
- Tablets be purchased for many more youth to enhance platform discussions
- Publication of articles should be included on the blogs managed by the youth;
- A chart of youth Non-Governmental Organizations (NGOs) should be made at national level and their activities promoted on social media.

ABSTRACTS – POSTER PRESENTATIONS

Non-Communicable Diseases and Maternal, Newborn, Child, Adolescent and Youth Health (MNCAYH)

DE2: Strengthening the provision of service for women with perinatal depression in primary care: experience form the spectra study

Authors: Bibilola Oladeji, Jibril Abdulmalik, Lola Kola, Olufemi Idowu, Oye Gureje

Introduction:
Perinatal depression is a common mental health condition occurring among women during pregnancy and shortly after childbirth. The condition is associated with considerable disability in the mothers and poor growth and development in the infants. Even though effective treatments are available, affected mothers rarely get the treatment they need, principally because frontline providers are poor at identifying women with the condition. It is therefore useful to explore the bottlenecks affecting identification of the condition in primary maternal care with a view to instituting appropriate remedies so that affected women get the care they need. Nigeria has less than 500 psychiatrists serving her population of over 160 million people, scaling up mental health care will require developing and testing innovative ways to effect training for frontline primary health care providers who are usually the first point of call for most women with perinatal depression. This study sought to explore the detection of perinatal depression by PHCWs prior to and following the training of the providers as well as explore the effects of introducing a brief screening tool (the 2-item Patient Health Questionnaire (PHQ-2)) and booster training with supportive supervision on detection of perinatal depression.

Methods:
The SPECTRA is an implementation study in 18 selected primary health care centers (PHCCs) in Ibadan, Nigeria. A cascade training programme was used to train frontline PHCWs (Community Health Officers, Community Health Extension Workers and Nurses) in the use of the WHO Mental Health Gap Intervention Guide (mhGAP-IG), a tool designed to aid the delivery of evidence-based mental health care by non-specialists. The knowledge of the PHCWs about depression was assessed before, immediately after, and six months post-training. Consecutively registered women presenting for antenatal care were screened with the Edinburg Postnatal Depression Scale (EPDS) after being attended to by the PHCW and the record of the visit assessed for documentation of depression diagnosis.

Results:
Prior to the initial training, the PHCW identified only 1.4% of cases of perinatal depression. Following training, the detection rates improved to about 4.4% in clinics not using the PHQ-2 screening questions and 13.8% in those using PHQ-2. Knowledge of depression improved following training but there was a slight decline in the scores six months post-training (mean scores- pre-training- 46.6±14.1; immediate post-training- 61.4±12.7) and 6-month post-training- 58.2±12.4). Despite screening and the considerable retention of knowledge, detection rates remained poor following the first round of trainings. This suggests that improved knowledge does not necessarily translate to improved identification. Following the booster training as well as the implantation of a structured supportive supervision implemented twice a month by the trainers, the detection rates improved to 51% in the PHQ-2 clinics. In the non PHQ-2 clinics, where there was only implementation of supportive supervision without the booster training, detection rates improved to 9.0%.

Conclusion:
Multiple factors affect adequate detection and appropriate treatment for perinatal depression. While training is important in improving the knowledge of providers, the use of support tools and provision of supportive supervision are critical in improving the delivery of quality service for women with perinatal depression.

Key Recommendations:
Policy should be developed to support the training of frontline maternal care providers to improve their capacity to deliver effective care to women with perinatal mental health problems. The delivery of effective care should be enhanced through the provision of clinical

support tools such as the PHQ-2 for screening to aid identification and also ensure that there is ongoing support and clinical supervision.

DE3: Leveraging social capital to integrate nutrition-sensitive and nutrition-specific activities for improved nutrition outcomes in Northern Ghana

Authors: Joseph Jutile Loiseau, Mariama Bogobire Yakubu, Yunus Abdulai, Joseph Ashong.

Introduction:

The prevalence of malnutrition among children under 5 years remains high in Northern Ghana with prevalence of stunting, underweight and wasting; 33.1, 20.0% and 6.3% respectively compared with the national prevalence of 18.8%, 11.0% and 4.7% (DHS 2014). Data from routine health information reports indicates improvement in the region (DHIMS 2017), however this improvement is relatively small compared to the levels of resources and efforts made by various institutions such as USAID, UNICEF. According to the Lancet Maternal and Child Series, to make the needed progress in nutrition outcomes, there is a need to adopt a multi-sectoral approach of nutrition-specific and nutrition-sensitive development programming. Nutrition-sensitive programming addresses the key underlying determinants of malnutrition. The Resiliency in Northern Ghana (RING) project is a 5-year integrated project funded by the USAID Feed the Future (FtF) Initiative is designed to contribute to Government of Ghana (GoG) efforts to sustainably reduce poverty and improve the nutritional status of vulnerable populations. Village Savings and Loans Associations, a key livelihoods activity under RING offers the opportunity to layer agriculture activities (soybeans, Orange Flesh Sweet Potatoes, or Green Leafy Vegetables cultivation), Nutrition activity Mother-to-Mother Support Groups, cooking demonstration, durbars) or another livelihoods activity (small ruminants, poultry).

Methodology:

A VSLA is comprised of 25-30 women who contribute to a saving funds weekly, discus funds management take loans and pay back. Two women from each VSLA are trained as group facilitators by the District Health Administration (DHA) and Facility whose catchment the community falls providing them with training in C-IYCF. The trained group leaders become MTMSG facilitators who lead discussions in IYCF topics during MTMSG meetings which are held after VSLA meeting. Facility level health staffs and monitors provide technical guidance to these groups until the group becomes functional usually after 4 to 6 months period.

Key Findings:

The aim of the VLSA activity is to ensure a sustainable impact on vulnerable households by increasing food security, allowing women the opportunity to invest in income generating activities and supporting family needs such as supplementary food, healthcare, education, and building stronger social cohesion in communities. RING project's goal is to reach out to 100% of VSLAs, a total of 2874 VLSAs across 1472 communities, with layered interventions, as a result 1723 MTMSG s have been formed, of which 15,122 women reached with OFSP vines for the cultivation of OFSP. Additionally, 180,397 reached with cooking demonstration and 10,918 reached with the dissemination of the stunting advocacy video and discussions through MTMSG approach. Through this unique approach the knowledge and skill of the women in these groups have been enhanced to lead C-IYCF discussions during group meetings which doubles as the VSLA meeting and aided the members to gain recognition in their various communities and among community leaders. Most of the groups have used the C-IYCF knowledge gained during the MTMSG discussions to engage in self-initiated projects with the support of opinion leaders and general community members. Such activities include leading clean-up exercises, campaigns on the adaptation of appropriate IYCF practices through house to house visits and other social platforms like naming ceremonies, funerals among others while also providing support for other women who are challenged with adopting positive nutrition and health practices, and promoting the use of tippy taps (hand washing facilities) in their homes for improved hygiene practices.

Conclusion:

Layering nutrition sensitive activities with nutrition specific activities has proven to be viable, acceptable to beneficiaries, an efficient and cost effective, and sustainable approach to building the capacity of community members to adopt positive nutrition, livelihoods, health, sanitation practices It is hypothesized that layering of agricultural and livelihoods with nutrition and Water Hygiene and Sanitation (WASH) activities will yield better impact on nutritional status of children under five years of age and women.

Recommendations:
Based on the evidence, this approach provides an avenue for empowering caregivers through the building of social capital to ensure a more comprehensive way of providing adequate nutrition for the families, it is highly recommended this approach to be can be replicated in similar setting like that of Northern region of Ghana as it has the highest prevalence of malnutrition in the country. Ghana Health Service as an owner and user of this approach should ensure sustainability through provision of quality support. This platform is an opportune pathway to communicate to the different segments of the population. Support group leaders should be integrated in outreach services to express more leadership and gain more appreciation form their peers.

DF4: "World Health Organization Package of Essential Non-communicable Diseases" WHOPEN Approach: a tool for the prevention and care of principal NCDs in Peripheral Health Centres.

Authors: Houinato Dismand, Houehanou Corine; Mizehoun Carmelle; Amidou Salmane.

Introduction:
NCDs are responsible for 68 % of global deaths (2012) including 80% of deaths in poor countries. Among them over 40% are premature deaths. The NCDs provoke considerable economic losses and push millions of people into poverty.
In Benin, a 2015 STEP investigation observed the following outcomes from female subjects:

- 12.2% prevalence of diabetes;
- 23.4% prevalence of hypertension;
- 10.1% prevalence of obesity;
- 0.5% prevalence of tobacco use;
- 16.9% prevalence of harmful alcohol consumption;
- 18.7% prevalence of insufficient physical activity;
- 92.8% prevalence of insufficient consumption of fruits and vegetables.

The plan for the implementation of global strategy is aimed at preventing and combating Non-communicable Diseases (NCDs) approved by the World Health Assembly in May 2008. Objective 2 of the plan underpins the need to put in place national policies and plans for preventing and combating NCDs.

Methodology:
The pilot phase of WHO-PEN was initiated in 2009 in nine peripheral health centres in the South of Benin.
The phase was conducted in 06 stages:

- Stage 1: Evaluation of the capacity of the PHC candidate to WHO-PEN
- Stage 2: Training of trainers by WHO Afro
- Stage 3: Documents preparation
- Stage 4: Training of workers and provision of materials (glucometer, height gauge, scales, tensiometer, tape measure)
- Stage 5: Protocols application by workers trained in the field
- Stage 6 : Monitoring

Outcomes:

- From 2009 to 2015, at national level, 21 health zones were covered out of the 34 presented. WHO-PEN training made it

possible to reach 1,022 participants including 42 doctors and 980 paramedics.

- From 2015 to date, with the support of ENABEL, 9 health zones out of 9 where 582 participants were trained. Among them were 81 doctors and 501 paramedics.

Besides the achievements, the training modules were reviewed; 134 health Centres were equipped in 4 departments, supported by ENABEL, with glucometer, scales, peak flow meter, inhalation chamber, mono-filament. WHO-PEN supervision were included in the supervision plan of the zonal support teams.

From the supervisions performed, the personnel showed a clear will to practicalize the care protocols. Nonetheless, the Diabetes cases were immediately referred and not notified in the health centres' registers. Readjustments will be made to make the clinical records more complete, easily comprehensible and precise.

The following necessary lessons must be learnt for a proper implementation of WHO-PEN:

- Good regular supervision of the trained personnel;
- Adequate resource allocation for the health zones to encourage the involvement of local Authorsities;
- Retention of the trained workers at their posts;
- Training of local trainers;

Endowment of the peripheral health centres with technical material and equipment and their regular renewal.

Conclusion:

Benin was the second country after Eritrea to implement the WHO's WHO-PEN in the African region. After an experimental phase and progressive upscaling, we were confronted with some difficulties that obstructed the implementation of the intervention. This state of affairs made us review our strategy and suggested the need for proper technical and financial support and, most of all, a proper regular formative supervision of the trained personnel.

Recommendations:

The key recommendations for ensuring the implementation of the approach are:

- Formative supervision of the WHO-PEN must be strengthened in the zonal support team;
- Support must be lent to finance resource mobilization BN and PTF to ensure regularity of integrated supervision;
- Advocacy must be conducted with all stakeholders for upscaling WHO-PEN to national level;
- The Government must be lobbied to retain the personnel at their posts;
- The health structures including the personnel must be endowed with the minimum standard equipment to conduct NCD training;
- Essential drugs must be made available to all the levels of the health pyramid through a good information and logistical management system.

Canopy Walkway, Kakum National Park, Cape Coast

Facilitator and Keynote Speakers

Facilitator and Keynote Speakers at Plenary Sessions.

DESIGNATION / STATUT	BIO-PROFILES
Prof. Akinyinka OMIGBODUN	 **Main Facilitator** Professor Akinyinka O. Omigbodun was appointed Professor of Obstetrics & Gynaecology at the University of Ibadan, Nigeria in October 1997. His research interests include reproductive biology especially of female genital tract cancers, population and public health, and the education of healthcare professionals. He has been the recipient of many coveted international awards, including the Audrey Meyer Mars Fellowship of the American Cancer Society in 1992 and an award by the American Society for Reproductive Medicine for distinct contribution to science in 1996. He was the Provost of the College of Medicine, University of Ibadan from August 2006 until July 2010. He served in several key positions the West African College of Surgeons (WACS) before becoming the 28th President of WACS from 2015 – 2017. Professor Omigbodun was the Foundation Chairman of the Board of Management of the Consortium for Advanced Research Training in Africa (CARTA) and he is the current Chairman of the Regional Council for Health Professionals' Education, an organ of the West African Health Organization (WAHO). Nigeria's Osun State Government bestowed the State's Merit Award on him in September 2010, for his contributions to the Science and Practice of Medicine. He was elected a Fellow of the Nigerian Academy of Science (FAS) in 2012 and a Fellow of the Royal College of Obstetricians & Gynaecologists of the United Kingdom, ad eundem, in 2017. He has published over 130 scholarly articles and book chapters. He is the Editor-in-Chief of the *Proceedings of the Nigerian Academy of Science* and editorial adviser to several other journals. Email: omigbodun@yahoo.com
Prof. Irene Akua AGYEPONG Ghana Health Services Accra	 **Main Key Note Speaker at Plenary Session 1 (Governance & Accountability)** Irene A. Agyepong is a Public Health Physician with the Dodowa Health Research Center of the Research and Development directorate of the Ghana Health Service. She is also a member of the Public Health Faculty of the Ghana College of Physicians and Surgeons. She has previously been Regional Director of Health Services for the Greater Accra region of Ghana, District Director of Health Services in the Dangme West district and seconded full time to the University of Ghana School of Public Health by the Ghana Health Service in October 2012 for two years. She has been part time faculty in the School of Public Health since its foundation in 1994, in addition to providing field supervision to MPH students. She held the position of Professor to the Prince Claus Chair in Development and Equity (2008 – 2010) in the University of Utrecht, in the Netherlands. She was awarded the Arnold Kalunzy Distinguished Alumni Award 2008 by the University of North Carolina at Chapel Hill, Public Health Leadership program, School of Public Health. Dr Agyepong is currently a member of the Independent Advisory Committee (IAC) for the Global Burden of Disease. She has held various other national and international positions. She was the Chairperson of the Board of Health Systems Global (2012-2014), Member of the Council of Deans for the 1st and the 2nd Global Symposium on Health Policy and Systems Research and of the Advisory Group for the WHO Global Strategy for Health Systems Research. She was a member and subsequently Chair of the Scientific and Technical Advisory Committee (STAC) of the Alliance for Health Policy and Systems Research, WHO Geneva as well as Chair of the Scientific Oversight Group (SOG) of the Implementation Research Platform (IRP), WHO, Geneva. Her research interests include Health Policy and Systems. Email: irene.agyepong@gmail.com

Namoudou KEITA,
West African Health Organization(WAHO)
Bobo-Dioulasso,
Burkina Faso

Introduction at Plenary Session 1
(Governance & Accountability)

Dr. KEITA Namoudou is in charge of Primary Health Care and Health Systems Strengthening at WAHO from 2008 to date. He holds a postgraduate diploma in Public Health and Social Medicine and has a Master's degree in Biological and Medical Sciences and DEA. He has 30 years of experience in primary health care, clinical and managerial capacity building including leadership and governance, promotion of implementation research, health promotion, community-based interventions and quality insurance and patient safety. He is currently coordinating the process of ECOWAS Best Practices Forum in Health since 2013.
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USAID's HEARD Project

Stefano Bertozzi

&

Key Note Speaker at Plenary Session 2
(Governance & Accountability)

Stakeholders' commitment in the establishment of priorities in science and research implementation.

Stefano Bertozzi, Dean Emeritus, Professor, School of Public Health University of California, Berkeley: Dr. Bertozzi is Dean Emeritus and Professor of health policy and management at the UC Berkeley School of Public Health and serves as co-chair of the Health Working Group for the UC–Mexico Initiative and co-editor of the Disease Control Priorities (DCP3) volume on HIV/AIDS, Malaria & Tuberculosis. Previously, he directed the HIV and tuberculosis programs at the Bill and Melinda Gates Foundation. Dr. Bertozzi worked at the Mexican National Institute of Public Health as director of its Center for Evaluation Research and Surveys. He was the last director of the WHO Global Programme on AIDS and has also held positions with UNAIDS, the World Bank, and the government of the DRC. He is a member of the National Academy of Medicine. He holds a bachelor's degree in biology and a PhD in health policy and management from the Massachusetts Institute of Technology. He earned his medical degree at UC San Diego, and trained in internal medicine at UC San Francisco.

Maeve MCKEAN,

Maeve McKean, Senior Policy Advisor, Center for Immigrant, Refugee and Global Health at City University of New York (CUNY), USAID's Health Evaluation and Applied Research Development (HEARD) Project: Maeve McKean, JD, MSFS, is the Senior Policy Advisor for the USAID Health Evaluation and Applied Research Development (HEARD) Project and a Distinguished Lecturer at the City University of New York's School of Public Health. A human rights lawyer, she previously she served as the Senior Advisor to the Assistant Secretary for Global Affairs at the U.S. Department of Health and Human Services where she was the office's lead on human rights policy issues, including women and children's health and LGBT health, as well as the agency lead on the Health Data Collaborative. Serving as the first ever Senior Advisor for Human Rights at the State Department's Office of the Global AIDS Coordinator Maeve was the primary lead for prioritizing human rights within the US Government's six billion dollar PEPFAR program. Maeve graduated from Georgetown University where she received a joint degree from Georgetown in International Law as well as a Master's Degree from the Walsh School of Foreign Service. After law school she spent a year as a legal fellow through the Ford Foundation and Georgetown's Women's Law and Public Policy Fellowship Program working to secure reproductive rights for HIV-positive women. Before returning to graduate school, Maeve worked for U.S. Senator Dianne Feinstein both in her regional office in San Diego as well as on Capitol Hill. She was a Peace Corps Volunteer in Mozambique.
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Mario FESTIN,
WHO

Key Note Speaker at Plenary Session 3 (Governance & Accountability - Task Shifting/Sharing)

Dr. Mario Philip R. Festin is a medical officer at the Human Reproduction Team of the Department of Reproductive Health and Research at WHO. He is an obstetrician- gynaecologist, with additional graduate degrees in Clinical Epidemiology and Health Professions Education. He was previously Executive Director of the National Institutes of Health Philippines, Vice Chancellor of the University of the Philippines Manila, and Assistant Director for Health Operations at the Philippine General Hospital.
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Rodrigue NGOUANA

Partenariat
de Ouagadougou
Dakar; Sénégal

Key Note Speaker at Plenary Session 3
(Governance & Accountability - Task Shifting/Sharing)

Rodrigue NGOUANA, est le Directeur Technique de l'Unité de Coordination du Partenariat de Ouagadougou. Entièrement dévoué à l'amélioration du bien-être des populations en Afrique, M. NGOUANA considère les partenariats et le partage d'expériences comme des maillons essentiels dans ce travail.
Il s'efforce à promouvoir la création des alliances collaboratives parmi un large éventail de partenaires, d'organisations et de gouvernements, afin de surmonter les défis majeurs auxquels font face les pays africains. Il cumule plusieurs années d'expérience en Afrique centrale et en Afrique de l'ouest dans la coordination, le développement des collaborations, le plaidoyer et la mobilisation de ressources pour des programmes de santé sexuels et droits reproductifs et toute particulièrement la planification familiale.
Il est économiste démographe de formation et possède un Master en Economie Conseil et Gestion Publique de l'Université de Rennes 1 en France.
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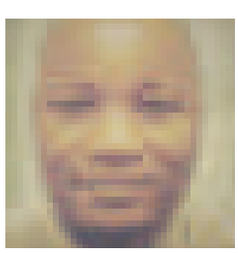
Simtokina N'GANI,
Ministry of Health,
Togo



Key Note Speaker at Plenary Session 3 (Governance & Accountability - Task Shifting/Sharing)

Expert in Reproductive Health and Family Planning; Manager of Health Projects; Head of Family Planning Section at DSMIPF; Focal Point of the Ouagadougou Partnership in Togo.

Asa CUZIN-KIHL,
WHO

Key Note Speaker at Plenary Session 3
(Governance & Accountability - Task Shifting/Sharing)

Åsa is a Technical Officer from the WHO's RHR Department, where she has worked during the past 19 years first to develop the WHO Reproductive Health Library (RHL), conducting workshops on Evidence-based Decision-Making in Reproductive, Implementing Best Practices Initiative, country capacity building activities, involved in implementation and operations research projects. She holds a postgraduate diploma in public health from the University in Geneva, Switzerland and a Diploma in Human rights.
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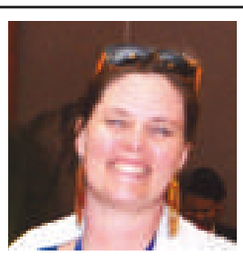
Séni KOUANDA, (MD, PhD) (Institut de Recherche en Sciences de la Santé – IRSS Ouagadougou)	 **Key Note Speaker at Plenary Session 3 (Governance & Accountability - Task Shifting/Sharing)** Medical epidemiologist, senior researcher, head of the public health department of the "Institut de recherche en sciences de la santé "(IRSS), Kaya Health and Demographic surveillance system (Kaya HDSS) site leader, professor of epidemiology and deputy director of "Institut Africain de Santé Publique" (IASP), EDCTP senior research fellow. Email: skouanda@irss.bf
Mr. Mbaye Khouma SYLLA Consultant	 **Key Note Speaker at Plenary Session 4 (Public Private Partnership & IT)** Mbaye Khouma est Ingénieur d'Agronomie Tropicale diplômé de Sup Agro/Montpellier. De retour au Sénégal, il a travaillé au Ministère des Eaux et Forêts dans la Fixation des dunes du littoral Nord entre Dakar et St Louis (Kayar-Lompoul) A la suite de son MBA obtenu au CESAG de Dakar, il fait une riche carrière de plus de 25 années, dans la gestion d'entreprise au sein des grandes multinationales que sont Nestlé, Coca-Cola et Airtel. Stratège reconnu, il a exercé ses talents dans tous les domaines du marketing, passant des produits de grande consommation au marketing social, marketing politique et le marketing des pays pour la promotion du tourisme et des Investissements privés. Reconverti consultant, il s'est concentré au cours des 5 dernières sur le Partenariat Public Privé (PPP) dans le domaine des infrastructures et des services aux usagers notamment dans le domaine des systèmes de santé
Gloria Quansah Asare Ghana Health Service	 **Speaker at Plenary Session 4 (Public Private Partnership & IT)** Deputy Director General, Ghana Health Service Dr. Gloria Quansah Asare (BSc. Human Biology, MB, ChB, MPH, Dr.PH, FGCPS) is a Medical Doctor; a Public Health Consultant and currently the Deputy Director-General of the Ghana Health Service. She has extensive experience in Programme Management and research and is a passionate advocate for Reproductive Health/Family Planning, Maternal, Newborn, Child & Adolescent Health (RMNCAH), Nutrition and Women & Development. She was the first Director of the Family Health Division; and prior to that the National Programme Manager for Family Planning and Expanded Programme on Immunization and Control of Diarrheal Diseases (EPI/CDD) programmes of the Ghana Health Service. She is a Foundation Fellow (Public Health Faculty) of the Ghana College of Physicians & Surgeons, and former Deputy Head of Population, Family & Reproductive Health Department, University of Ghana School of Public Health. She served as a Member (Global South Representative) of the Reproductive Health Supplies Coalition Executive Committee (2013 -2017). She is adjunct lecturer at the Ensign School of Public Health, Ghana.
Temitayo Erogbogbo MSD for Mothers	 **Speaker at Plenary Session 4 (Public Private Partnership & IT)** Temitayo has two decades of combined private sector and international development experience, 10 years of which was spent in the pharmaceutical industry in multiple roles that included community relations, government affairs, marketing, and sales. As the Director of Advocacy, Tayo is responsible for developing and strategically directing Merck for Mothers' program engagement in advocacy initiatives. He contributed to the development of the Global Strategy for Women's, Children's, and Adolescents' Health 2016 -2030.

Arinze Awiligwe Concept Foundation	 **Speaker at Parallel Session (Public Private Partnership & IT)** Arinze has years of experience in clinical and regulatory pharmacy practice combined with international project management in development contexts where he has worked on projects to bridge the gap between academic discourse, private interests and public policy to improve access to medicines through programs, advocacy and innovations. He holds Pharmacy qualifications from the University of Lagos and Global Health qualifications from the Institute of Global Health of the University of Geneva in Switzerland. He currently supports the African portfolio for Quality of Maternal Health Medicines at Concept Foundation in Geneva.
	KNOWLEDGE CAFE
Ginette Hounkanrin, E2A/Pathfinder	 Ginette is a medical doctor specialized in Population and Health. Over the last 12 years, she has been working on integrating AYRSH and SRH/FP within MCH programs providing technical assistance to CSOs and Governments. She joined E2A/Pathfinder since May 2017 as Senior. Youth Advisor.
Sheila Mensah Senior Communications, Monitoring and Evaluation Advisor	 Sheila is the primary contact for communications in the Regional Health Office, responsible for disseminating results, information and narratives about health interventions in West and Central Africa, using tools such as the health quarterly she founded, ParlerHealth. She also manages the office's flagship regional capacity building agreement with the West African Health Organization and its evaluation and research contract with International Business & Technical Consultants, Inc. Previously, she held positions and consultancies in the private sectors of the USA and Ghana. She holds a Bachelor of Science in Chemical Engineering from the University of Pennsylvania and a Master of Business Administration from the University of Cincinnati.
Matié YANOGO, Coordonnateur de Projet à MSBF.	 A health attaché in nursing and obstetrics and holder of a master's degree in project management, Matié has been the coordinator of the project delegating tasks in the field of family planning to Marie Stopes Burkina Faso since January 2017. He has more than 18 years of experience in public health. He has worked at the community level, in the management teams of employees of peripheral public structures. He has experience in both the public and private sectors, particularly in maternal and neonatal health.
Anne TAIWO, Research, Metrics and Evaluation Manager at Marie Stopes International Organization Nigeria	 Anne Taiwo has been RME Manager at MSION since June 2015. Prior to that she worked for over ten years as a Senior Research Officer for the Association of Reproductive and Family Health. She has a PhD in Public Health from the University of Atlanta and an Msc in Health Geography from the University of Ibadan.
Elise Petitpas, Equilibres & Populations	 Elise has about 10 years of experience as a human rights and women's rights advocate in different settings, including at European and Africa level. As Innovation and Advocacy Expert for Equilibres & Populations, she works with Francophone West Africa CSOs in building, implementing and monitoring innovative social mobilisation and advocacy projects on adolescent and youth SRHR.

Mariam Diakité, Conseillère Technique régionale en Suivi, Apprentissage, et Evaluation Institute for Reproductive Health (IRH), Georgetown University, Mali	 Specialized in promotion and health education, Mariam Diakité has been working with IRH for more than seven years in monitoring, learning and evaluating interventions on changing social norms for RH / FP and scaling up these interventions. She has experiences from in Mali, Senegal, Niger, Benin and DRC. In addition, she is familiar with gender approaches and interventions that target women, men, adolescents and youth at the community level.
Norbert Coulibaly, Technical Specialist of Family planning and Reproductive Health Commodity Security, UNFPA West and Central Africa	 Dr. Norbert Coulibaly has joined the UNFPA West and Central Africa regional office as Technical Specialist of Family planning and Reproductive Health Commodity Security (FP/RHCS) since March 2016. Dr. Norbert Coulibaly began his career with the Ministry of Health in Burkina Faso at the district level before being appointed as Regional Director of Health for the Central East Region. During the 16 years (1993 to 2009) he worked at the Ministry of Health, he acquired solid experience in Health development, Management of health programs and Strengthening Health systems. Most recently, Dr. Coulibaly worked for the UNFPA Country Office of Burkina Faso, first as RHCS Program Officer from 2009 to 2014, then as Program Analyst Reproductive Health/Family Planning (RH/FP) from March 2014 to February 2016
Blami Dao Technical Director, Western and Central Africa, Jhpiego	 Dr Dao is an obstetrician gynecologist from Burkina Faso with more than 20 years' field experience in MNH and FP in Africa. He joined Jhpiego 8 years ago as its director of MNH, then he transitioned to the position of technical director for Western and central Africa a few months ago. His experience includes setting up a oncology unit in a hospital department of OB/GYN and working with women's groups and NGOs to promote cervical and breast cancer screening in Burkina Faso.
Bethany Arnold, Coordinator at JHPIEGO Corporation	 Bethany Arnold has a Masters of Science in Public Health (MSPH) from the Johns Hopkins Bloomberg School of Public Health. She has over 10 years of experience in global health, with a focus on youth and adolescents as well as Family Planning and Reproductive Health (FP/RH). Ms. Arnold is a technical-focused Program Officer working with both the West Africa and FP/RH teams at Jhpiego, providing technical advising and collaborating on organizational initiatives focused around postaboration care, postpartum family planning, and social and behavior change.
Prof. Ama AIKINS University of Ghana CO/ Dr William BOSU (wbosu@wahooas.org)	 **Key Note Speaker at Plenary Session 5** Professor Ama de-Graft Aikins is a social psychologist with a primary interest in experiences and representations of chronic physical and mental illnesses and Africa's chronic non-communicable disease (NCD) burden. Her current collaborative research focuses on diabetes and obesity among Ghanaians in Ghana and Europe, food beliefs and practices among Ghanaians in Ghana and the US, and community-based cardiovascular (CVD) and mental health interventions in Ghana. She is also conducting independent longitudinal research on diabetes experiences in Accra. She teaches graduate courses in Psychology, the Philosophy of the Social Sciences and Qualitative Research Methods at the University of Ghana. She has supervised graduate theses in Social Psychology, Social Policy, Public Health and Population Studies at the University of Ghana, London School of Economics and Political Science (LSE), London School of Hygiene and Tropical Medicine, New York University and the University of Sussex. Email: adaikins@ug.edu.gh

Prof Olanrewaju Rita-Marie AWOTONA

Nigerian Professor of Pharmacognosy
Legacy University in Banjul-the Gambia

Key Note Speaker at Plenary Session 6 (Traditional Medicine)

She was appointed the first female Ag. Director Academic Planning in 2008, became first female tenured professor of the Niger Delta University in October 2011 and Director Academic Planning in 2011 till 2012. Reestablished the Directorate of Advancement and Linkages as Director from 2012 till 2013. She was Ag. HOD of the Dept. of Pharmacognosy and Herbal Medicine 2009/2010. She became the first female Dean of the Faculty of Pharmacy, Niger Delta University, on the 1st of August, 2013 till 2016. She is currently the Head of Department of Pharmacy and Pharmaceutical Sciences of the Legacy University, The Gambia, where she is developing the pharmacy and herbal medicine programs.

She is member of various learned societies and organisations, Nigerian Society of Pharmacognosy (NSP), Nigerian Association of Academic Pharmacists (NAAP), Pharmaceutical Society of Nigeria (PSN), Third World Organisation for Women in Science (TWOS), American Society of Phamacognosy, Phytochemical Society of North America and The Society for Medicinal Plant Research (GA).

She has been the recipient of several fellowships and grants. Among which are the Alexander von Humboldt fellowship, UNDP training fellowship on Traditional Medicine, World Bank Assisted Fellowship. Her research has focused surveys of herbs and Herbsellers, ethnobotanical surveys of Baylesa state, standardization of medicinal plants and herbal medicine, phytochemistry and Herbal medicine formulation. Recently, she has been more interested in helping Herbal Medicine to have a voice by assisting to document verifiable evidence from the use of Traditional medicine. She is currently a member of the WAHO expert committee on the Second volume of the West African herbal Pharmacopoiea.
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Slave Castle, Cape Coast, Central Region.

University of Ghana, Legon

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