197: CAN A QUALITY ASSURANCE (QA) BASED FAMILY HEALTH PROGRAM IMPROVE HEALTH SERVICES UTILIZATION IN DEVELOPING RURAL AREAS?

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Objective:
Improve the utilization of Family Health Services (FHS) in implementing a Quality Assurance Based Family Health Program

Methods:
The five years Quality Assurance Based Family Health Program (PROSAF) funded by USAID has been implemented since May 1999 in Borgou Alibori the two east northern departments of Benin according to the following steps.
Step 1: (*Norms and Standards Definition*): A departmental orientation workshop was held on QA principles and components, PROSAF objectives components and implementation strategies, the expected levels of performance of the health systems and quality of health services delivered in Borgou Alibori in 2004 after the program lifetime.
Step 2: (*Quality Management Assessment*): An assessment of the actual performance of the health subsystems including health care delivery, Planning, supervision, training, logistics, services organisation, IEC, client satisfaction and knowledge on health related topics was conducted. This was followed by strategic and operational planning sessions of the more relevant actions to improve and maintain performance where needed at both DDSP and Health Zone (HZ) levels.
Step 3: Implementation of selected actions to improve subsystems and health workers performance such as training, formative supervision, quarterly monitoring, integration of health services within the seven HZ. Two HZ (Banikoara and Bembèrèkè-Sinendé) were chosen as test HZ also called zones of concentration (ZC). In these two HZ, in addition to the above cited interventions PROSAF reinforced and coached 21 health clinics management committees, and implemented Community Based Services (CBS) run by 218 CBS agents.
Step 4: Settlement in the ZC of 21 Quality Improvement Teams (QIT), one per health centre (HC). Each QIT is built of both care providers and community representatives trained on QA principles and problem solving techniques. After their training, the QIT underwent problems solving process such as utilization of prenatal care (PNC) and children immunization. Steps3 and 4 were those of *Quality improvement*.
Step 5: After 4 years of implementation, data on six indicators: utilization of PNC, rate of pregnant women immunized "VAT2", rate of deliveries in health facilities, utilization of post natal care, rate of new users of Family Planning (FP) services and fully vaccinated rate among children 12-23 months. The data were compiled quarterly from the 1rst quarter of 1997 up to the 4th quarter of 2002. For comparison purposes, the 2nd quarter of 1999 when PROSAF was launched has been used as the basis. In addition, the two ZC were compared to the others. To control for seasonal fluctuations a coefficient of fluctuation was applied. Graphs of the trends of each indicator were then performed.

Results:
There is a clear increase starting from the 2nd quarter 1999 in the utilization of PNC (+ .3), rate of pregnant women immunized "VAT2" (+.5), rate of new users of FP services (+ .8) in the ZC. The trend of the utilization of postnatal care is mitigated: there is a significant increase in the zones of concentration during 2000 followed by a regular decrease in 2001. The data did not show any significant difference among the compared zones in the trends of the rate of deliveries in health facilities, and fully vaccinated rate among children 12-23 months. This is not consistent with the efforts made in the two ZC to improve deliveries in HC and children immunization.

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Conclusions:
The above results suggest that QA strategy combined with community-based interventions can significantly improve the utilization of family health services. Routine health services data can serve as a good tool to monitor at low cost the effects of a health intervention on the utilization of a health services at departmental level.

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