La rédaction d'une note d'information stratégique qui est une synthèse des résultats de la recherche regroupant des données probantes locales et issues des revues systématiques pour éclairer la prise de décision et informer les délibérations sur les politiques, est un exercice nécessitant le recours à une méthodologie de recherche précise. Elle implique entre autre la collecte des données probantes sur la question ayant été portée à l'attention des décideurs et appelant une réponse. Dans la présente bibliographie annotée, nous rassemblons les documents ayant servis de références bibliographiques pour la rédaction des notes d'information stratégiques du Centre pour le Développement des Bonnes Pratiques en Santé. Ces documents traitent de questions variées à l'exemple de comment optimiser l'utilisation des services de consultation prénatale au Cameroun, comment maintenir les personnels soignants dans les zones rurales et enclavées du Cameroun ?ou encore quelles sont les stratégies pour améliorer la gouvernance en vue du développement du district de santé au Cameroun, renforcer le Système d'Information Sanitaire pour Accélérer la Viabilisation du district de Santé, stimuler l'engagement des parties prenantes pour améliorer la gouvernance et accélérer la viabilisation des districts de santé au Cameroun, réussir la réforme du programme « Agent Relais Communautaire » au Cameroun.

Note d'information stratégique:
Optimiser l'utilisation des services de consultation prénatale

1- **Beninguisse, G., Haddad, S., Fournier, P., & Nikièma, B. (2005). L'accessibilité culturelle : une exigence de la qualité des services et soins obstétricaux en Afrique. Dans U. Isiugo-Obnihe, E. Ngwe, & V. Kokou, *African Population Studies, Suppl.* Paris.**

L'accès aux services obstétricaux est une des composantes essentielles d'une bonne santé reproductive en Afrique. Le contexte épidémiologique de la maternité, particulièrement préoccupant, le justifie pleinement. D'après les estimations de l'OMS (OMS, 1998), le ratio de mortalité maternelle pour 100000 naissances vivantes est de 870 en Afrique contre 36 en Europe, 11 en Amérique du Nord, 190 en Amérique Latine et Caraïbes et 390 en Asie. La mortalité périnatale est estimée à 75‰ en Afrique contre 13‰ en Europe, 9‰ en Amérique du Nord, 39‰ en Amérique Latine et Caraïbes et 53‰ en Asie (WHO, 1996). Cet article documente l'importance de l'accessibilité culturelle comme critère de la qualité des services et des soins obstétricaux aux côtés de l'accessibilité économique et géographique. L'amélioration de la qualité passe donc nécessairement par une adéquation de l'offre aux attentes et préférences, ce qui fait appel à une complémentarité dans l'action entre les systèmes traditionnel et biomédical, la recherche d'un espace thérapeutique commun pour la prise en charge de la grossesse et de l'accouchement. La tâche n'est certes pas facile au regard de nombreuses pesanteurs à surmonter : la longue pratique du cloisonnement disciplinaire pouvant créer l'inertie du changement, la dépendance économique et sanitaire de l'Afrique vis-à-vis l'occident (porteur et diffuseur du système de santé biomédical), la crise économique et celle du système de santé que traverse le continent. Cette tâche est rendue difficile aussi par une possible incompatibilité entre certaines attentes et les standards d'efficacité et les capacités des services de santé. Ainsi par exemple, le souhait de discrétion de la grossesse à ses débuts est incompatible avec la précocité de la première consultation prénatale fixée normativement au premier trimestre de la gestation. De même, le refus de toute présence masculine parmi le personnel soignant et de l'utilisation collective des salles d'accouchement, de séjour et du matériel d'intervention obstétricale peuvent être incompatible avec les capacités d'organisation des services de santé. Néanmoins, une réflexion approfondie mérite d'être engagée ou poursuivie en se nourrissant des leçons du

passé caractérisées par trois principales impasses : le cloisonnement des actions sanitaires, la non-prise en compte des réalités culturelles et des attentes associées et la participation absente ou insuffisante des populations.

2- **Africa Progress Panel. (2010). *Maternal Health: investing in lifeline of healthy societies and economies*. Africa Progress Panel.**

One woman dies per minute in childbirth around the globe. Almost half of these deaths occur in Sub- Saharan Africa. Despite the progress made in many countries in increasing the availability of maternal healthcare, the majority of women across Africa remain without full access to this care. Countries face a variety of obstacles to improved maternal health: insufficient data prevents ministries from implementing programmes most effectively, while cost and other access issues prevent women from using the available resources. There are known, cost effective interventions that can dramatically reduce maternal mortality. Investing in maternal health is a political and social imperative, as well as a cost effective investment in strong health systems overall. Three key approaches can considerably improve the health of women in Africa: maximizing services of health workers; efficient financing mechanisms; and building political partnerships. African governments and policymakers have ultimate responsibility for their people and the economic growth and development of their country. All African governments have made commitments both regionally and internationally to improving maternal health. Realizing these commitments requires political leadership at the highest level. Moreover, national development plans and strategies for improving maternal health must be articulated and drive action on the ground, including the implementation of health programs.

3- **Bhutta, Z., Darmstadt, G., Hasan, B., & Haws, R. (2005). Community-based interventions for improving perinatal and neonatal health outcomes in developing countries: a review of evidence. *Pediatrics, 115*, 519.**

Background. Infant and under-5 childhood mortality rates in developing countries have declined significantly in the past 2 to 3 decades. However, 2 critical indicators, maternal and newborn mortality, have hardly changed. World leaders at the United Nations Millennium Summit in September 2000 agreed on a critical goal to reduce deaths of children <5 years by two thirds, but this may be unattainable without halving newborn deaths, which now comprise 40% of all under-5 deaths. Greater emphasis on wide-scale implementation of proven, cost-effective measures is required to save women's and newborns' lives. Approximately 99% of neonatal deaths take place in developing countries, mostly in homes and communities. A comprehensive review of the evidence base for impact of interventions on neonatal health and survival in developing country communities has not been reported.
Objective. This review of community-based antenatal, intrapartum, and postnatal intervention trials in developing countries aimed to identify (1) key behaviors and interventions for which the weight of evidence is sufficient to recommend their inclusion in communitybased neonatal care programs and (2) key gaps in knowledge and priority areas for future research and program learning.
Methods. Available published and unpublished data on the impact of community-based strategies and interventions on perinatal and neonatal health status outcomes were reviewed. Evidence was summarized systematically and categorized into 4 levels of evidence based on study size, location, design, and reported impact, particularly on perinatal or neonatal mortality. The evidence was placed in the context of biological plausibility of the intervention; evidence from relevant developed-country studies; health care program experience in implementation; and recommendations from the World Health Organization and other leading agencies.
Results.A paucity of community-based data was found from developing-country studies on health status impact for many interventions currently being considered for inclusion in neonatal health programs. However, review of the evidence and consideration of the broader context of knowledge, experience, and recommendations regarding these interventions

enabled us to categorize them according to the strength of the evidence base and confidence regarding their inclusion now in programs. This article identifies a package of priority interventions to include in programs and formulates research priorities for advancing the state of the art in neonatal health care.
Conclusions. This review emphasizes some new findings while recommending an integrated approach to safe motherhood and newborn health. The results of this study provide a foundation for policies and programs related to maternal and newborn health and emphasize the importance of health systems research and evaluation of interventions. The review offers compelling support for using research to identify the most effective measures to save newborn lives. It also may facilitate dialogue with policy makers about the importance of investing in neonatal health.

4- **Bloom, S., Lippeveld, T., & Wypij, D. (1999). Does antenatal care make a difference to safe delivery? A study in urban Uttar Pradesh, India. *Health Policy and Planning, 14*, 38–48.**

Evidence to support that antenatal screenings and interventions are effective in reducing maternal mortality has been scanty and studies have presented contradictory findings. In addition, antenatal care utilization is poorly characterized in studies. As an exposure under investigation, antenatal care should be well defined. However, measures typically only account for the frequency and timing of visits and not for care content. We introduce a new measure for antenatal care utilization, comprised of 20 input components covering care content and visit frequency. Weights for each component reflect its relative importance to better maternal and child health, and were derived from a survey of international researchers. This composite measure for antenatal care utilization was studied in a probability sample of 300 low to middle income women who had given birth within the last three years in Varanasi, Uttar Pradesh, India. Results showed that demarcating women's antenatal care status based on a simple indicator--two or more visits versus less--masked a large amount of variation in care received. Logistic regression analyses were conducted to examine the effect of antenatal care utilization on the likelihood of using safe delivery care, a factor known to decrease maternal mortality. After controlling for relevant socio-demographic and maternity history factors, women with a relatively high level of care (at the 75th percentile of the score) had an estimated odds of using trained assistance at delivery that was almost four times higher than women with a low level of care (at the 25th percentile of the score) (OR = 3.97, 95% CI = 1.96, 8.10). Similar results were obtained for women delivering in a health facility versus at home. This strong positive association between level of care obtained during pregnancy and the use of safe delivery care may help explain why antenatal care could also be associated with reduced maternal mortality.

5- **Carroli, G., Villar, J., Piaggio, G., Khan-Neelofur, D., Gulmezoglu, M., Mugford, M., et al. (2001). WHO systematic review of randomized control trials of routine antenatal care. *Lancet, 357* (9268), 1565-70.**

Background: There is a lack of strong evidence on the effectiveness of the content, frequency, and timing of visits in standard antenatal-care programmes. We undertook a systematic review of randomised trials assessing the effectiveness of different models of antenatal care. The main hypothesis was that a model with a lower number of antenatal visits, with or without goal-oriented components, would be as effective as the standard antenatal-care model in terms of clinical outcomes, perceived satisfaction, and costs.
Methods: The interventions compared were the provision of a lower number of antenatal visits (new model) and a standard antenatal-visits programme. The selected outcomes were preeclampsia, urinary-tract infection, postpartum anaemia, maternal mortality, low birthweight, and perinatal mortality. We also selected measures of women’s satisfaction with care and cost-effectiveness. This review drew on the search strategy developed for the Cochrane Pregnancy and Childbirth Group of the Cochrane Collaboration.Overall, we showed equivalence for low birthweight within the preset margin. When we stratified meta-analyses by unit of randomisation, the results had the same pattern and were similar in clinical terms,

although we could not claim statistical equivalence because of the lower power. Although we did not show statistical equivalence for preeclampsia within the upper margin established for low birthweight (a 20% increase), the rates were clinically very similar and the upper limit of the 95% CI (a 26% increase) was very close to this margin. Similar considerations applied to the upper limit of the 95% CI for perinatal mortality (1·36, or 36% increase risk). For these outcomes with low prevalence the power is lower. Two approaches can be explored to facilitate their interpretation: the first is to set larger limits of clinical equivalence based on the absolute risk; the second is to decrease the level of confidence (ie, 90% CI). Providers are unlikely to realise actual cost savings from a lower number of antenatal visits; however, women's time and energy, staff, and buildings would be freer for other more useful activities. The objective of routine antenatal care is to deliver effective and appropriate screening, preventive, or treatment interventions. Thus, the number of visits should be the result of how these effective interventions can be delivered in a timely way during pregnancy. The results of this systematic review suggest that these effective interventions can be provided within fewer visits than presently recommended, without any clinically important increase in the risk of adverse outcomes.

6- **De Brouwere, V. (2008). Réduire les barrières financières aux soins obstétricaux dans les pays à faibles ressources. Dans V. De Brouwere, *Studies in HSO&P* (p. 25). Antwerp**

L'objectif de cet ouvrage est de contribuer à une meilleure connaissance des expériences en cours pour réduire les barrières financières à l'accès aux soins de santé maternelle de qualité, quelle que soit l'échelle à laquelle ces expériences sont réalisées. Bon nombre d'expériences ne sont pas encore formellement documentées, et la qualité des évidences disponibles varie. Il est néanmoins crucial que les stratégies innovantes, qu'elles aient abouti ou non, soient rendues publiques. Il est important que les décideurs aient accès à cette information alors que leurs efforts pour atteindre les OMD s'intensifient. Ce volume débute par un article de contexte qui donne un aperçu du coût des soins obstétricaux et de leurs conséquences sociales et économiques pour les ménages (Borghi*et al.* 2008). Les chapitres suivants présentent une variété d'expériences récentes visant à réduire les obstacles financiers. Notre choix d'études de cas a pour but de présenter un éventail d'approches et de contextes allant de l'exemption de paiement à l'assistance en espèces, du district au pays, de l'Afrique à l'Asie et l'Amérique Latine et du ciblage à la couverture universelle. Les leçons tirées sont importantes, mais uniquement lorsqu'elles sont replacées dans un contexte plus global. Il est maintenant largement reconnu que « des systèmes de santé fonctionnels et réactifs sont une condition préalable essentielle pour s'attaquer largement et durablement à la santé maternelle et infantile » (UN Millennium Project 2005). Cela implique de s'attaquer à l'environnement politique, social et économique dans lequel ces systèmes sont intégrés. Ces derniers sont nationaux et internationaux par nature. Si l'on se penche sur les histoires du Sri Lanka et de la Malaisie qui ont abouti à la réduction de la mortalité maternelle et infantile, on observe que le financement n'est qu'un des piliers de toutes les stratégies interdépendantes auxquelles il faut s'atteler pour réduire la mortalité maternelle (Pathmanathan*et al.* 2003). Il n'en est pas moins un composant essentiel pour avoir un « système de santé fonctionnel et réactif », et des femmes et des communautés en bonne santé.

7- **Desclaux, A., Msellati, P., & Sow, K. (2011). Genre et accès universel à la prise en charge. Dans *Les femmes à l'épreuve de VIH dans les pays du Sud*. Paris: ANRS Collection Sciences Sociales et Sida.**

Plus de 80% des femmes et de 90% des enfants atteints par le VIH au plan mondial vivent en Afrique. La vulnérabilité des femmes face au VIH y est manifeste ; elles y sont davantage contaminées que les hommes du fait de la conjugaison de facteurs biologiques et sociaux que Msellati et coll. passent en revue en préambule de cet ouvrage. Par ailleurs, la dernière décennie a permis des progrès majeurs grâce à la mobilisation internationale en faveur de

l'accès universel à la prise en charge ; ainsi, fin 2010, plus du tiers des personnes nécessitant un traitement antirétroviral y ont accès dans les pays à ressources limitées. L'ouvrage traite des différences entre hommes et femmes et des questions spécifiques concernant les femmes au travers de cinq thèmes, abordés par des études en santé publique et sciences sociales réalisées principalement dans les pays francophones d'Afrique de l'Ouest et du Centre.

8- **Edgerley, L., El-Sayed, Y., Druzin, M., Kiernan, M., & Daniels, K. (2007). Use of a Community Mobile Health Van to Increase Early Access to Prenatal Care. *Maternal and Child Health Journal, 11* (3), 235-239.**

Objective:
To examine whether the use of a community mobile health van (the Lucile Packard Childrens Hospital Women's Health Van) in an underserved population allows for earlier access to prenatal care and increased rate of adequate prenatal care, as compared to prenatal care initiated in community clinics.
Methods:
We studied 108 patients who initiated prenatal care on the van and delivered their babies at our University Hospital from September 1999 to July 2004. One hundred and twenty-seven patients who initiated prenatal care in sites other than the Women's Health Van, had the same city of residence and source of payment as the study group, and also delivered their babies at our hospital during the same time period, were selected as the comparison group. Gestational age at which prenatal care was initiated and the adequacy of prenatal care - as defined by Revised Graduated Index of Prenatal Care Utilization (RGINDEX) - were compared between cases and comparisons.
Results:
Underserved women utilizing the van services for prenatal care initiated care three weeks earlier than women using other services (10.2 +/- 6.9 weeks vs. 13.2 +/- 6.9 weeks, P = 0.001). In addition, the data showed that van patients and non-van patients were equally likely to receive adequate prenatal care as defined by R-GINDEX (P = 0.125).
Conclusion:
Women who initiated prenatal care on the Women's Health Van achieved earlier access to prenatal care when compared to women initiating care at other community health clinics.

9- **Ensor, T., & Ronoh, J. (2005). Effective financing of maternal health services: a review of the literature. Health Policy, 75, 49-58.**

Health care can be funded in a number of ways ranging from direct user charges (out of pocket) payments to indirect methods that pool across time (prepayment) and across different risk and wealth groups (insurance and general taxation). All these methods can be used to finance maternal health services. When assessing the impact of financing mechanisms it is important to be aware of the different ways they effect service delivery patterns and utilisation. Specifically most systems have both equity and efficiency aspects that combine to impact on health service utilisation and health status.
In general indirect methods that help families to pool the costs of maternal health services are preferable to direct methods of payment. It is also clear, however, that user charges may sometimes help to mitigate deficiencies in systems of pooled funding. Available literature suggests that financing mechanisms for maternal health services could be improved by systems that increase transparency, help to mitigate demand-side costs of services and provide funding for that promote transparent charging for services. While the limited experience of demand-side mechanisms for improving access to maternal health services more evaluation is required.

10- Grilli, R., Ramsay, C., & Minozzi, S. (2009). Mass media interventions: effects on health services utilization. *The Cochrane Library, Issue 1.*

Background

The mass media frequently cover health related topics, are the leading source of information about important health issues, and are targeted by those who aim to influence the behaviour of health professionals and patients.

Objectives

To assess the effects of mass media on the utilization of health services.

Search methods

We searched theCochrane Effective Practice andOrganisationofCareGroupspecialised register (1996 to 1999),MEDLINE, EMBASE, Eric, PsycLit (to 1999), and reference lists of articles. We hand searched the journals Communication Research (February 1987 to August 1996), European Journal of Communication (1986 to 1994), Journal of Communication (winter 1986 to summer 1996), Communication Theory (February 1991 to August 1996), Critical Studies in Mass Communication (March 1984 to March 1995) and Journalism Quarterly (1986 to summer 1996).

Main results

Twenty studies were included. All used interrupted time series designs. Fifteen evaluated the impact of formal mass media campaigns, and five of media coverage of health-related issues. The overall methodological quality was variable. Six studies did not perform any statistical analysis, and nine used inappropriate statistical tests (ie not taking into account the effect of time trend). All of the studies apart from one concluded that mass media was effective. These positive findings were confirmed by our re-analysis in seven studies.

The direction of effect was consistent across studies towards the expected change.

Authors' conclusions

Despite the limited information about key aspects of mass media interventions and the poor quality of the available primary research there is evidence that these channels of communication may have an important role in influencing the use of health care interventions. Although the findings of this review may be affected by publication bias, those engaged in promoting better uptake of research information in clinical practice should consider mass media as one of the tools that may encourage the use of effective services and discourage those of unproven effectiveness.

11- Jaffré, Y., & Olivier de Sardan, J. (2003). *Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'Ouest*. Paris: Karthala.

Cet ouvrage dresse un constat systématique et appuyé sur des observations solides. Il fournit aux étudiants une image exacte de la situation dont l'analyse est malheureusement aplatie par un interactionnisme limité. C'est un très bon documentaire, néanmoins dépourvu de clés pour en sortir. La réforme invoquée demeure largement un vœu pieux. Les conclusions normatives formulées sont faciles à partager mais ne constituent probablement pas une formulation anthropologique originale pour penser le sens et les causes des situations observées dans lesquelles des figurants noirs s'agitent dans la santé des Blancs.

12- Lagarde, M., & Palmer, N. (2006). *Evidence from systematic reviews to inform decision making regarding financing mechanisms that improve access to health services for poor people*. Geneva: The Alliance for Health Policy and Systems Research.

This policy brief reports the findings of a series of systematic reviews that assessed the impact of five health financing policy options on access to health services, particular for poor populations. It was produced to illustrate and bring to life the challenges and opportunities in using research evidence to inform policy-making. The policy brief does not aim to provide a comprehensive overview of all of the research evidence relevant to policy-making in the area. In focusing on global research evidence about effects (both benefits and harms) and hence on

studies that use research designs that are best suited to examining effects (i.e., randomized controlled trials, controlled before/after studies, and interrupted time series), it excludes other types of research evidence. This policy brief presents findings from a series of systematic reviews conducted by the authors and funded by the Bill and Melinda Gates Foundation. The review offers an assessment of the different methods for increasing the uptake of health services by poorer groups in low and middle income countries. The brief covers four mechanisms which are of topical interest in the debate on extending access to health services to poor people, namely, user fees, community based insurance, social health insurance, and contracting out to non-state providers. It further evaluates an innovative demand-side financing strategy which has received a great deal of attention: conditional cash transfers. Conditional cash transfers are not a financing mechanism per se, but they are a way of using financial incentives to increase the uptake of services by poor people and hence increase access. Each of these mechanisms is highly topical within current debates about how best to increase access to health services for poorer groups, or reduce the potentially devastating consequences of out-of-pocket payments required when people fall ill. The brief focuses on the demand-side perspective only and does not address provider perspectives in any detail.

13- **Lassi ZS, Haider BA, Bhutta ZA. Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes**.

Background:

While maternal, infant and under-five child mortality rates in developing countries have declined significantly in the past two to three decades, newborn mortality rates have reduced much more slowly. While it is recognised that almost half of the newborn deaths can be prevented by scaling up evidence-based available interventions such as tetanus toxoid immunisation to mothers; clean and skilled care at delivery; newborn resuscitation; exclusive breastfeeding; clean umbilical cord care; management of infections in newborns, many require facility based and outreach services. It has also been stated that a significant proportion of these mortalities and morbidities could also be potentially addressed by developing community-based packages interventions which should also be supplemented by developing and strengthening linkages with the local health systems. Some of the recent community-based studies of interventions targeting women of reproductive age have shown variable impacts on maternal outcomes and hence it is uncertain if these strategies have consistent benefit across the continuum of maternal and newborn care.

Objectives:

To assess the effectiveness of community-based intervention packages in reducing maternal and neonatal morbidity and mortality; and improving neonatal outcomes.

Search Strategy:

We searched The Cochrane Pregnancy and Childbirth Group's Trials Register (January 2010), World Bank's JOLIS (12 January 2010), BLDS at IDS and IDEAS database of unpublished working papers (12 January 2010), Google and Google Scholar (12 January 2010).

Main Results:

The review included 18 cluster-randomised/quasi-randomised trials, covering a wide range of interventional packages, including two subsets from one trial. We incorporated data from these trials using generic inverse variance method in which logarithms of risk ratio estimates were used along with the standard error of the logarithms of risk ratio estimates. Our review did not show any reduction in maternal mortality (risk ratio (RR) 0.77; 95% confidence interval (CI) 0.59 to 1.02, random-effects (10 studies, n = 144,956), I^2 39%, P value 0.10. However, significant reduction was observed in maternal morbidity (RR 0.75; 95% CI 0.61 to 0.92, random-effects (four studies, n = 138,290), I^2 28%; neonatal mortality (RR 0.76; 95% CI 0.68 to 0.84, random-effects (12 studies, n = 136,425), I^2 69%, P value < 0.001), stillbirths (RR 0.84; 95% CI 0.74 to 0.97, random-effects (11studies, n = 113,821), I^2 66%, P value 0.001) and perinatal mortality (RR 0.80; 95% CI 0.71 to 0.91, random-effects (10 studies, n =

110,291), I² 82%, P value < 0.001) as a consequence of implementation of community-based interventional care packages. It also increased the referrals to health facility for pregnancy related complication by 40% (RR 1.40; 95% CI 1.19 to 1.65, fixed-effect (two studies, n = 22,800), I² 0%, P value 0.76), and improved the rates of early breastfeeding by 94% (RR 1.94; 95% CI 1.56 to 2.42, random-effects (six studies, n = 20,627), I² 97%, P value < 0.001). We assessed our primary outcomes for publication bias, but observed no such asymmetry on the funnel plot.

Authors' Conclusions:

Our review offers encouraging evidence of the value of integrating maternal and newborn care in community settings through a range of interventions which can be packaged effectively for delivery through a range of community health workers and health promotion groups. While the importance of skilled delivery and facility-based services for maternal and newborn care cannot be denied, there is sufficient evidence to scale up community-based care through packages which can be delivered by a range of community-based workers.

14- La Qualité des Soins Prénatals selon la Perspective des Clientes au Cameroun. (Districts de santé de Nkongsamba, Bafang et Mfou)

Etant donné que la qualité des soins détermine la demande de soins maternels et directement le risque qu'une mère décède pendant l'accouchement ou quelques jours après, en cas de complications, nous nous sommes fixé comme objectif dans cette étude d'évaluer son niveau dans le cas camerounais, en nous orientant vers la perspective des clientes. Les données utilisées ici sont celles d'une enquête que nous avons menée, en août 2005 dans le district de santé de Nkongsamba (Province du Littoral) et en janvier février 2006 dans les districts de santé de Bafang (Province de l'Ouest) et Mfou (Province du Centre), auprès des femmes ayant fréquenté les services des soins prénatals au cours des six derniers mois.

Il ressort des analyses effectuées que, même si dans les milieux étudiés des problèmes importants ont été observés dans les études antérieures aux niveaux structurels et du processus des soins dans les formations sanitaires publiques et privées, les enquêtées ayant utilisé les services des soins prénatals au cours de la période de référence ci-dessus mentionnée ont été pour la plupart satisfaites de l'état des ressources physiques et des matériels, de l'organisation des services, du traitement qu'elles ont reçues pendant les consultations prénatales, etc. Toutefois, le taux de satisfaction s'est avéré, dans la plupart des cas des éléments de la qualité considérés, davantage faible chez celles ayant utilisé les formations sanitaires publiques à l'exception du cas du système de recommandation des clientes. La première conclusion qui ressort des résultats de cette étude est que les clientes tolèrent recevoir les soins prénatals de qualité moindre dans les milieux étudiés. La seconde est que le niveau de la qualité des soins prénatals varie selon le type de formations sanitaires et le district de santé. L'on devrait tenir compte de l'ensemble de ces éléments dans les politiques d'amélioration de la qualité des soins prénatals dans les milieux étudiés.