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FAMILY HEALTH AND POPULATION:

USAID/DAKAR

by

William D. Bair

March 4 to April 4, 1985

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GLOSSARY

ANSFS	Association nationale des Sages-femmes sénégalaises (National Association of Senegalese Midwives)
ASBEF	Association sénégalaise pour le Bien-être familial (IPPF Affiliate, Senegalese Association for Family Welfare)
BNR	Bureau National de Recensement (National Census Bureau)
CEDPA	Centre for Development and Population Activities
CESSI	Centre d'Etudes supérieures en Soins Infirmiers (Graduate School of Nursing)
CONAPOP	National Population Commission
DRPF	Division de la Recherche, Planification et Formation (Research, Planning and Training Division of the MOH)
ENIIE	Ecole nationale des Infirmiers et Infirmières d'Etat (National School of Nurses)
ENSFE	Ecole nationale des Sages-femmes d'Etat (National School of Midwives)
FAFS	Federation des Association féminines du Sénégal (Senegalese Federation of Women's Organizations)
FMAP	Femmes mariées en age de procréer (Women of reproductive age)
GOS	Government of Senegal
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
LOP	Life of Project
MCH	Maternal and Child Health
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MOP	Ministry of Plan
MSD	Ministry of Social Development
MST	Maladies Sexuellement Transmissibles (Sexually Transmitted Diseases)

MWRA	Married Women of Reproductive Age
NFP	Natural Family Planning
NGO	Non-governmental Organization
OR	Operations Research
ORT	Oral Rehydration Therapy
PID	Project Identification Document
PMI	Protection Maternelle et Infantile (Maternal and Child Care)
PP	Project Paper
PST	Project Santé Familiale (Family Health Project)
STD	Sexually Transmitted Diseases
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization
Family Health	Used in this project to refer to an integrated program including family planning, treatment of STD and treatment of infertility

ACKNOWLEDGEMENTS

The consultant wishes to express his appreciation for the leadership provided by the USAID Population Officer, Sara Seims, and the Chief of the Health and Population Office, Dr. Michael White. Their technical competence, their understanding of Senegalese conditions and approaches and their good working relations with the Senegalese leadership facilitated our work considerably.

The support from the secretarial staff and the administrative coordinator, Mrs. Julie Staglione, was outstanding.

It was a pleasure to work with all members of the consultant team, who produced a considerable quantity of excellent work in the period. This consultant worked especially closely with Laura Evison in developing the training plan and the plans for the non-governmental sector. Laura's enthusiasm, training, and broad experience, as well as her excellent capabilities in working with Senegales, helped her to make an outstanding contribution.

Not the least was the contribution and cooperation of the Senegalese leadership with whom we worked. We had occasional differences of opinion which were expressed clearly and frankly on either side. However, a cordial, professional working relationship was maintained which bodes well for further collaborative project development and implementation.

EXECUTIVE SUMMARY

The consultant was requested by USAID/Dakar to participate with other consultants to assist USAID and the government of Senegal (GOS) in developing a project paper for a $27 million, seven-year Family Health and Population Project.

The original scope of work, which focused on training and activities for the private sector, was modified when new Senegalese leadership requested changes in approach. Changes were required in the basic Project document to clarify the integrated nature of service delivery, to place more emphasis on sexually transmitted disease (STD) and infertility, and to address more comprehensively issues of health status in Project evaluation, and to reduce emphasis on demographic impact. The consultant was requested to participate in presenting alternative language to resolve these issues. However, one other important issue, that of support to the private sector, remained questionable to some Senegalese.

The appendices contain reports prepared for USAID in response to a modified scope of work.

The private sector report defers the selection of specific subprojects for the present, providing instead that the technical assistance contractor make the selection. The report establishes procedures for subproject development and approval. A training plan was developed for the several categories of health workers. The plan provides that most of the training will be carried out in Senegal with emphasis on institutional development.

A detailed description of a field training program to improve integration and the health team approach is provided in a separate document. Recommendations for improving service delivery stress that a major challenge will be to provide sensitive assistance to the GOS in assessing its present service delivery model. The question is whether it currently has the potential to reach enough clients to have a public health impact. Project actions would include improvement of management practices and initiation of operations research. Training and the non-governmental sector are also designed to improve service delivery.

The evaluation plan addresses the GOS concern for reviewing health impact but recognizes the difficulty of measuring changes in health status, especially when the level of output is not expected to have an initial widespread effect on public health. Therefore, although some attention will be given to impact analysis, evaluation will focus primarily on process and performance.

I. INTRODUCTION AND BACKGROUND

I.1 The Family Health and Population Project

The consultant was requested to assist USAID/Dakar and the government of Senegal (GOS) in preparing a project paper (PP) for the Family Health and Population Project. This seven-year, $27 million Project is described in detail in the mission Project Implementation Document (PID), pages 7 and 8 of which are attached to this report as Appendix C. The Project will provide assistance to (i) the national governmental family health program (an integrated approach to family planning, sexually transmitted disease [STD] and infertility), (ii) a national government effort of improved demographic data collection and policy development, and (iii) non-governmental organizations in the provision of family planning information and service[1/].

I.2 The Design Team

The other consultants and members of the USAID Project Design Committee are listed in Appendix D. They worked under the overall direction of the USAID population officer, Dr. Sara Seims. Dr. Maria Waiver assisted in the design of the integrated family health service delivery. Laura Evison assisted in the design of training and the non-governmental sector activities. Jay Friedman and Toni Boni assessed the contraceptive requirements and designed the logistics strategy. Elaine Murphy designed the information, education, and communication (IEC) components. Carol Kramer provided the economic and financial analyses. Selma Sawaya, Wanda Kelly, and Susan Inea designed the support for the census. Julie Staglioni handled the administrative coordination of the effort.

I.3 The Scope of Work and Accomplishments - William Bair

Due to a change in the Ministry of Health (MOH), the consultant's first task was to assist in revising the French document being used as the basic understanding of the Project (Appendix E). USAID had worked closely with most of the members of the GOS design team in the preparation of the PID, or original version of Appendix E. After a change in the Ministry of Health, however, the Director of Technical Services took some positions which had not previously been voiced. He expressed a greater reluctance to support the private sector than had earlier been evident. He also requested that greater emphasis be given both to the integration of family health initiatives into other clinic services and to the importance of treatment of STD and infertility as part of these services. In addition, he raised the issue of which elements should be emphasized in evaluation of the Project, urging that maternal and child health achievements be documented. The team convinced him that, while desirable, definitive conclusions

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1/ While not identical to the description in the PID, this listing reflects the USAID mission's view of the major project components.

on the health impact could not be reached so early in the Project life. As a result of discussion on these various points, changes, in large part semantic, were made in the language of the French document. The non-governmental (private) sector portion, however, is still under consideration by the Director of Technical Services.

As a result of the shifts of emphasis described above, the consultant's scope of work changed (see Appendix A). The original focus had been on the private sector and community-based distribution (items B,C and D in Appendix A). Because the GOS was still in the process of studying these matters, the consultant, (with the assistance of Laura Evison), prepared a much more general document than had originally been contemplated (Appendix H). Together with a scope of work for the Technical Assistance Contract (Appendix G), which was a more detailed document than had been anticipated (item E of Appendix A), the section on Non-Government Sector Activities was considered by the mission to satisfy the requirements for items B,C and D.

As originally planned, a training plan (item A of Appendix A) was prepared (with the assistance of Laura Evison)(Appendix F). Additionally, the consultant suggested that field training be provided to clinic staff to ensure that the integrated approach to service delivery give adequate attention to all aspects of health care, including family planning. At the request of the mission, the consultant provided his recommendations in a separate appendix (Appendix I), to permit early consideration by the GOS.

USAID also requested Bair to write the evaluation plan (Appendix J) and to recommend conditions and covenants for the grant agreement (Appendix K).

II. OBSERVATIONS AND FINDINGS

II.1 Non-governmental Sector

Some elements of the GOS are uncomfortable with direct support of the private sector. They are uneasy with external support to private physicians or private midwives and suspicious of the lack of control in dispensing contraceptives that they fear would result from community-based distribution and commercial retail sales of contraceptives. In a larger context, they support family planning only as a health measure, and therefore, are not concerned with issues of expanding coverage to achieve demographic impact. There are also some temporary problems of competition and misunderstanding among several of the major non-governmental organizations likely to be active in family planning in the future.

Nevertheless, there is considerable strength and interest in family planning in the private sector. There are also GOS elements, especially in the Ministry of Social Development (MSD), who are quite supportive of work with non-governmental organizations. USAID's determination to continue this emphasis is well placed.

II.2 Training

There is a wide variety of training required: modern methods in reproductive health, family planning (FP), STD, infertility, integrated health team approach, pedagogy, management, logistics, IEC, statistics, and data gathering for policy development. Most categories of personnel require this training -- physicians, nurse-midwives, nurses, allied health personnel, faculty members from schools for nursing and nurse-midwives, health center teams, pharmacists, IEC specialists and community leaders.

There is no one institution strong enough to manage all this training, although several have the capability for parts of the task. As much of this training as possible should be done in Senegal, and Senegalese training institutions should be strengthened in the process. Nevertheless, enough of the training will have to be done outside the country to give Senegalese leadership the opportunity to meet with leadership of other countries and to consider different approaches to the issue of population and other methods of delivering family planning services.

II.3 Service Delivery

The GOS is strongly committed to a clinic-based approach to family planning, with a considerable emphasis on laboratory tests and physical examinations by midwives and/or physicians before contraceptives are made available. Its emphasis is on the need for broad educational approaches and the inclusion of treatment for STD and infertility along with family planning in family health care. Family health, in turn, is viewed as a service which should be integrated with other health services at the health center. This service delivery model places extensive management and training requirements on the program and has serious implications for the numbers of clients likely to be reached.

III. RECOMMENDATIONS

III.1 General

The recommendations can be found in the several papers and summaries written for USAID attached as Appendices F through K. In brief, the recommendations are as follows:

III.2 Non-governmental Sector

The report recommended that about $2 million be set aside with which the technical assistance contractor would finance subprojects in the private sector which would be developed later. Procedures were recommended for a review committee with government and private sector participation and financial management to be handled by a local public accounting firm (Appendix H).

III.3 Training

The training plan (Appendix F) recommends a series of in-country and overseas training activities for each of the categories of health and social and economic development workers involved. Emphasis is to be given to institutional development at the University of Dakar medical faculty and the National School of Midwives to prepare them for increased participation both in pre-service and in-service training in family health. However, recognizing the need to give Senegalese maximum opportunity to be acquainted with approaches outside their own conservative environment, the plan also provides for training in the United States and other developing countries. The recommendations call attention to the need to respect Senegal's approach to service delivery while providing sufficient information to permit Senegalese to assess the limited coverage potential of this model and to review approaches used by other programs around the world. The training plan for health center personnel (Appendix I) recommends that a field training team provide three to four days training at each health center, to focus primarily on helping the center's personnel work as a team to integrate family health into their health center's program.

III.4 Service Delivery

The scope of work of the technical assistance contract (Appendix G) identifies actions needed for improving the management of the present centers and those to be added to the program. Improved planning, training, supervision, and analysis of service statistics and surveys are among the necessary actions for making the present system more functional. The scope of work was expanded and additional technical assistance recommended to handle these tasks, along with the additional responsibilities for expanding service delivery through subprojects in the non-governmental sector. One of the recommended covenants in the grant agreement (Appendix K) calls attention to the need of the government continually to assess its service delivery approaches (see section c of Appendix K). Additionally, suggestions are made for a series of small operations research (OR) activities which could improve the efficiency of present approaches and experiment with more outreach oriented delivery.

III.5 Evaluation

The evaluation plan (Appendix J) recommends ongoing evaluation as a part of each of the sub-activities as well as three periodic evaluations during the life of the project. To accomodate the interest in including health status indicators in impact measurement, the plan recommends that measures of reproductive health be included as part of initial and fifth year contraceptive prevalence surveys. This limited approach was the best that appeared feasible, given the early stage of the project and the long time necessary for a widespread public health impact to be felt. Similarly, because it is evident that the project will only begin the process of birth rate reduction, relatively more emphasis is placed on process evaluation and evaluation of performance in providing the various project inputs than on demographic impact.

BIBLIOGRAPHY

Alpha Dieng, Les Institutions privées et semi-privées concourant au developpment sanitaire du Senegal, March 1985.

Laura Evison, Technical Assistance and Training in Family Planning for Senegalese Midwives, September, 1984.

Elaine Murphy, Report on the Evaluation of the Senegal Family Health Project, July, 1984.

Family Health International, Contraceptive Dispensation Activities in the Private Sector of Senegal, February, 1985.

Ministère de la Santé publique - Direction de la Recherche de la Planification et de la Formation, Programmation sanitaire du Senegal, 1982.

USAID/Senegal, Project Identification Document - Family Health and Population Project, December, 1984.

APPENDIX A

SCOPE OF WORK

APPENDIX A

SCOPE OF WORK

NCLASSIFIED
ID 2/11/85
PNO:MWHITE
NPNO:SSEIMS:PB
ONE
ID AMB DCM, CHRON

MEMBASSY DAKAR
ECSTATE WASHDC
NFO AMEMBASSY ABIDJAN

IDAC
ECSTATE FOR ST/POP/FPSD, AFR/TR/POP
BIDJAN FOR REDSO

.O. 12356:N/A
UBJECT: POPULATION: ISTI CONSULTANT BILL BAIR FOR
ENEGAL FAMILY HEALTH PROJECT PAPER

. PLEASE CONTACT MR. BILL BAIR AND PROVIDE HIM WITH
HE FOLLOWING DESCRIPTION OF HIS UPCOMING CONSULTANCY
OR SUBJECT PP.

WORK WITH GOS, CONSULTANTS AND USAID PERSONNEL TO:

) PROVIDE GUIDANCE FOR FAMILY PLANNING TRAINING
ROGRAMS FOR PHYSICIANS, MIDWIVES, NURSES AND PARA-
EDICAL PERSONNEL AND ESTABLISH AN AGENDA FOR THIS
RAINING FOR THE NATIONAL FAMILY PLANNING PROJECT.

) DEVELOP A WORK PLAN OF FOLLOW-ON FAMILY PLANNING
CTIVITIES TO BE UNDERTAKEN BY PRIVATE SECTOR MIDWIVES
RAINED AT THE MODEL CLINIC OF SENEGALESE MIDWIVES
SSOCIATION/CEDPA-SENEGAL.

) EXAMINE OTHER PRIVATE SECTOR POSSIBILITIES FOR
AMILY PLANNING AND DEVELOP A TENTATIVE IMPLEMENTATION
LAN FOR THE THIRD AND SUBSEQUENT YEARS OF THE PROJECT.

) DEVELOP A PRELIMINARY PROPOSAL FOR COMMUNITY BASED
ISTRIBUTION OF CONTRACEPTIVES WITH BOTH THE NATIONAL
ID MIDWIVES/CEDPA PROJECT, WHICH WILL BE REVISED BY
HE GOS.

) IDENTIFY IN DETAIL, HOW THE FAMILY PLANNING
ECHNICAL ASSISTANCE CONTRACTORS CAN TAKE CHARGE OF

UNCLASSIFIED

PROCESSING TRAVEL REQUESTS, EXPENSE REPORTS, TRAVEL ADVANCES, TRAINING, COMMODITIES PROCUREMENTS, AND GASOLINE, IN SUCH A MANNER THAT USAID'S ROLE IS MINIMIZED AND THAT RESPONSIBLE MANAGEMENT AND FINANCIAL PROCEDURES ARE FOLLOWED.

2. DRAFT REPORTS OF 5-10 PAGES SHOULD BE PREPARED ONE AT A TIME FOR EACH OF THE ABOVE 5 AREAS TO BE COMPLETED BY THE THIRD WEEK OF THE CONSULTANCY. THE REPORTS WILL BE THEN TRANSLATED INTO FRENCH, DISCUSSED WITH THE GOS AND MODIFIED ACCORDINGLY BEFORE THE END OF THE LAST WEEK OF THE IN-COUNTRY CONSULTANCY.

3. PLEASE CABLE MR. BAIR'S ETA.
BRAY##

APPENDIX B

PERSONS CONTACTED

APPENDIX B

Persons contacted

Ms Sara Jane Littlefield	Director USAID
Mrs Carole Tyson	Deputy Director
Mr. James Ito	Controller
Mr. Steve Wallace	Administrative Officer
Dr. Mike White	Chief, HPNO Office
Mrs Sara Seims	Population Officer
Dr. Corréa	Chief OB/Gyn - Le Dantec Hospital- Medical Faculty
Dr. Nakolima	Chief MCH/MOH Medecin-chef PMI Medina
Mr. Ismaïla Ndiaye	Ministry Social Development
Mr. Alioune Fall	Health Education MOH
Mr. Massar Gaye	Training Division MOH
Colonel Sy	Deputy Chief Technical Division MOH
Mrs Maty Cissé	Division of Training MOH
Mrs Emily Gomis	Director Ecole des Sages-Femmes
Ms Lary Cissé	President Assoc. mid-wives
Mrs. F. Tandiang	CEDPA - Min. Social Dev.
Mr. Alpha Dieng	Author of report - Private Sector Health Organization 1984
Mr. Kanté	Executive Officer - Red Cross
Mr. Ousmane Samb	Director Project Santé Familiale
Mr. Masseck Seck	Controller, Project Santé Familiale
Dr. Guy	Research Triangle Consultant to Santé Familiale
Mr. Amadou Seck	Ministère des Finances
Dr. Ngom	Le Dantec - Medical Faculty
Mme Aminata Niang	Santé Familiale coordinator - PMI Médina
Dr. Sarr	Abasse Ndao Hospital
Dr. Lauroy	Abasse Ndao Hospital
Nurse midwife	Abasse Ndao Hospital
Midwife at PMI	Pikine
" "	Bel-Air
Pharmacist	Pikine
Physician and midwife	SOTRAC clinic
Physician, Nurses & Director	Institute of Social Hygiene
Mme Mame Boyo M'Baye	Midwife at private clinic - Jamm

APPENDIX C

EXCERPT FROM PID FOR FAMILY HEALTH AND POPULATION PROJECT

12

EXCERPT FROM PID FOR FAMILY HEALTH AND POPULATION PROJECT

I. PROJECT DESCRIPTION

A. Perceived Problem

At the present time, Senegalese families suffer from distressingly high infant and maternal mortality and morbidity rates. For example, about 15 percent of infants die before the age of one (Infant Mortality Rate - IMR 140). By the age of 5, only about two-thirds of those born will still survive. It is widely recognized that if women could have more effective means at their disposal to better space their births and if related family health services were made available, there would be fewer low birth weight babies born, fewer babies would die and mothers would be stronger and healthier.

By providing couples with access to safe, effective and voluntary contraception, this project will not only improve family health, but also will enable parents to better feed, educate and care for their children.

Senegal's population of 6,500,000 is increasing at about 3 percent annually. If current trends continue, the population size will double every 23 years, each time from an ever increasing base. With a Crude Birth Rate (CBR) of 48 and an estimated Total Fertility Rate (TFR) of 7.1, the age structure of the population is such that larger and larger numbers of women enter the reproductive ages every year. The rapid rate of population increase and the concomitant high dependency ratios make it much more difficult for the GOS to provide basic health and social services for the Senegalese people.

B. Project Goal and Purpose

The goal of this 7 year, $27.4 million project is to improve the health of Senegalese women and their children and to help achieve population growth rates compatible with Senegal's capacity to provide basic health and social services for its people.

The purposes of this project are to:

1) Improve the capacity of the public and private sector to provide safe and effective contraception to 15 percent of Married Women of Reproductive Age (MWRA) - approximately 200,000 couples;

2) To provide comprehensive support to Maternal and Child Health (MCH) services, for example the detection and treatment of sexually transmitted diseases and infertility; the provision of integrated family planning and malaria treatment at the community level.

3) Improve the demographic data base so that more effective development planning can take place;

4) Increase the awareness of policy makers, planners and the general community of the impact of rapid population growth on development;

C. Expected Achievements/Accomplishments

By the end of this project, medical, paramedical, auxilliary health personnel and other appropriate organizations and groups in the private and public sector will be trained to deliver family planning services in both an integrated and non-integrated fashion. Family planning services will be available in service sites in all the 10 regions in Senegal, community based distribution (CBD) programs will be ongoing in selected urban and rural areas and commercial retail sales (CRS) of contraceptives will be initiated. It is expected that family planning services will be available in all GOS health centers and about 25 percent of the dispensaries by the end of the project.

Information, Education and Communication (IEC) programs concerning the impact of rapid population growth on development, the importance of childspacing as a health measure and the use and availability of contraception will be developed, tested and modified. This program will be sufficiently effective so as to significantly increase commitment to family planning and awareness of contraceptive practises and availability throughout Senegalese society.

We expect that the 1986 census will be fully processed and analyzed to the extent that up-to-date and accurate data will be available for planning purposes, and that a sufficient number of surveys will have been fielded and analyzed so that good quality and timely information of contraceptive Knowledge, Attitudes and Practices and standards of MCH will be obtained. The project will assist the National Census Bureau (BNR) publish census results in a timely fashion.

APPENDIX D

CONSULTANT TEAM AND USAID PROJECT DESIGN COMMITTEE

Appendix D

CONSULTANT TEAM AND USAID PROJECT DESIGN COMMITTEE

UNITED STATES GOVERNMENT

memorandum

DATE: March, 18th 1985

REPLY TO ATTN OF: HPNO: Sara Seims/Julie Stagliano

SUBJECT: Senegal Family Health Project

TO: See Distribution

There will be an update meeting for the Project Design Committee in the Conference Room at 15:30 hours on Tuesday 26 March 1985. Please plan to attend.

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114
☆ U. S. GPO: 1980—311-153/5526

UNITED STATES GOVERNMENT

memorandum

DATE: March 15, 1985

REPLY TO ATTN OF: HPNO, Sara Seims/Julie Stagliano

SUBJECT: Senegal Health Project Paper update

TO: See distribution

The PID (French version) has been revised by the interministerial team chaired by Dr Nakoulima. This group, composed of Maty Cissé Samb, Ousmane Samb, Ismaïla Ndiaye, Fara Mboge, Mme Bâ, Dr Nakoulima, Alioune Fall, Sara Seims, Bill Bair, Mike White and Julie Stagliano, deliberated lengthily to make the PID acceptable to the GRS.

We are awaiting the accord of Mr Sy of Plan so that the proposed small working groups, which are to define and elaborate the various tasks in each volet, may get to work.

Within the mission our target date for Project Paper approval by the Director is May 15, 1985.

The P.P Consultants here now or who are expected this week are as follows:

Name of Consultant	Origin	Specialty or contribution
Bill Bair	ISTI Consultant 3/3 - ~~31/3~~ 3/4	Organization of Population Programs
Carol Kramer	Local	Economic Analysis
Wanda Kelly) Selma Sawaya) Susan Enea)	Bureau of the Census 10/3 - 25/3	BNR Volet
Laura Evison	Amer. College of Nurse/Midwives 15/3 - ~~17/3~~ 7/4	Medical Training Activities in non-governmental Sector
Elaine Murphy	S&T/Population 29/3 - 17/4	IEC
Jay Friedman	CDC 12/3 - 31/3	Contraceptive Logistics Procurement Plan
Maria Waiver, MD	Columbia University 17/3 - 29/3	Medical Training
Toni Boni	S&T/Population 1/3 - 10/3	Contraceptive Logistics

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114
☆ U. S. GPO: 198?—311-183/5526

The following tasks are the responsibility of in-house staff: some of these tasks can be completed now while others depend on further development of the document:

Program/Sam La Foy	Relationship to CDSS
PDO/Bill Anderson	Relationship among project outputs, purpose & goal, Log Frame
PDO/Anna Bathily	Social Soundness Analysis
Engineering/Barney Mosley	Environmental Exclusion, 611 A Engineering , concerns, construction costs
Controller/M. Horween J. Ito	Cost estimate & financial plan
USAID/Lawyer/E. Dragon	Section 611 certification Waiver problems Conditions precedent

Distribution

DIR : S. J. Littlefield
DDIR : C. Tyson
PDO : W. Anderson
HPNO : M. White
ENG : B. Mosley
PRM : S. La Foy
PRM : McClusky
RCON : J. Ito
RCON : J. Gillis
PDO : A. Bathily
SMO : C. Sembène
ECU : C. Black
RCON : M. Horween
LA : E. Dragon
: L. Evison
: M. Wawer
: C. Kramer
: B. Bair
: J. Friedman

APPENDIX E

FRENCH DOCUMENT CONTAINING BASIC PROJECT PRINCIPLES AND OBJECTIVES

FRENCH DOCUMENT CONTAINING BASIC PROJECT PRINCIPLES AND OBJECTIVES

DESCRIPTION DU PROJET

A. Problème

On enregistre actuellement au Sénégal des taux élevés de morbidité et de mortalité dans les groupes les plus vulnérables de la population c'est-à-dire la mère et l'enfant. En effet, près de 14% des enfants meurent avant d'atteindre leur premier anniversaire tandis que ceux qui survivent jusqu'à l'âge de cinq ans représentent moins des trois quarts. En milieu rural où le phénomène est plus accentué, cette proportion est inférieure à deux tiers. Chez les mères, 20% environ des décès de femmes en âge de procréer ont pour origine la grossesse, l'accouchement et les suites de couche. Par ailleurs, les femmes souffrent d'infécondité temporaire et définitive (de l'ordre de 3%). Le développement des maladies sexuellement transmissibles au sein des populations devient également de plus en plus important.

On reconnaît en général qu'en améliorant les conditions de vie des populations, en allégeant le travail des femmes, en mettant à leur disposition des moyens plus efficaces pour mieux espacer leurs naissances et des services connexes de santé familiale, il y aurait moins de bébés de faible poids à la naissance, moins de décès d'enfants et les femmes s'en porteraient mieux.

En assurant aux couples l'accès à une planification familiale saine, efficace et volontaire, ce projet, non seulement, rendra meilleure la santé familiale mais permettra également aux parents de mieux nourrir, éduquer et soigner leurs enfants.

En outre, le projet devra concourir à une meilleure connaissance de la situation démographique en vue d'une meilleure planification de la santé. En effet, les efforts des pouvoirs publics dans ce domaine sont en partie annihilés par les effets défavorables d'une population de plus en plus nombreuse s'accroissant au taux de 3% par an, conséquence d'une fécondité particulièrement élevée (le taux global de fécondité étant évalué à 7,1 enfants).

But et objectif du projet

L'objectif de ce projet d'une durée de 7 ans est d'améliorer la santé maternelle et infantile et d'aider les pouvoirs publics sénégalais à disposer de données démographiques suffisantes afin de mieux orienter les actions en matière de santé et de protection sociale.

Les objectifs du projet se présentent comme suit:

1) Améliorer la capacité du pays à assurer un programme de planning familial sain et efficace à 15% de toutes les femmes en âge de procréer (FMAP) - environ 200.000 couples;

2) Fournir un soutien complet aux services de protection maternelle et infantile (PMI), par exemple la détection et le traitement des maladies sexuellement transmissibles et de la stérilité, la planification familiale intégrée et le traitement du paludisme au niveau communautaire;

3) Améliorer la base de données démographiques pour permettre une planification plus efficace du développement;

4) Sensibiliser davantage les responsables et les planificateurs sur un équilibre entre le niveau du développement de la croissance démographique.

C. Résultats attendus

Avant la fin du projet, le personnel médical, paramédical et les auxiliaires de santé ainsi que d'autres organismes et groupes appropriés seront formés en vue d'assurer des services de planification familiale. Dans chaque centre de santé il y aura un personnel avec une formation adéquate en planning familial. Cependant, le personnel du centre travaillera en équipe pour fournir un service de soins maternels et infantiles dans lequel le planning familial sera intégré. Des services de planification familiale seront disponibles au niveau des 10 régions du pays. Il est à prévoir que des services de planification familiale seront disponibles dans tous les centres publics de santé et 25% des dispensaires avant la fin du projet, et dans quelques régions où les agents de santé rurale aux soins primaires fourniront les services non médical de planning familial.

Il sera mis au point, testé et modifié, s'il y a lieu des programmes Information, Education et Communication portant sur l'importance de l'espacement des naissances, comme mesure sanitaire, l'importance de tous les aspects de santé familiale comme la nutrition, l'immunisation, la prévention des maladies sexuellement transmissibles et l'infécondité, etc, ainsi que l'utilisation et la disponibilité de produits contraceptifs. Ces programmes seront suffisamment efficaces de façon à accroître sensiblement l'engagement des couples en faveur de la planification familiale et la sensibilisation aux méthodes de l'espacement des naissances ainsi que la disponibilité de ces produits à tous les niveaux appropriés de la société sénégalaise.

Il est à prévoir que le recensement de 1986 sera traité et analysé de manière à disposer de données précises et à jour aux fins de planification et qu'un nombre suffisant d'études auront été initiées et analysées pour obtenir à temps une information de qualité sur les connaissances, les attitudes et les pratiques concernant les contraceptifs et les types de PMI. Le projet aidera le Bureau national de Recensement (BNR) à publier à temps les résultats du recensement.

D. Grandes lignes et fonctionnement du projet

Le présent Document d'identification de projet propose un programme d'activités de 7 ans comportant les cinq volets suivants:

1) planification familiale/santé familiale (y compris la recherche opérationnelle et bio-médicale)
2) formation
3) information, éducation et communication (IEC)
4) amélioration des données de base

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5) Mise au point d'une politique en matière de population.

L'USAID estime qu'un seul accord avec le ministère de l'Economie et des Finances sera nécessaire et ceci comprendra notamment des protocoles d'accord avec le MSP, le MDS, le BNR et des établissements privés.

6) Une recherche opérationnelle sur les services de santé.

1. Prestations de services de planification familiale/de santé familiale

Le projet actuel de santé familiale est une initiative conjointe de deux ministères - le ministère de la Santé publique (MSP) et celui du Développement social (MDS). Le MDS est chargé de toutes les activités de planification familiale. C'est des agents en provenance de ce ministère qui avaient la responsabilité de tous les programmes IEC de l'actuel projet Santé familiale. La division de l'éducation dans le Ministère de la Santé publique aussi participe à l'éducation de la santé familiale. Les services IEC étaient disponibles au niveau de plusieurs structures du MDS qui ont été rénovées et équipées avec des fonds du projet. Les agents du MSP sont chargés des services cliniques. Avant la fin du projet (30 juin 1985) les services de planification familiale/santé familiale seront disponibles au niveau de 22 centres dans six des dix régions du Sénégal. Ce projet a été évalué en août 1984 et une copie du résumé du rapport d'évaluation est jointe en annexe.

L'objectif du nouveau projet est de faciliter davantage l'accès aux services de planning familial sûrs et efficaces en profitant des résultats du programme conjoint MDS/MSP, et il contribuera en outre au développement de plusieurs structures de prestations de services. Il est à prévoir qu'avant la fin du projet, des services de planning familial seront fournis à 15% des femmes en âge de procréer.

Pour les quatre premières années du projet, le programme conjoint du MDS/MSP sera concentré dans les six régions actuelles d'activité. Au cours des trois dernières années, le programme conjoint étendra ses prestations de services à l'ensemble du pays.

Les activités de planification familiale/santé familiale du projet comportent notamment:

(a) Un programme conjoint (MDS/MSP)

1) Consolidation et extension des prestations de services au niveau de 22 centres opérationnels à la fin de l'actuel projet Santé familiale. Il s'agira notamment d'augmenter sensiblement l'efficacité avec laquelle le planning familial est assuré par l'équipe de santé dans la clinique et aussi la disponibilité de ce service à tous ceux qui la fréquente.

2) Extension du nombre de centres du programme conjoint dans les six régions en le portant à dix centres au cours de chacune des sept années du projet;

3) Etendre au cours des trois dernières années du projet les centres du programme conjoint MDS/MSP aux autres régions du Sénégal en complétant et si nécessaire en prenant le relais du FNUAP de sorte que d'ici la fin du projet les prestations de services seront disponibles au moins au niveau de deux centres dans chacune de ces régions.

Pour ce faire, il faudra procéder à certains aménagements et petits travaux de construction de structures du MSP et du MDS. Si l'on juge par l'expérience en ce domaine, il ne s'agira pas de dépenses importantes.

S'agissant des projets du programme conjoint, le diagnostic et le traitement de la stérilité et des maladies sexuellement transmissibles seront assurées ainsi que des services d'appui de PMI (tels que le suivi de la croissance, les conseils en matière de nutrition et le soutien aux activités de vaccination limitée. Les petits projets auxiliaires seront également fournis pour aider le MDS dans ses efforts de vulgarisation destinés à améliorer la condition de la femme (élaboration de matériel d'alphabétisation, fourniture de moulins à mil etc). Ces activités seront coordonnées avec les actions de planification familiale, elles seront soigneusement sélectionnées et seront conçues de manière à ne pas constituer un poids supplèmentaire pour l'équipe du MDS/MSP.

Il convient de souligner que toutes les activités du projet, notamment ceux ayant directement trait aux services cliniques dépendent de la mise à disposition par le MSP et le MDS d'un nombre suffisant de personnel bien formé. Cet aspect a été et continuera à être discuté en profondeur avec le GRS. Vous trouverez plus loin une estimation de la contribution du Sénégal.

(b) Démarrage de divers programmes visant à intensifier la participation du secteur non gouvernemental. Les organisations sous tutelle des ministères du GRS telles que l'Association Nationale de Sages Femmes, l'Association de Médecins, l'Association de Pharmaciens et d'autres seront assistés dans toutes les activités appuyant les objectifs du programme national de santé familiale. L'assistance technique surviendra de plusieurs organisations comme l'Institut International de Science et Technologie (ISTI), le American College of Nurse-Midwives, le centre pour les Etudes de Population et de la famille de l'Université de Columbia ou d'autres; pour la planification, formation et management du projet. Les activités proposées sont les suivantes:

1) programmes d'éducation et d'information concernant le planning et la santé familiale et mis à la disposition de groupes religieux, organisations d'hommes, femmes et jeunes et les syndicats.

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2) faciliter la disponibilité et l'accès de l'information et les services de planning familial en associant médecins privés, sages-femmes, pharmaciens, services de santé industrielle et par la voie d'organismes non-gouvernementaux.

Des dispositions seront prises pour récupérer une partie des coûts financés par le projet en assurant que les frais pour la formation, les contraceptifs et autres matériels informatifs seront une contrepartie des organismes privés. Cette approche permettra aux médecins et sages-femmes opérant dans le secteur privé d'offrir leurs services aux utilisateurs qui ne sont pas en mesure d'en assumer les frais.

Un groupe de techniciens sera établi afin d'examiner les demandes d'appui qui seront soumises par les différents organismes sénégalais voulant obtenir un support financier par le projet. Ce comité assurera que les organismes en faisant la demande soient accrédités par le GRS et que les activités qu'ils proposent soient appropriées à leur but déclaré aussi bien que le mandat du projet.

La gestion financière et le contrôle des comptes seront confiés à une agence comptable locale.

(c) Initiation de plusieurs actions de recherche opérationnelle en vue d'évaluer l'efficacité des programmes de santé familiale intégrés à la santé rurale aux soins primaires en tant que mécanisme de prestations de services. Ces petites actions pilotes seront évaluées rapidement et les approches les plus prometteuses seront adaptées. Les actions initiales de recherche opérationnelle porteront principalement sur la région du Sine Saloum de manière à être intégrées dans les activités du Projet de Santé rurale du Sine Saloum financé par l'USAID et à Pikine - une ville de la banlieue de Dakar où vit 10% de la population nationale.

(d) Exécution d'études en vue d'évaluer le caractère acceptable et pratique de la vente de contraceptifs. Si les études démontrent le caractère approprié de cette activité, des projets de planification familiale seront initiés avec des groupes du secteur privé tels que l'Association des Pharmaciens en vue d'initier des programmes de vente des contraceptifs à des prix subventionnés. C'est ainsi que les produits deviendront accessibles aux zones excentriques et urbaines. Au cours des deux premières années du projet, les responsables du projet MDS/MSP organiseront un stage de formation pour les pharmaciens en respectant la loi sénégalaise concernant les produits pharmaceutiques.

(e) Appui à un certain nombre de projets de recherche biomédicale et psychosociale en matière de contraception, par exemple, l'évaluation de l'efficacité de diverses méthodes telles que les contraceptifs oraux de faible dose, l'efficacité des efforts pilotes de planification familiale naturelle (PFN), l'attitude des patients aux services de planning familial et à leur réaction aux différents contraceptifs, ainsi qu'une évaluation des méthodes utilisées pour le projet pour le traitement des MST et de la stérilité. Ce volet du projet bénéficiera également d'une contribution de l'AID/Washington.

Le projet fournira des produits pour toutes les activités ci-dessus.

2. Formation

La formation se fera en concertation avec les services compétents du ministère de la Santé publique (DRPF). Seule la formation dans le domaine médical, paramédical et en matière de logistique est couverte dans le cadre de cette section. La section IEC portera sur les besoins de formation dans ce domaine particulier.

Le projet se servira du personnel ayant déjà reçu une formation en planification familiale dans le cadre du présent projet et profitera également du centre de formation en planification familiale basé à Dakar et installé à l'hôpital Le Dantec par l'Universitté John Hopkins. Au nombre des activités de formation prévues dans le cadre de ce projet figure ce qui suit:

(a) Formation de 20 sages-femmes, de 20 infirmières et infirmiers et de 20 auxiliaires par an dans le cadre de ceux qui auront une responsabilité spéciale pour le planning familial. La plus grande partie de cette formation se fera au Sénégal avec les formateurs sénégalais. Il est à prévoir qu'il y aura des stages chaque année. Des services de consultant seront assurés par des organismes tels que l'Université de Californie/Santa Cruz et le Centre pour la Population et la Santé familiale de l'Université Columbia. Près du tiers des sages-femmes formées recevront un enseignement aux Etats-Unis. Cette formation comprendra notamment des principes de base de la protection maternelle et infantile tels que les mesures visant à prévenir un faible poids à la naissance. Promouvoir l'allaitement au sein. Aider au diagnostic et au traitement des maladies sexuellement transmissibles et de la stérilité.

(b) Formation de 20 médecins environ dans les domaines de la contraception, la gestion de programme de planification familiale, le diagnostic et le traitement de maladies sexuelles transmissibles et de la stérilité. Selon les prévisions, une partie de cette formation aura lieu à l'hôpital Le Dantec.

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(c) Organisation annuelle d'un stage sur la gestion de la planification familiale, la gestion des produits contraceptifs et la logistique, les systèmes d'enregistrement des malades et de collecte des données. Ce projet appuiera également des services importants de consultants étrangers et nationaux dans ce domaine et financera la formation en gestion de la planification familiale de 50 personnes au Sénégal et à l'étranger.

(d) Formation annuelle du personnel des centres de santé afin de leur permettre d'acquérir une connaissance générale en planning familial et les compétences pratiques que nécessite le travail en équipe et la stratégie des SSP en travaillant comme une équipe intégrée pour l'approvisionnement des soins de santé familiale.

(e) Organisation annuelle d'au moins deux stages de formation sur les prestations de services de planification familiale pour les pharmacies et autres groupes appropriés du secteur non gouvernemental.

(f) Financement de stages annuels de formation portant sur la planification familiale et relatifs à des sujets tels que le rôle de l'allaitement maternel en tant que méthode naturelle de planification familiale.

(g) Formation d'une vingtaine de sages-femmes, d'infirmières et infirmiers et de personnel auxiliaire, par an, travaillant à la fois dans les secteurs public et non gouvernemental en vue d'en faire des formateurs en matière de planification familiale pour leurs collègues.

3. Information, Education et Communication

Ce projet continuera en collaboration avec la division de l'Education pour la Santé à appuyer les actions IEC qui ont lieu actuellement dans le cadre du projet MDS/MSP. A mesure que se développent les prestations de services, il faudra apporter des aménagements aux actions IEC. Ainsi, le projet mettra l'accent sur l'élaboration et l'évaluation de nouvelles approches IEC. Il faut absolument que toutes les actions IEC soient étroitement coordonnées avec les activités de prestations de services de planification familiale étant donné que ces deux actions s'appuient mutuellement.

En d'autres termes, ce projet appuiera les actions IEC suivantes:

Programme MDS/MSP

a) Consolidation et extension de la formation IEC et mise au point de matériel IEC dans les 22 centres opérationnels du programme avant la fin du présent projet de Santé familiale. Il s'agira notamment d'affiches, de diapositives, de films en plus des articles personnels portant l'emblème de la santé familiale (tels que des sacs en plastique, des tee-shirts, des porte-clés, etc).

b) Extension des actions IEC au cours des trois dernières années du projet aux quatre régions du Sénégal où n'opère pas le projet Santé familiale.

c) Appui au Gouvernement du Sénégal dans la mise en place d'un programme d'éducation des jeunes en matière de vie familiale.

d) Conception et exécution des actions IEC par le biais des chaînes nationales et régionales en collaboration avec le Ministère de la Santé Publique, le Ministère du Développement Social et le Ministère de l'Information. Il est à prévoir qu'avant la deuxième année du projet, il y aura régulièrement sur la chaîne régionale des programmes portant sur la planification familiale, notamment des informations sur les lieux offrant ces services. A mi-parcours du projet, au plus tard, des émissions au niveau national auront lieu.

e) Mise en place d'une stratégie visant à initier des actions IEC télévisées. Ces émissions télévisées démarreront à mi-parcours du projet.

f) Mise au point de programme IEC pour les besoins particuliers du secteur non gouvernemental. Il s'agira, par exemple, notamment d'une formation spéciale et de la préparation du matériel pour les pharmaciens et les sages-femmes travaillant dans les cliniques privées.

g) Rénovation et fourniture d'équipement, au besoin, aux centres du MDS participant au projet.

Ces activités nécessiteront la formation de 20 animatrices et autres agents de développement, au moins, par an grâce à divers stages locaux, régionaux et nationaux. En outre, cinq agents, au plus, iront chaque année recevoir à l'étranger une formation en IEC. Des contractants financés par l'AID/Washington assureront l'assistance technique.

Les actions IEC seront adaptées aux différentes régions du Sénégal et comprendront notamment des programmes spéciaux pour hommes, adolescents et responsables communautaires.

Voyages d'études pour voir des programmes réussis de planification familiale dans d'autres pays. Par exemple, ce projet financera la visite des responsables sénégalais dans des pays ayant des programmes actifs de planification familiale, de responsables de planification familiale pour étudier des programmes étrangers réussis et de personnel IEC dans des pays où le IEC s'est avéré particulièrement efficace. Une dizaine de personnes seront envoyées chaque année dans le cadre de ces voyages d'études.

4. Amélioration de la base de données

Dans le cadre de ce volet du projet, il sera entrepris des activités visant à améliorer la base de données démographiques du Sénégal en vue de fournir à temps des chiffres précis pour la planification du développement et pour sensibiliser davantage les pouvoirs publics sur le rapport entre la croissance démographique et le développement. Ce projet aidera le Bureau national de Recensement (BNR) à publier les résultats du recensement trois ans après l'opération.

Pour ces activités, le projet travaillera surtout en collaboration avec le BNR. Ce Bureau est chargé du recensement de 1987 ainsi que de la fourniture au GRS de données relatives à la démographie, à la santé et aux questions annexes. Il est à prévoir que par le biais d'un accord avec le Bureau de Recensement des Etats-Unis, ce projet apportera une assistance pour ce qui suit:

a) Elaboration et pré-test du questionnaire du recensement.

b) Production de cartes actualisées du recensement.

c) Mise en place de programmes informatiques et fourniture de micro-ordinateurs en vue d'aider à la mise au point, au dépouillement, à la présentation et à l'analyse du recensement de 1987.

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d) Formation et assistance technique en vue d'aider à la diffusion des résultats du recensement de 1987 auprès des responsables du GRS chargés de planifier le développement. Il s'agira notamment de stages et de séminaires organisés par le BNR adaptés aux besoins des différents ministères. Ces séminaires mettront l'accent sur l'impact des facteurs démographiques sur la réalisation des objectifs sectoriels.

e) Formation sur place et à l'étranger de planificateurs et de démographes du GRS en vue d'améliorer leurs compétences en matière d'analyse et de statistique. Il est à prévoir que deux personnes à peu près par an recevront une formation de longue durée à l'étranger et il sera organisé au Sénégal au moins, un stage en informatique/statistique.

f) Exécution d'études périodiques couvrant des sujets tels que la planification familiale, la protection maternelle et infantile, et l'évolution démographique. Cette activité viendra compléter l'étude relative au Projet Santé rurale du Sine Saloum financée par l'USAID en 1982. Il sera fait appel à des ressources de l'AID/Washington pour compléter le financement de ces études.

5. Politique en matière de population

Les activités de la présente section seront consacrées à la tâche très importante consistant à mobiliser le soutien des responsables et des planificateurs des secteurs public et privé du Sénégal en faveur de la planification familiale et des activités en matière de population. Il faudra s'assurer dans ce cadre que les actions de collecte de données bénéficiant de l'assistance de l'USAID n'auront pas été vaines en ce sens que ces données seront analysées et présentées aux responsables nationaux.

Le projet assurera précisèment ce qui suit:

- Formation sur place et à l'étranger pour cinq personnes au moins sur la population et le développement dans des établissements spécialisés tels que le cours de trois mois de l'Université de Michigan à l'intention des planificateurs du développement. Il y aura, au moins, un stage sur place destiné à porter les résultats du recensement et de l'étude à la connaissance de la presse, des personnalités, des chefs religieux du Sénégal.

- Assistance technique en vue d'élaborer des modèles économiques/démographiques et de planification familiale grâce à l'informatique. Ces modèles seront présentés aux responsables des secteurs public et privé s'occupant de politique démographique.

- Séminaires sur la politique en matière de population et recherche qui étudieront les sujets destinés à attirer l'attention sur l'impact d'une croissance démographique rapide sur le développement du Sénégal et qui analyseront les rapports entre les facteurs culturels (tels que l'Islam et la condition de la femme) et l'acceptation de la planification familiale. Le projet bilatéral viendra compléter les activités en cours dans ce domaine financées par l'AID/Washington.

Plan d'Evaluation

Une évaluation effectuée à la fin de la deuxième année fera le point de l'efficacité relative aux diverses approches en matière de prestations de services de planification familiale et fournira des conseils sur les problèmes de gestion et ceux liés au programme auxquels il faudra trouver une solution pour la réalisation de l'objectif du projet. Une évaluation finale aura lieu au cours de la sixième année du projet en vue d'identifier les approches qui se sont révèlées les plus utiles et d'élaborer, au besoin, un futur programme d'assistance technique en matière de population.

L'objectif primaire du projet est l'amélioration de la santé maternelle et infantile au moyen d'espacement des naissances et d'autres interventions de la santé familiale. Cependant, il a été prouvé par d'autres projets de planification familiale qu'il est difficile voir impossible d'évaluer des réductions de mortalité et de morbidité infantile et maternelle. La mesure des répercussions différentes de diverses interventions sanitaires comme indiqué est presque impossible. De même que les mesures intermédiaires seront utilisées comme indices subrogés des répercussions du projet. L'emploi de planning familial (fréquences de contraception) sera une mesure intermédiaire. D'autres indices de la santé reproductrice seront utilisés.

Au début du projet une enquête établira le pourcentage de femmes ayant des grossesses à haut risque: un âge au dessous de 16 ans ou au dessus de 35 ans, un intervalle de l'état de grossesse de moins de 24 mois, plus de 4 enfants ou une grossesse trop rapprochée et sans soins préliminaires. Parmi ces femmes à haut risque on va vérifier le pourcentage de celles qui ont déjà une connaissance ou ayant accès aux méthodes de planning familial.

A la cinquième année du projet une enquête similaire sera effectuée pour déterminer le pourcentage des naissances attribué aux femmes à haut risque qui ont déjà une connaissance et qui utilisent des méthodes de planning familial. Comme d'autres décisions concernant certaines interventions, traitements et préventions des MST sont prises, une enquête sera établie.

Contribution du Gouvernement du Sénégal

Selon les prévisions le GRS fournira une vaste gamme de structures et du personnel au volet programme MDS/MSP du présent projet. Aux termes de ce dernier, les services de planification familiale/santé familiale seront disponibles au niveau de la cinquantaine de centres de santé et de près de 25% des postes de santé. Au niveau national, il faut neuf agents à plein temps et un obstétricien-gynécologue à temps partiel. Pour le personnel à plein temps, il s'agira du Directeur, du Directeur adjoint, du chef de l'IEC et de son adjoint, du chef des services cliniques et de son adjoint, de deux spécialistes de la logistique, un comptable, plus un directeur technique.

Pour chaque service, il faudra au moins deux sages-femmes ou une sage-femme et une infirmière. Il faudra que ces agents consacrent 50% environ de leur temps de service aux activités de planification familiale. L'expérience acquise avec le projet actuel MDS/MSP montre que les cliniques fonctionnent mieux avec deux sages-femmes travaillant à temps partiel qu'avec une sage-femme à plein temps. En ce qui concerne le tableau ci-après, on suppose qu'il faudra l'équivalent de 1,5 sages-femmes/infirmières à plein temps pour chaque clinique. Ces sages-femmes auraient une formation adéquate en planning familial (y compris la capacité d'insérer les DIU). Ils prendront le pas pour la surveillance des services de planning familial mais en même temps ils travailleront dans l'équipe du centre de la santé en fournissant les soins de santé maternelle et de la famille d'une façon intégrée. D'autres personnel des centres de santé recevront moins de formation en planning familial et donneront leur appui aux sages-femmes dans le secteur du planning familial aussi bien que des consultations avec tous les patients sur les bénéfices de l'espacement des naissances, la dispensation de contraceptifs (sauf les DIU), l'enregistrement de l'histoire médicale et le maintien des statistiques appropriées, et le maintien des dossiers et statistiques. En outre, pour réaliser de façon convenable le travail long et à forte intensité de main d'oeuvre que constitue le IEC au niveau communautaire, il faudra deux vulgarisatrices au niveau de chaque clinique ainsi que deux assistantes pour aider la sage-femme/infirmière à prendre les nouveaux rendez-vous et à assurer le suivi des autres, à remplir les fiches, à surveiller les stocks. Des gardiens seront nécessaires en fonction de l'importance de la clinique et des aménagements effectués. En supposant qu'un gardien à plein temps soit indispensable pour la moitié des centres, le tableau ci-après présente un résumé de la contribution nécessaire du GRS.

Personnel et structures du GRS nécessaires par année

Programme MDS/MSP	1	2	3	4	5	6	7
Nombre de structures	32	42	52	62	74	86	98
Sages-femmes/infirmières*	48	63	78	93	111	129	147
Vulgarisatrices*	64	84	104	124	148	172	196
Assistantes des sages-femmes*	64	84	104	124	148	172	196
Gardiens*	16	21	26	31	37	43	49
Personnel du Siège*	9.5	9.5	9.5	9.5	9.5	9.5	9.5

*équivalent plein temps
Vulgarisatrices: terme général pour animatrices, monitrices, encadreurs, etc.
Les besoins pour formateurs seront spécifiés dans le document du projet

Le présent projet ne préconise pas le recrutement de nouveaux agents mais plutôt que les sages-femmes, infirmières, vulgarisatrices, assistantes, gardiens, etc travaillant actuellement pour l'Etat consacrent une partie de leur temps au projet. Il y a environ 400 sages-femmes travaillant actuellement pour l'Etat. L'Ecole des sages-femmes forme chaque année une quarantaine de personnes. Au cours de ce projet, le nombre d'élèves des promotions sera ramené à 20. Par conséquent, il sera particulièrement important pour le GRS de veiller à la disponibilité de sages-femmes à long terme. On ne propose pas au GRS de construire de nouvelles structures - les locaux existent déjà. Le projet assurera quelques travaux de construction et d'aménagement.

Pour avoir une idée de la valeur en dollars du concours du pays bénéficiaire, les hypothèses suivantes ont été faites:

Salaires des sages-femmes/infirmières à raison de 2500 dollars par an, augmentation annuelle de 10%	$2,012,000
Salaires des vulgarisatrices à raison de 1500 dollars par an, augmentation annuelle de 10%	1,934,000
Salaires des assistantes des sages femmes à raison de 1500 dollars par an, augmentation annuelle de 10%	1,934,000
Salaires des gardiens à raison de 1500 dollars par an, augmentation annuelle de 10%	483,000
Salaires de tous les agents de l'Etat du siège à raison de 40.000 dollars par an, augmentation annuelle de 10%	455,000
Fourniture de locaux; (notamment dépenses de fonctionnement et quelque matériel) estimations 1.000 dollars annuellement par centre, augmentation annuelle de 10%	639,000
	$ 7,457,000

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Recommandations

La commission recommande que le problème de la motivation des agents sur le terrain soit étudiée entre les ministères du Développement Social, de la Santé Publique et l'USAID.

APPENDIX F

TRAINING PLAN

TRAINING PLAN

SUMMARY OF TRAINING PLAN

Although considerable training has already been provided, there is still much to be done to achieve the objectives of the family health and population project. Emphasis will be placed on developing skills that will be put to use and ensure that Senegalese institutions can be more involved with both pre-service and in-service training.

Given the broad spectrum of training called for in this project, the training program will include a variety of approaches, activities and institutions. The technical assistance contract team will work with the National Project Santé Familiale and the Training Division of the Ministry of Health to coordinate these activities.

Provision is made for both long and short-term training in the United States especially for nursing and medical faculty, statisticians and development planners. Nearly 200 person months of training are planned for these persons in the United States and another 55 person months of observation travel to other countries. Considerably more training will be carried out in Senegal particularly for supervisors and service providers of government and non-government family health. Emphasis is on an integrated approach to providing services in the health system along with a strong program of Information, Education and Communication supported by the Ministry of Social Development, the Ministry of Health and non-governmental organizations. More than a thousand person months of pre-service and in-service training will be provided with Senegalese training institutions being strengthened in the process, becoming largely self-sustaining at the end of the project.

The Senegalese institutions involved will be the national office of the Family Health Project (Santé Familiale), the National School of midwives, the National School of nurses, the University Medical Faculty, the regional ministry of health training teams and the Senegalese Association of midwives. Persons trained will be physicians, nurse-midwives, nurses, supervisors, allied health workers, health center health team, pharmacists, IEC especialists, members of men's, women's or youth clubs, military or police, statisticians, demographers and development planners. Technical assistance will be secured from the American College of Nurse-Mid-wives, Johns Hopkins University, Columbia University and the University of California at Santa Cruz.

The expected cost over 7 years is approximately $3. million

Annexes will provide details of all the training components.

TRAINING

1. INTRODUCTION

Much of the success or failure of this project will depend on the quality of the training program, the vigor with which it is carried out, the care in selecting trainees and the degree to which trainees become actively employed in activities associated with project objectives.

A major challenge will be to organize training which is consistent with the Senegalese service delivery model and procedures. Yet at the same time the training must provide sufficient information so the Senegalese will be able to continue to review that delivery model in the light of public health and coverage objectives and the risks to mothers and chidren of exposure to high risk or undesired pregnancies. The objectives of the project are stated in terms of improving the health and well being of Senegalese families by the provision of family health services. Training must help Senegalese leaders and service providers evolve procedures that facilitate delivery of appropriate service to enough of these families to have a public health impact. Members of the consultant group who have reviewed present procedures in Senegal have serious reservations as to whether the present approach can be successful in achieving this public health impact. The preponderance of world wide experience suggests that this approach has some considerable limitations. The consultants do not question the right and responsibility of Senegalese leadership to develop their own policies and procedures. However, it is hoped that training will provide sufficient information so that leadership will be fully informed as they make these program policy and service delivery priority decisions.

There has been considerable training of Senegalese personnel in the past, much in the United States. However, for several reasons there is still a substantial training gap. In many cases training was essentially consciousness raising, not the training of committed person requiring only the necessary skills in order to begin the work. In other cases, institutional and program development did not procede fast enough in Senegal to take advantage of skills provided which may no longer be up to date. Additionally, there was little success in introducing family planning into the curriculum of pre-service training institutions like the school of nurses and school of midwives. Present graduates are nearly as lacking in family planning training as those of a decade ago. Thus, with a growing program, the training of personnel will continue to be a key requirement. Some of this training will still be consciousness raising, especially to provide exposure to more public health/coverage oriented delivery approaches. However, now that family

planning services are being made available more widely in Senegal, the training can be more skill oriented with those who receive these skills being able to put them into practice. There are some new skills to be taught as more attention is given to sexually transmitted disease (MST) and sub-fertility. Additionally, it now appears possible to place more emphasis on Senegalese training institution development, providing a higher percentage of the training in Senegal and involving the Senegalese training institutions in both pre-service and in-service training.

2. TYPES OF PERSONS TO BE TRAINED AND GENERAL SUBJECT MATTER

A. Physicians:

1) Those who will be directly involved in planning and providing family planning, MST or sub-fertility services (family health) will require specialized training in these skills. Some may require observation training to see how these services are delivered in other countries.

2) Those such as regional and health center medecin-chefs (chief doctors) who will be involved in the organization and management of integrated health services (including family health) - will require general training in these subjects especially in recognizing how they impact on and inter-relate with other health interventions and how to manage an integrated health program providing these among other services.

3) Medical faculty in areas related to family health - will require specialized updating and post graduate training.

4) Private physicians in family practice or specialties related to family health - will require updating and briefing on government programs being developed.

B. Nurses and nurses-midwives:

1) Service providers: those who will be providing family health service in the government and non-governmental clinics will require skill training in family health. Nurse-midwives require the full rqnge of skills including IUD insertion. Nurses should be trained to re-supply pills and provide barrier methods.

2) Supervisors: those in national or regional supervisory positions in family health, primary health, and maternal-child health will require general knowledge of the impact and inter-relation of family health with other health interventions and skills in planning, managing and supervising integrated health services.

3) Faculty members: faculty members, especially from the school of nurse-midwives, but also from the school of nursing and CESSI will require advanced post graduate training in family health skills, management of integrated family health programs and in some cases pedagogic methods.

C. Health center/health team:
As family health services are to be provided in an integrated fashion at the health center, all service providers in the center will require general knowledge of these subjects. They will need training in how to integrate family health into other health activities, working as a health team to provide these services. Among other aspects, attention must be given to supply management and reporting, and information and education activities.

D. Logistics and supply and service statistic personnel:
Those involved in the government and non-governmental sector in the handling and storing of materials and commodities, the maintenance of client records and reporting will require initial training in these tasks and continual on-the-job assistance.

E. I.E.C. specialists:
A core group of specialists working in public and non-governmental sectors (media, SFP, MOH, MSD and Ministy of Education) will require training in developing an IEC strategy, developing family life education curricula, mass media and other IEC materials, interpersonal communication techniques, pre-testing and evaluating materials.

F. Pharmacists:
Majority of the oral contraceptives now being provided in Senegal are supplied through commercial imports and are available by medical perscription in the pharmacies. Approximately 190,000 pill cycles were sold in 1983. Additionally some 350,000 condoms and spermicidal tablets were sold in these channels. There is little point of purchase informational material (except that which comes in the package) and pharmacists apparently are not involved in client education. Training for pharmacists should include ways to better inform the public and ways to make more efficient or less costly the provision of contraceptive service to the public.

G. Other health workers:
At lower levels of the health system workers such as agents sanitaires and traditional birth attendant can be provided simple training in family planning concepts.

H. Policy related personnel:
Government planners and researchers will require training in current techniques for reviewing the inter-relationship of demographics growth and various development objectives.

Popular and program leaders will require exposure to family health delivery procedures in other countries to provide the basis for more informed judgement about the kinds of approaches that could be used in Senegal.

3. TYPES OF TRAINING PROGRAMS

A. For physicians

1) Le Dantec:
The Project Santé Familiale (PSF) will cooperate with Le Dantec and Johns Hopkins to expand the activities of the JHPIEGO regional training center to provide for a ten day course every 18 months for fifteen to twenty physicians and some nurses in modern techniques in reproductive health. The course will provide technical information in family planning, MST and sub-fertility for the physicians directly involved in the provision of these family health services either in the governmental or non-governmental sector. The methods and procedures will be taught in such a way to assist physicians in reviewing the public health impact of particular approaches and to understand the inter-relationship of these family health services with other health interventions. During the course, arrangement would be made for follow-up practical experience for those physicians requiring this additional training. For the first courses Johns Hopkins professors would be expected to take a prominent role. In succeeding courses Le Dantec faculty would be expected to carry the major responsibility with Johns Hopkins assistance. Finances of the course would be provided by a tuition grant for each participant to Le Dantec from the PSF to cover University costs and the travel and per diem of participants. Johns Hopkins costs would be covered by their grant from AID/W.

The JHPIEGO training for laparoscopy will continue at Le Dantec and other regional centers but separate from this project.

2) Seminars on the management and supervision of integrated health, nutrition and population program:
Every two years a seminar would be organized by PSF in cooperation with the MOH/DRPF and MSD for physicians (and midwife regional supervisors and MSD supervisors) who are responsible for organizing and supervising the program of family health at the regional and health center level. This two week seminar for approximately 40 participants will deal with the issues of integrating family health services into ongoing health and social development activities. Management, supervision and evaluation will be stressed along with emphasis on better understanding of the inter-relationship of family health with various health and social development interventions. An institution with experience in these areas such as Columbia University would provide technical assistance to the seminars. Costs of technical assistance, travel and per diem of participants, facilities and educational materials would be handled by the PSF

3) Short-term training at Johns Hopkins:
Three to five physicians will be sent each year to Balitmore or to other John Hopkins regional training sites to participate in short courses in the management of sexually transmitted diseases and infertility. Preference will be given to faculty members of the school of medicine but other physicians in lead roles in family health may also be selected. Costs would be handled by the AID/W JHPIEGO grant or the PSF if necessary by PIO/Ps

B. Nurses and nurse/midwives:

The program of training for nurses and nurse/midwives is described in more detail by Laura Evison (ACNM). Basically it will consist of the following:

1) Faculty training:

a) Six to eight of the twelve faculty members of the school of Sage-femmes will receive post graduate (short-term) training in the United States. This training will be at Santa Cruz, the University of Florida or another institution capable of providing French language advanced training to midwives in the knowledge and skills necessary to integrate family health into all appropriate aspects of midwife pre-service training. Additionally, these faculty members will be assisted/trained for four years by a nurse-midwife from the technical assistance contract. Three to six MOH regional supervisors should be included, as well as five from the Senegalese Association of Midwives. Costs will be covered by the PSF with PIO/Ps.

b) Five to eight faculty members from the school of nurses will receive training similar to that provided to the faculty of the school of midwives.

c) One or two faculty members from CESSI (regional post graduate nursing institution), could receive similar training.

d) Four to six faculty members selected from the national school of health technicians and the Saint-Louis School of Health Agents will receive training in the U.S. which would prepare them in a more general way to include family health aspects into the training for technicians in allied health fields (these faculty members may or may not be nurses or midwives). The short course in integrated Health, Population and Nutrition at Columbia University could be useful if taught in French.

e) Following the training of the first two groups to go to Santa Cruz or Florida, faculty from the training institution will be requested to support them in Senegal to carry out a similar program for faculty training in country and to initiate the in-service training at the school of sage-femmes.

f) As part of the long term plan for institution building, two faculty members (School of Nurses, School of Sage-Femmes) should be selected for post graduate training to the MPH level with emphasis on maternal child health (family planning). One person from the cadre of MOH regional nurse-midwife supervisors should receive similar training.

2. Pre-service training:
Particular emphasis will be given (as discribed in Laura Evison's report) to developing an integrated family health curriculum in the National School of Nurse-Midwives. As possible, attention will be given to assistance of a less intensive nature to CESSI and the National School of Nurses.

3. In-service training:
To expand the family health service delivery capabilities of the governmental and non-governmental sectors will require in-service/continuing education training for approximately 400 nurses and nurse-midwives over the LOP (this provides adequate numbers for drop out). These trainees should have all the requisite skills for organizing and implementing family health activities. They will require skills as trainers to provide general training and supervision to their colleagues with whom they will work as a health team in the health institutions.

Several alternatives have been considered for implementing this training. The PSF has already had training (from Santa Cruz) in developing a curriculum. In 1982 PSF carried out a training program for approximately 20 nurses-midwives. Although an additional training course has been planned, no further training has been carried out. In the next stage of the project the PSF will be required to put more of their efforts into supervision of the clinic and service delivery system and training in actual integrated service delivery at the clinic level. This may leave them less time for the nurse and nurse-midwife training.

The faculty of the School of Nurse-midwives has limited capacity at the moment to provide family health training and little recent experience with continuing education. However, it is a well organized training institution with substantial interest in family health. It should have excess teaching capacity as government austerity measures have required it to reduce the student body by 50%. Prospects are good for its future participation in a program of continuing education. The institution building aspect of its participation is attractive, as is the simplification of programming if this institution were to be involved in both the pre-service and in-service training.

The school of nursing has a somewhat similar capacity to that of the nurse-midwives. In Senegal the key role in family planning has been played by nurse-midwives. Thus at present there is not as much interest in family planning at the nursing level. This can be expected to change as service delivery protocols are modified and training is provided to the faculty. In later years of the project the school can be expected to participate in the in-service training.

The Association of Midwives has considerable interest in family health, and particularly in participation in the training. Their assistance would be particularly helpful for training in the non-governmental sector. The Association contains considerable talent and several nurse-midwives already capable of providing family health training. Bureaucratic complexities both internal to their institution and in their relations with the government place some constraints on their immediate participation.

Within the Ministry of Health system there are regional training teams with a spotty record of providing training, especially in primary health care, to para-professional personnel.

Some combination of effort is necessary in these circumstances, with the following a likely scenario:

a) In the third or fourth quarter of 1985 implementation of in-service training course for 15-20 midwives will be organized by PSF in coordination with MOH/DRPF. (A similar course for nurses would be organized in 1988 to prepare for the expansion of service to health posts).

b) U.S. training of faculty of the School of Nurse-Midwives will begin as soon as courses are available. This would lead toward beginning continuing education in the third or fourth quarter of 1986 for 20 nurse-midwives and 20/year thereafter. This could be financed on a tuition grant/student from the PSF. Some personnel assistance (Senegalese) for direct involvement in organizing and implementing the training could be provided by the project technical assistance contract. Practical training would be carried out especially at PMI de Médina and PMI de Pikine (assuming case loads will be adequate at Pikine by then). Some additional renovation/expansion would be necessary in both locations to accomodate this additional activity. Additive personnel would not be required at the centers. Both the pre-service and in-service trainees would come to the center with a faculty member accompanying them, thus actually expanding the service delivery capability of the center. In-service trainees should be selected by PSF and the MOH/DRPF to meet the needs of those centers which will be actively engaged in the provision of family health services. Several places in each continuing education class should be reserved for nurse-midwives working in the non-governmental sector. The PSF would participate in the training to assure propect objcetives and procedures are learned along with the technical skills of family health delivery. The DRPF should participate to assure that MOH objectives and procedures are understood.

c) It is expected that by mid or late 1986 the Association of Midwives will have facilities and institutional arrangements to enable them to participate more activelyin training. They could provide services for their members, such as producing a newsletter, sponsoring seminars, identifying training opportunities etc. By late 1986 the Association of Midwives will likely be in a position to provide a training program in family health for nurse-midwives with a heavy emphasis on practic in a clinic they may operate. Eight to ten non-governmental sector nurses and midwives might be trained each year. The Association would need to arrange the core cost of salaries from the government or other sources. Tuition grants from the project for each student would help defray other expenses. The

Association could also be active, possibly in association with the Senegalese Association of Women or CEDPA or the Association of Pharmacists in providing seminars or training programs for other groups such as mens', womens', youth and/or sports clubs, local health committees, unions, police, military.

d) The school of nurses can begin in-service/continuing education courses by 1989 for approximately twenty students each year.

c) The PSF and the technical assistance contract team will work with the MOH regional training teams to strengthen their capacity to train nurses in family planning, MST and infertility management. Personnel time, materials, tranportation and per diem for trainers and trainees and training materials will be provided. Work would be begun in 1987 in one of the projects' regions which has a more effective team. This would be duplicated gradually in the other regions. Courses would be held in the region for two to three weeks. Ten nurses would be trained in 1987 with a gradual increase to forty per year.

C. Health Center Health Post / Health Team

A several day visit to health centers by a field training team will be a key element in providing the skills and impetus for a proper integration of family health into the work of the local health team; improving the coordination between PSF, MOH and MSD and laying the groundwork for ongoing supervision and support.

This team, composed of members of PSF, MOH and MSD regional offices, and project technical assistants, will visit each health center at least once in the course of the project. The scope of work is discussed in detail in a paper attached. This should provide training to approximately 400 members of local health teams (doctors, nurses, nurse-midwives, auxiliaries) in the course of the project. The costs of travel and per diem of the team and the salary of technical consultants to the team would be paid from the PSF.

D. Logistics, Supply and Service Statistics Personnel

Essential for project operation will be the maintenance of an adequate supply of contraceptives, drugs and IEC materials throughout the system. A main basis for project evaluation and management decision will be the reports of client visits and contraceptive flow. Provision has been made for this as described in a report by Jay Friedman (CDC). Three approaches to this training are contemplated to involve 75 persons/year.

1) Training at the clinic level by PSF logistics supervisor at the time of the field team visit described (C) above.

2) A series of visits, when the PSF supervisor will work with the center personnel to assure records are maitained correctly and to fill out the monthly reports. These visits will be carried out monthly until the system is firmly established and less often (at the time of contraceptive resupply) thereafter. This system will be decentralized as more centers are included.

3) Seminars on logistics and record keeping to keep personnel well informed of changes in supply and procedure. This would be once a year for the first two years of the project and less often thereafter.

E. IEC Specialists

This essential training will be discussed by Elaine Murphy. It will provide training for those involved in several ministries as well as in the private sector.

F. Pharmacists

The Association of Pharmacists, perhaps with the Association of Midwives or CEDPA will be assisted to carry out a series of seminars and training events for its members and their lead employees. Training would be provided on availability and use of contraceptives and MST drugs, and their risks and benefits. There are 100 pharmacies in the country (66 in Dakar). Training two or three persons from each establishment (a total of about 250) would require four or five one day seminars during the life of the project. More intensive training would be required if it appears the pharmacists can be more actively involved in advertising and selling project products.

G. Other health workers

As the project progresses consideration will be given especially through operations research and actions of the regional health training team to provide training to agent sanitaires (whose participation in the health system requires standardization) and traditional birth attendants. The American College of Nurse Midwives can provide TA especially for the traditional birth attendants.

H. Policy related training

The paper by Sara Seims and that of the BUCEN team describes the requirements for long and short term training overseas in policy development and demographic data collection.

Additionally a series of observation travel training events will be organized for popular leaders and for family health leaders and managers. The purpose will be to see how family health programs are handled in countries with similar cultural aspects and with successful family planning programs. The types of travel contemplated would be, for example:

- Additional travel to Morocco and Egypt to see family health programs in Muslim countries.

- Travel to Kenya and Zimbabwe to see integrated and less integrated, clinical and non-clinical, governmental sector and non-governmental sector family planning activities.

- To Zaire to observe coordination of the government and non-governmental sectors, involvement of unions, training programs, rural health and family planning programs by the non-governmental sector.

- To Nigeria, Zaire, Kenya or Haiti to observe operations research activities.

- Mauritius to see family planning programs using contraceptives and programs stressing natural family planning.

- Mexico, Colombia, Brazil to see government health and family planning and non-governmental family planning activities.

No more than six or seven persons should be included in each group. One such training event each year should help Senegalese better understand other approaches. Additional travel should be made available for individuals for specific observation purposes or for international meetings and conferences - four per year should be sufficient.

4. EVALUATION

Each of the training programs and courses will make provision for before and after knowledge and competency testing of the students. The results of these course evaluations will be made available to the PSF, the DRPF and the project technical assistance group for review and analysis. During the periodic overall project evaluations, provision will be made for follow-up interviews of a sample of trainees to ascertain if skills learned were being applied in a useful way to improve program performance and to meet project objectives.

( ) means Overseas

Type of Personnel	Institution providing training	Type of training	Year 1 No.Students	Year 1 Person Months	Year 2 No.Students	Year 2 Person Months	Year 3 No.Students	Year 3 Person Months	Year 4 No.Students	Year 4 Person Months	Year 5 No.Students	Year 5 Person Months	Year 6 No.Students	Year 6 Person Months	Year 7 No.Students	Year 7 Person Months	Cost per Person/Month Training
			- $ 000 -														
1) Physicians & some nurses & midwives, service providers	Le Dantec/ JHPIEGO	Modern techniques of reproductive health (10 days)			20	6.6	20	6.6			20	6.6	20	6.6			$ 1,060
					$7		$7				$7		$7				
2) Physicians & some nurses, midwives, planers - MOH regional supervisors	PSF with DRPF and MSD Columbia University	Management & supervision, integrated health, nutrition & family planning (15 days)					40	20					40	20			$ 1,500
							$30						$30				
3) Medical faculty & lead service physicians	Johns Hopkins	MST & Infertility (3 weeks)	(3)	(2)	(5)	(3.3)	(5)	(3.3)	(5)	(3.3)	(5)	(3.3)	(5)	(3.3)	(5)	(3.3)	$ 900
			$2		$3		$3		$3		$3		$3		$3		
4) Nurse midwife & nursing faculty, CESSI & schools of health technicians & allied health field. Some MOH regional supervisors & Association of Midwives	Santa Cruz or Florida State or Columbia University	Advanced training in family health and/or integration of family health in related health fields (8 weeks)	(8)	(16)	(4)	(8)	(8)	(16)	(4)	(8)	(4)	(8)					$ 3,460
			Oct. 85 and April 86 $64		$32		$64		$32		$32						
	Santa Cruz or Florida	Training in-country (8 weeks)			20	40											$ 1,500
					$60												
5) Nurse, nurse midwife faculty - MOH, nurse midwife supervisors	Tulane or University of North Carolina	MPH in Public Health, emphasis MCH/FP (30 months)					(1)	(30)	(2)	(60)							$ 2,500
							$75		$150								
6) Pre-service training for nurse midwives (School of Nursing and CESSI not included)	Ecole Sage Femme ACNM	Integrated Family Planning (during 3 years)					20	35	60	30	60	30	60	30	60	30	$ 260
							(20 graduates)		(20 graduates)		(20 graduates)		(20 graduates		(20 graduates)		
							$20		$10		$10		$1		$1		

( ) means Overseas

Type of Personnel	Institution providing training	Type of training	Year 1 No.Students	Year 1 Person Months	Year 2 No.Students	Year 2 Person Months	Year 3 No.Students	Year 3 Person Months	Year 4 No.Student	Year 4 Person Months	Year 5 No.Student	Year 5 Person Months	Year 6 No.Student	Year 6 Person Months	Year 7 No.Students	Year 7 Person Months	Cost per Person/Month Training
			- $ 000 -														
7) In-service training – nurses & nurse-midwives who are service providers	PSF/DRPF	Delivery of integrated family health service (FP/MST/Infertility (4 to 8 weeks)	$32 20(midwife)	40					$16 20(nurse)	20							$ 800
	Ecole Sage-Femme				20 $14	30	20 $14	30	20 $14	30	20 $14	30	20 $14	30	20 $14	30	$ 466
	Association Sage Femme				4 $4	4	4 $4	4	6 $6	6	8 $8	8	8 $8	8	8 $8	8	$ 1,000
	Ecole Infirmière										30 $15	30	30 $15	30	30 $15	30	$ 500
	Regional training team for nurses ACNM	Integrated family health (2 weeks)					10 $5	5	10 $5	5	20 $10	10	30 $15	15	40 $20	20	$ 1,000
8) Other categories of health workers, volunteers, military, police, men, women, youth groups	Association Sage Femme CEDPA	Family life education (2-day seminar)			100 $5	6.6	200 $10	13.3	300 $15	19.9	400 $20	26.6	400 $20	26.6	400 $20	26.6	$ 757
	Regional training team ACNM	Concepts of family planning for Agents Sanitaire & TBA (1 week)									$10 6 trainers 30 workers $2	3 8	$10 12 trainers 90 workers $4	6 22	$10 12 trainers 210 workers $6	6 52	$ 1,000 $ 150
9) Health Center Health Team :	PSF/MOH/MSD CESSI DRPF Columbia or Santa Cruz or ACNM	Field Training team seminar (2 weeks)	30 $30	15			30 $30	15									$ 2,000
		Clinic-by-clinic training at local level (4 days)	20 $5	3	100 $8	13.3	200 $16	26.6	200 $16	26.6	200 $16	26.6	200 $16	26.6			$ 601
10) Logistics, supply and service statistics personnel	PSF with CDC	Field training team			20	.6	40	1.2	40	1.2	40	1.2	40	1.2	40	1.2	Cost is in No. 9
		Visit by logistics supervisors (average 2 persons/center)	80	3	160	6	160	6	180	7	180	7	200	7	200	7	Normal supervisor cost
		Seminar			30 $3	2	60 $6	4			60 $4	4					$ 1,500
11) IEC Specialists			$20		$30		$30		$20		$20		$20		$20		Estimates – to be determined by Murphy

( ) means Overseas

- $ 000 -

Type of Personnel	Institution providing training	Type of training	Year 1 No.Students	Year 1 Person Months	Year 2 No.Students	Year 2 Person Months	Year 3 No.Students	Year 3 Person Months	Year 4 No.Students	Year 4 Person Months	Year 5 No.Students	Year 5 Person Months	Year 6 No.Students	Year 6 Person Months	Year 7 No.Students	Year 7 Person Months	Cost per Person/Month Training
12) Pharmacists and employees	Association of Pharmacists - PSF, Association of Midwives	Seminar on contraceptives and MST drugs			30	$2 1	60	$3 2			60	$3 2			80	$4 5	$ 2,000
13) Policy Planners and Economists - Statisticians	University of Michigan and BUCEN	short term			(50)		(50)		(50)		(20)		(20)		(20)		Estimates - to be determined by Seims
		long term					(175)										
		short term					(50)		(50)		(50)		(50)		(20)		
		long term							(175)								
14) Policy F.P. and popular leaders	Project Technical Contract	Group observation, travel	(6)	$30 (6)	(6)	$30 (6)	(6)	$30 (6)	(6)	$30 (6)	(6)	$30 (6)	(6)	$30 (6)	(6)	$30 (6)	$ 5,000
		Individual observation or international meetings	(2)	$10 (1)	(4)	$20 (2)	(4)	$20 (2)	(4)	$20 (2)	(4)	$20 (2)	(4)	$20 (2)	(4)	$20 (2)	$5,000
		Sub-total	(193)		(268)		(642)		(612)		(296)		(283)		(211)		
		Contingency 12%	23		32		77		73		36		34		25		
		Total	$ 216		$ 300		$ 719		$ 685		$ 332		$ 317		$ 236		
													GRAND TOTAL		$2,805		

Inflation must be added and assumptions about exchange rate.
(At 5% compounded from Year 2 the total is $ 3,180.)

PID total - $ 3,100
+12% - 370

$ 3,470

Training Budget - (with Estimated figures for IEC and Policy included for illustrative purposes)

A; Assumptions

In developing the budget the following assumptions were used flexibly, since each case had a different mix of travel, tuition, type of personnel involved, requirements for consultant travel, etc.

1. Short-term training in U.S.

   8 weeks (per AID/W circular, costs at Santa Cruz) $ 8,000

2. Long-term training in U.S. - per month $ 2,500

3. Workshops in Dakar

for those staying overnight	$ 25/day
for those not staying over	5/day
travel per trainee	25/ per person

4. Workshops out of Dakar

trainers	$25/day plus $50 travel
trainees	5/day

5. Tuition at Le Dantec

   2 weeks continuing education (includes cost to university and per diem and travel) $ 350/student

6. Tuition to School of Sage-femmes (6 weeks) $ 700/student

7. Tuition to School of Nurses (4 weeks) 500/student

8. Tuition to Association des Sage Femmes (4 weeks) $ 1000

9. Observation travel $ 5000/person

APPENDIX G

SCOPE OF WORK FOR TECHNICAL ASSISTANCE CONTRACT

SCOPE OF WORK FOR TECHNICAL ASSISTANCE CONTRACT

SUMMARY - SCOPE OF WORK FOR THE TECHNICAL ASSISTANCE CONTRACT

The contract will provide technical assistance to the Family Health and Population project during its seven year life. The assistance required is primarily for the National family health project (Project Santé Familiale) and the project activities of the non-governmental sector. The technical assistance office will also serve as a meeting and training locale for other organizations. The office will provide logistics support to all other contractors/grantees associated with the population program in Senegal.

During the course of the project some 252 person months of technical assistance will be provided by long-term expatriate residents in management, clinical and organizational skills and IEC. Senegalese professionals will provide another 134 months of assistance, largely to the non-governmental sector, in organization and training. Roughly 150 person months of short-term technical assistance, two-thirds from Senegalese and one-third from expatriate advisors will be for special assistance in training, media research and evaluation.

The contractor is expected to be relatively self-sufficient in operating, handling all the arrangements for its own office and staff housing. Also, through its liaison officer, the contractor will facilitate USAID's role in project management minimizing the administrative tasks of commodity procurement, participant training, arranging for specific technical assistance, progress reporting etc. Particularly in the area of stimulating and assisting projects in the non-governmental sector area, the contractor will be expected to take an active role in sub-project development. In all the assistance provided for management in the public sector, training in the pre-service curriculum development, in-service continuing education, or work in the non-governmental sector, the contractor is expected to become a partner with the Senegalese institutions in planning and implementing these activities in an expeditious fashion. In the non-governmental sector the contractor will take a leading role in developing the structure for project review and approval and in developing the individual sub-projects. The specific requirements of the contractor are spelled-out through the detailed job descriptions of the team members.These are provided in Annex ___.

The cost of providing this technical assistance and maintaining the office in Dakar is estimated at approximately $5 million for seven years.

The technical assistance contractor will also be responsible for purchasing all equipment, materials and commodities (except contraceptives). The contractor will charge an additional fee based on the total dollar value of the purchases for this service. T

Scope of work for the Technical Assistance Contract

A. General description of the project

The USAID and the government of Senegal have entered into a seven-year cooperative program, the Family Health and Population project, to provide family health/family planning services to 15% of Senegal's reproductive age couples, and to improve demographic data. This project will have five major components, 1) family planning/family health service delivery, 2) training, 3) information, education and communication (IEC), 4) data base improvement and 5) population policy development. The project, which will eventually become nation wide, will work with three major groups in carrying out these activities:

1) A joint program with the Ministry of Health (MOH) and the Ministry of Social Development (MSD) to organize and deliver family health and family planning services - (Santé Familiale).

2) A program to assist the National Census Bureau (BNR) to plan, carry out and publish the 1987 census.

3) A program to assist a variety of organizations in the non-governmental sector to provide family planning/family life information and education as well as family planning service to a segment of the population not being served by the governmental sector.

B. Type of Assistance required from Contractor

Much of the assistance required will be defined in terms of technical assistance to Senegalese agencies which have the ultimate responsibility for these project activities. Yet USAID will expect the contractor to be sufficiently involved operationally to assure adequate project performance. Thus diplomatic and organizational skills will be required as well as technical competence.

The contractor will provide three general types of assistance:

1) Long term resident technicians to:

(a) Assist the MOH/MSD plan, implement and evaluate the Santé Familiale project, taking an active role to assure that implementation plans are carried out and operational targets met.

(b) Assist organizations in the non-governmental sector to plan and carry out family life education and family planning service activities. This will include sub-project development, approval and funding as well as assistance with implementation.

(c) Provide a liaison function between these governmental and non-governmental organizations and USAID, assisting them in the bureaucratic procedures of project implementation. This will also require working with the USAID contracted public accounting firm to assure that all implementing agencies comply with fiscal procedures.

(d) Provide logistic support to short-term consultants secured by the contractor or population consultants from such organizations as The Center for Disease Control (CDC), The American College of Nurse-Midwives (ACNM), The Bureau of Census (Bucen), Columbia University, The Center for Development and Population Activities (CEDPA), Family Planning International Assistance (FPIA), Research Triangle Institute (RTI), Family Health International (FHI), AID/W or visitors from other developing countries.

2) Short-term technical assistance to MOH/MSD and the non-governmental sector to meet specific requirements in training, IEC, evaluation, etc.

3) Procurement of commodities (except contraceptives) for all elements of the Family Health and Population project.

The specific programs and quantitative goals toward which this technical assistance will be directed are to be found in the Project Paper for the Population and Health project. This, as modified from time to time by the USAID and the GORS, should be considered the overall guide for this Contract.

C. Functions of the Technical Assistance Team Resident in Dakar

The Contractor will rent office space in Dakar suitable for the technical assistants to work as a team on various activities common to all elements of the project. This office will provide a large conference room available for meetings of various non-governmental agencies and for training sessions. Space and equipment will also be provided for short term consultants supplied by the contractor as well as those from other population agencies. If the FHI research center is established, facilities will also be shared with them. Office space will also be provided for other participating NGO's if necessary.

The office will be fully equipped with word processing and photocopying capability. One van type vehicle for 6-9 passengers and two medium size passenger vehicles will be maintained by the contractor.

Two of the resident advisors will also have office space (provided by the GORS) with the Santé Familiale project where they will spend at least half of their time each day.

The resident Contract team will handle their own logistics with back up support from their U.S. headquarters. U.S. government regulations will be followed to provide furniture (import or locally purchased), import appliances, ship household effects, rent and maintain housing, enroll children in school, provide travel and home leave for employees and families, develop appropriate work schedules and handle personal affairs in country. Project commodities, household and personal effects and vehicles will be addressed to USAID and assistance is available for clearance through customs. Limited assistance is available (at project cost) in handling much of the above from a contract support unit based in Dakar. The USAID administrative office will provide guidance in carrying out these functions but the contract team should expect to be relatively self-reliant in a country where most of these matters can be handled without excessive difficulty.

The team will be composed of:

1) Team Leader ..... 7 years
2) Liaison Officer ..... 7 years
3) Nurse Midwife ..... 4 years
4) IEC generalist ..... 2 years
5) Senegalese professional ..... 7 years
6) Senegalese professional ..... 4 years

(this total of 252 person/month of expatriate technical assistance is more than the 210 of the PID due to extra responsibility envisioned, especially in the private sector).

This resident team effort will be augmented by approximately 150 person-months of contract assistance to provide for specific project requirements. This would be short-term technical assistance from overseas or short or longer term contracts with Senegalese professionals (not government employees) to work on specific project requirements for training, IEC or management.

The specific tasks and qualifications required of the resident technicians follow.

1) <u>Team Leader</u>

The team leader should have a broad management background in the organization of maternal and child health and family planning programs. Public health training at the masters level is required. Management and organizational skills are more essential than medical capability. Skills in the use of service statistics, logistics reports and surveys for evaluation and program management purposes are desired. The ability to work in a collaborative fashion with African project leadership is essential. Fluency in French is required and several years experience in Africa is preferred. The team leader position will be continuous for the LOP.

(a) The team leader will be responsible for all aspects of planning for and supervising the technical assistance contemplated and will represent the contractor in all formal contacts with Senegalese institutions and with USAID. He/she will oversee the rental and management of the office and logistics of the team's and families' arrival, housing, travel, etc.

(b) At least half of the team leader's time will be devoted to direct involvement with the leadership of the Santé Familiale project (PSF) in planning, organizing, carrying out and evaluating their program of family health. This will involve assisting in clarifying the role and job description of staff members and their relationships with national, regional and local staff of MOH and MSD; assisting with the preparation of annual and quarterly work plans and budgets; the analysis of service statistics, financial and supervisory reports to prepare quarterly progress reports; planning for and participation in training programs and visits to clinics to assist with training and supervision; collaborating with PSF, MOH and USAID engineers to assure plans are appropriately developed for center renovation and that work procedes expeditiously. It is expected that the team leader will visit all health centers in the Santé Familial project once a year and those in the Dakar area several times and will be actively engaged with the PSF to develop and monitor an ongoing program of supervision by the PSF and MOH/MSD.

(c) A major objective of this assistance is to help the Santé Familiale project to improve the efficiency and rate at which it carries out the expansion of service delivery contemplated in the project. Training and IEC functions will be the key to how well this expansion goes forward as will improved supervision, performance in the logistics area and evaluation of supply flow and patient utilization of services. Securing the active collaboration of MSD personnel especially in the IEC activities will also be important. Helping the medical leadership reevaluate their procedures for dispensing contraceptives, especially those associated with screening prospective oral contraceptive clients, could make a substantial contribution to the expansion and public health impact of the project. These should be the emphases of the first 18-24 months of the Santé Familiale activities.

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(d) As part of the attention to improvement in the present clinical approach to family planning service delivery and eventual expansion, a series of operations research activities should be developed to test variations of approach to training, management and service delivery. Such approaches could include: giving more responsibility for service delivery to nurses, matrones or auxiliaries; post partum family planning information and service in hospitals and maternities; the use of village health care workers for non-clinical contraceptive delivery in the rural health or primary health care programs; involvement of MSD animatrices in delivery of non-clinical contraceptives; variations of the degree of "integration" of service delivery in the health centers or the model of team work service delivery; variations in training content, length and location of courses; variatioms in patterns of supervision. These approaches would generally be aimed toward simplifying procedures and making family planning information and services more readily available both in the health center and at the community level. Close collaboration will be required with AID/W funded research institutions such as Columbia University for operations research and with Family Health International for small projects of bio-medical research.

(e) Working with other members of the TA team, the USAID Supply Management Office (SMO) and the CDC logistics advisor, the team leader will be responsible for drawing up commodity specifications, quantities and shipping schedules. Actual procurement and shipment of contraceptives will be handled by AID/W but all other commodities will be procured and shipped by contractor headquarters. The team leader will work with USAID/SMO to assure proper customs clearance and delivery to appropriate agencies and will develop an inventory and property accountability system.

(f) The team leader will assist other members of the team in establishing policies and procedures for the non-governmental sector and will supervise progress in this area.

(g) In consultation with USAID the team leader will develop means of communicating results of the general service delivery program and operations and bio-medical research to opinion leaders in a way to aid in population policy development. The team leader will coordinate closely with USAID to keep informed of development in the policy area. However, it will not be the responsibility of the contractor to manage the broad policy development activities (population and development planning and modeling) envisaged in the project paper. These will be the responsibility of the USAID and AID/W. However the contractor will be required to provide in country logistics support for consultants and for trainees in this area.

2) Liaison Officer

The liaison officer should have advanced training in the management of public health programs with experience in Africa. Training to the MPH level is preferred but experience and good organizational ability can substitute. Previous knowledge of AID's procedures would be desirable. In its absence, arrangements should be made to attend one of AID's Project Implementation courses. Fluency in French is essential. This position will remain throughout the seven years of the project. The liaison officer will:

(a) provide assistance to both the USAID and Senegalese implementing agencies to assure that all bureaucratic procedures for project implementation and reporting are carried out in a timely and effective fashion. Major emphasis will be given to the Santé Familiale program but considerable work will also be required for the non-governmental sector. Assistance required for the BNR should be minimal.

(b) work with the leaders of the Santé Familiale project to assure that all fiscal and program progress reports are prepared in a timely fashion. Initially, special attention will be given to preparation of quarterly reports that provide information on numbers of clinics operational, persons trained, IEC materials developed, number of supervisory visits made, the movement of contraceptives and the numbers of family planning clients. Later, ad hoc reports will provide greater analysis of the performance of various clinics, effectiveness of the training or IEC program, observations related to the operations research projects, etc.

(c) work with the other members of the team and the non-governmental organizations involved, to provide similar reports for the non-governmental sector.

(d) prepare the basic information and drafts of all necessary project implementation orders (PIO/C, PIO/T, PIO/P).

(e) work with the Senegalese professional on the team and the Senegalese cooperating institutions to assure all the logistics are handled for in-country training activities.

(f) handle all the processing of trainees who are going abroad and those who are coming from other developing countries for population training in Senegal. This will involve advising all appropriate Senegalese agencies of the availability of training opportunities, clarifying the objectives and selection criteria, briefing trainees, making reservations, securing tickets, providing advances as needed, debriefing trainees, following up at a later date to see if training is being used. It will occasionally mean accompanying Senegalese leaders on observation travel. A file should be developed of all those trained in the past few years and in the future to avoid training duplication and to assure that knowledge and skills learned are utilized in the program.

(g) handle the logistics for all short term visitors and consultants, making hotel reservations, securing transportation in country as needed, arranging secretarial service, helping with appointments, etc.

(h) work with the USAID/Controller and the public accounting firm to assure they have full access to necessary information, that all involved institutions understand and follow the established procedures, that cash flow is expeditious and that reporting is timely.

3) Nurse-Midwife

The certified nurse-midwife (CNM) should be a representative of the American College of Nurse-Midwives (ACNM). She/he should have experience in organization and management of a public health or clinic service, preferably in Africa. She/he should also have training and experience as a trainer, as well as extensive clinical experience in the provision of maternal-child health and family planning services in the context of a comprehensive health care program.

The nurse-midwife will have a dual role: 1) to provide technical and training assistance to strengthen and expand the role of the Senegalese nurse and nurse-midwife in family planning/family health education, service delivery and management, and 2) to provide organizational and clinical technical skills to the project, especially through training and leading in the development of sub-projects in the non-governmental sector, to improve family planning/family health service delivery at all levels of the health care system in Senegal. Clinical and training skills, excellent communication and interpersonal skills, and organizational experience are required. Fluency in French is essential. This position will be maintained for four years.

The nurse midwife will:

(a) Work with the Ecole de Sages-Femmes, to develop and implement a revised curriculum to provide an integrated emphasis on family planning, including information on infertility and sexually transmitted disease. This curriculum will include a sound theoretical base and adequate practical experience to assure safe and effective service delivery to all sectors of the population.

(b) Work with the Ecole de Sages-Femmes, the School of Nurses, the Training Division of the Ministry of Health, the Association of Midwives (ANSFS), the leadership of the Santé Familiale Project, and other appropriate institutions to develop and implement a comprehensive continuing education program in family planning, infertility and sexually transmitted diseases for midwives and nurses.
This program will include a sound theoretical base and adequate practical experience to assure safe and effective service delivery to all sectors of the population. The program must provide new and existing SFHP clinics with trained personnel, and add significantly to the number of governmental and non-governmental midwives delivering family planning services.

(c) Assist the leadership of the Senegalese Family Health Project to review and maintain appropriate standards of training, clinical conditions, medical support, and supervision for the delivery of family planning services by several categories of health workers. Encourage service delivery procedures that will enhance public health impact by providing extensive coverage to the population, minimizing health risks (both of pregnancy and of contraception), minimizing inconvenience to the patient, and assuring proper medical surveillance.

(d) The nurse-midwife will also cooperate with the Senegalese professional and the Santé Familiale Project in organizing a training program to be carried out in collaboration with MOH and MSD personnel at the clinic level. This three or four day program in each clinic will provide general knowledge and practical experience for all health center personnel and local MSD personnel in an integrated approach to providing family health information and service delivery. It will help clarify the role and job description of all members of the clinic level health team and MSD personnel in providing this integrated service and clarify the relationship to regional and national leadership of the Santé Familiale project.

(e) Maintain contact with the Centre d'Enseignement Supérieur en Soins Infirmiers (CESSI), l'Ecole des Infirmiers et Infirmières d'Etat de Dakar, l'Ecole des Agents Sanitaires de Saint-Louis and l'Ecole Nationale des Techniciens Supérieurs de la Santé to identify ways in which limited assistance can be provided to integrate concepts of family planning and skills in family planning service delivery into their training programs as appropriate. Some of the Faculty should be included in the project's in country and overseas training program and IEC material should be provided. Appropriate Assistance will be provided to the National School of Nurses in a similar fashion to that of the School of midwives at a later date.

(f) Plan the training in-country or overseas for physicians, pharmacists, health planners and others who require in-service training in various aspects of family planning, working with the liaison officer who will handle the logistics as needed. This work will be coordinated with the expansion of reproductive health training at the JHPIEGO regional center at Le Dantec.

(g) Assist in the development of family planning education and service delivery protocols for health care workers in various settings.

(h) Maintain communication with governmental and non-governmental agencies involved in maternal-child health, primary health care, and family planning.

(i) Take the lead in working with other team members to develop a series of activities in the non-governmental sector:

1) Emphasize development of family planning service delivery projects with physicians, midwives, clinics, industrial employee dispensaries and other appropriate agencies.

2) Review strategies for marketing contraceptives in pharmacies and training pharmacists in family planning techniques.

3) Assist in forming a review committee to assure GOS clearances for proposed projects.

4) Assist in producing a simple project agreement format, including a relationship with the public accounting firm.

5) Encourage non-governmental agencies to produce project proposals in the areas of family planning information, education, communication, training and service delivery. Facilitate funding and implementation of such projects, review progress, and evaluate results.

(j) Work with the Association Nationale de Sages-Femmes du Sénégal in the broad areas of professional development, eg continuing education, clinical practice, organization and management, and communication.

(k) help to identify subjects for bio-medical and operations research and coordinate with Family Health International, Columbia University and other research institutions to assure these activities are carried out.

(l) identify requirements for short-term technical assistance to achieve the objectives stated above, working with the liaison officer and the team leader to secure this assistance.

4) IEC professional

The IEC professional should be a generalist in the field of communication with a background in health education, social communication, or public information. Training at the Masters level is preferred, but experience could substitute for advanced academic training. The person should have experience, preferably in Africa, in public information or health education programs having relevance for family planning and should have experience in training others in IEC. Broad knowledge of the communication field is more important than specific media skills, which should be acquired through short-term specialists. French is essential. This position will be for two years beginning toward the end of year one of the project.

The IEC professional will:

a) work with the leadership of the Santé Familiale project, the Health Education Division of the MOH and the Division of Family Welfare of the MSD to develop a comprehensive program of IEC for the Santé Familiale project. This will include informational materials in the clinic, community information programs carried out by agents of MSD and mass media programs of newspaper, radio and television and development of a family life education program for secondary students. Sensitivity to local customs and mores is essential. However, experimentation with various approaches and forward looking programming will be important. Pretesting of materials and surveys of public opinion will be required.

(b) participate with Senegalese counterparts on the training team that goes from clinic to clinic to develop the team work approach to delivery of family health/family planning information and service.

(c) work with the nurse-midwife and the Senegalese professional in developing various sub-projects in the non-governmental sector. This work will not be exclusively in the area of IEC but non-governmental sector activities will be expected to make a substantial contribution to the national IEC effort.

(d) assure where possible IEC and service delivery activities are closely associated. One avenue of achieving this will be through assisting in the development of operations research activities with the rural health program, primary health care and various promotional activities of the MSD. Major efforts should be made to include a strong IEC component in service delivery activities. At the same time initiative should be taken to encourage that wherever possible "educational/motivational" activities also include the delivery of non-clinical contraceptives.

e) maintain a library of relevant French language IEC materials and audio-visual aids.

f) develop an updated address list and other means of distributing material such as Population Reports (Johns Hopkins Population Information Program).

(g) identify requirements for short-term specialized T.A. in IEC and work with the team leader and liaison officer to meet these needs.

5) Senegalese Professional I

A Senegalese professional on the team will assure better comprehension of Senegalese approaches and sensitivities, and will assist with developing the appropriate contacts with governmental and non-governmental officials. This person should work as a generalist in all areas of project planning and implementation with particular emphasis depending somewhat on the technical qualifications of the person available. The person selected should have advanced academic training either in public health, communication or public or business administration. Experience in a leadership position in one of the Ministries or the University, a non-governmental organization or a private enterprise is essential. English language capability would be desirable but not essential. This will be a seven year position.

The Senegalese professional will:

a) work with the team leader and other team members to establish project policy and assure policy and procedures are consistent with Senegalese customs.

(b) review project correspondence with Senegalese cooperating agencies to assure it is accurate and of an appropriate style of communication.

(c) participate with the team leader as requested in negotiations with government or non-governmental organizations.

(d) take the lead in organizing the series of clinic-by-clinic training sessions, assuring that adequate advance planning has been carried out with MOH and MSD, that appropriate team members are available, and that contraceptive and informational materials are on hand. The Senegalese professional will take a role in the actual training consistent with his/her professional specialty.

e) take the lead with the assistance of the nurse-midwife and IEC professional in the development of the non-governmental sector sub-projects, representing the contractor on the non governmental project review committee.

(f) assist the liaison officer in making appointments for short-term T.A. or visitors and assisting them as required in meeting the objectives of their time in Senegal.

6) Senegalese Professional II

In year four of the project as expatriate resident T.A. is reduced, another Senegalese professional will be added to the project for the remaining LOP. His/her qualifications and work scope will be determined by the requirements at that time. It is expected that some shifting of roles will occur. Adequate attention must be given to the organizational requirements of project development and implementation in the non-governmental sector.

7) Office Staff

The office will require at least one bilingual secretary, one driver, one messenger, one cleaning person and two guardians.

D. Short-term Technical Assistance

Short-term technical assistance will be procured by the contractor from Senegal, other African countries and from the United States.

Some of the assistance for the project (especially for research, logistics, data base improvement and policy development) will be from centrally funded (AID/W) sources. In this case, the contractor's responsibility will be limited to collaborating with USAID in the identification of requirements and assisting with in-country logistics as requested.

For all other short-term technical assistance the contractor, in consultation with USAID and governmental and non-governmental institutions, will identify the need, prepare the scope of work, identify, hire and pay the consultant, handle international and in-country logistics and supervise the work. A report on the work done and an evaluation of its impact will be provided to USAID for each consultancy.

The Senegalese assistance will be largely in the area of the clinic by clinic training, training for nurses and nurse-midwives, development of IEC materials, research and evaluation, and for specific requirements in the non-governmental sector sub-projects.

Short-term technical assistance from overseas will be required from the contractor in the following general areas:

Training:	Clinical skills, management of family planning programs, curriculum development and implementation of training programs.
I.E.C.:	Specialized skills in media or development of non-literate materials.
Research:	Requirements to assist with centrally funded bio-medical and operations research activities.
Evaluation:	Requirements for surveys and general evaluation.

Approximately 150 person/months will be required. (This is an increase from the number included in the PID, as additional responsibilities have been added. However more of this assistance is expected to be provided by Senegalese).

Illustrative Budget for Technical Assistance Contract

Can't be completed until Mission has discussions with ISTI on overhead and makes decisions on actual level of technical assistance.

A. Assumptions

1) Expatriate resident adviser (Direct ~~line~~ hire $100,000) — 100,000/year
(Sample contract $86,000)
(Include salary and benefits and not overhead)

) Senegalese resident adviser — 25,000/year

3) Expatriate short-term adviser* — 10,000/month

4) Senegalese short-term adviser* — 2,500/month

5) Office staff (total) — 3,000/month

6) Operational cost - per year

a. rent	12,000	
b. utilities	7,000	
c. supply	3,000	
d. vehicle maintainance	15,000	
e. misc.	3,000	
		40,000/year

7) Office equipment - Year 1 15,000
Year 3 3,000
Year 5 5,000

8) Vehicles (1 van and 2 medium passenger vehicles

Year 1 50,000
Year 5 50,000

9) Overhead and fees unknown - [illegible] overhead will be negotiated and inflation factor will be determined by Mission and contractor.

*Of the 150 person/months of short term assistance, approximately 50 would be expatriate and 100 Senegalese. One half of the expatriates would be funded centrally and one half of the short-term Senegalese would be funded from the NGO projects.

APPENDIX H

NON-GOVERNMENTAL SECTOR ACTIVITIES

NON-GOVERNMENTAL SECTOR ACTIVITIES

Summary

There is a growing recognition that governmental actions can be usefully supplemented by those of the non-governmental sector in extending health services to the population. Reference is made to a 1985 report by Alpha Dieng which documents the strength of the private and semi-private sector in providing health care. The non-governmental sector portion of the project (less than 10% of the total) expects to stimulate this activity and channel it into areas in support of the objectives of the Family Health and population project.

In order to maintain flexibility to respond to changing ideas and institutions, family health projects will be developed with a variety of Senegalese NGOs. A technical review committee will be established, with representatives from the non-governmental sector, the ministries of Health and Social Development, the technical assistance contractor, and USAID. The technical assistance contractor will serve as the executive secretariate of the review committee and work with non-governmental organizations to develop projects for approval. The contractor will assist in implementation. A public accounting firm will be contracted to handle the financial management. The project remains open to whatever organization in the non-governmental sector (including para-statal), registered with the GORS, which wishes to present a project in support of the objectives of the family health and population project. A list of examples are provided in Annex_____of the kinds of projects expected in the area of family life education, family planning services, training, or small research activities. Initially, smaller projects would be encouraged but later the size could be expanded. It is expected that about 80 sub-projects totaling $2 million may be approved over the life of the project.

March 13, 1985

Bill Bair

Project design and organization - private sector (non-governmental)

Project committee - Family Health and Population

The PID project description, sector D, outlines the project in a fashion common to most population projects. It breaks down the activities in a practical way according to their functional elements i.e. family planning, policy development etc. Within most of these elements there is a component to be carried out by the public sector. For purpose of developing the organizational/implementation structure of the project, we may need to focus more on the distinction between public and private sector activities.

The public sector activities are largely clinical family planning and information, education and communication actions to be carried out by the Ministries of Health and Social Development. Demographic data collection is to be done by the National Census Bureau. These are straight forward, relatively non-controversial activities that can be planned in advance over a period of years with measurable inputs/outputs, etc.

On the other hand, some of the more innovative aspects of the project, but more controversial and more likely to change over time, are in the private sector. These would be in the areas of family planning service. We expect that service delivery approaches which are not presently acceptable to the Senegalese Government may become more acceptable in the future. To discuss them now with the government (let alone describe them and plan for them in detail) seems to be counterproductive. Similarly, there appears to be conflict between several of the major Senegalese private associations, a conflict that may take some time for them to resolve.

The private sector section needs to be only a small percentage of the project but it can make a very significant difference in whether the project makes appropriate growth and change iniits service delivery approach. It appears essential to maintain this project element. However, we should accept local sensitivities to the event of not using emotionally charged words e.g. use non-government instead of private sector and don't talk now about community-based distribution, commercial retail sales or voluntary sterilization.

It is probably more important to develop an administratively efficient mechanism within the project for planning, approving and managing future sub activities and selecting implementing organizations than it is to specify them in detail at this time.

The project committee is requested to consider the following suggestion, which is not unlike the Kenya private sector family planning project approach.

The project contemplates an 8-A set aside contract (probably with the International Science and Technology Institute) to provide technical assistance and handle commodity procurement. This could be expanded to include management of the private sector (non-governmental) activities. The project could reserve approximately $3,000,000 over the LOP for projects to be developed by the TA contractor with Senegalese non-governmental organizations or associations duly registered with the GRS. These projects would be to carry out family planning information and service activities which are within ~~are within~~ the scope of their Senegalese registration and the objectives of the family health and population project. The sub project approval process would include a review of the local organizations' management capabilities and provision for strengthening as needed with fiscal management and audit by a local public accounting firm.

This does now allow for the degree of government participation in the sub project approval process that many GRS officials probably want. Nor does it provide the kind of specificity usually desired for PP's and contracts. However, without this flexibility, it is unlikely that this non-governmental section of the project can be effective.

Further review of non-governmental sector interest and capability and the feasibility of possible actions would be required in the process of developing the background information for the PP. Care must be taken in this review to not unduly raise hopes on the part of non-governmental organizations or create unwarranted GRS concern about immediate project expectations.

NON-GOVERNMENTAL SEC TOR ACTIVITIES

A. INTRODUCTION

The great preponderance (75%) of the project activities are reserved for support of family health or demographic data collection activities in the governmental sector. As documented in a report by Alpha Dieng, "Les institutions privées et semi-privées concourant au développement sanitaire du Sénégal" 1984, there is also a considerable energy and physical infrastructure in the non-governmental sector. This capacity could be enlisted more directly to support the objectives of the government to improve the health and quality of life of the people of Senegal. Especially because the government has constrained planned growth in governmental investments in the health sector as part of its economic stability program, these non-governmental sector activities take on even more significance. An example of this mutually supportive role is the health committees "les APS" which have been formed in support of health center activities. The experience in the Pikine area is reported to be so successful that these health committees handle client charges in a way which makes a very significant contribution to the finances of the health post (as much as 10 times the level of government investment). There are reported to be 25 clinics, ten of which are for midwifery, and about 140 physicians' offices in the non-governmental sector. There are one hundred pharmacies, 66 of them in Dakar. The social security institute has three health centers in heavily populated urban zones. They include and wish to expand family planning service. There are six parastatal public service enterprises employing approximately 13,000 workers. These enterprises have health services and health insurance for the workers and their families. Several already provided and wish to expand family health services. All the industries of more than 200 workers have an "institute of prevoyance maladie (IPM)", a type of health insurance paying for services which are generally provided in non-governmental facilities. All industries with over 300 employees are required to have a health facility as well as the IPM. Most of Senegal's industrial workers are unionized

There are a significant number of professional and service organizations which have relevance to this portion of the project. A network of Catholic clinics (56 in total) provides health services. The Lebanese community supports 3 clinics. Both the Lions Club and Rotary Club are active in Senegal. The Red Cross supports a network of 13 health posts. Nurses, nurse-midwives, physicians and pharmacists all have professional associations. The Federation of Senegalese Womens' Organizations groups

some 48 organizations. A recently organized Center for Development and Population Activities/Senegal is affiliated with the organization of the same name in Washington. The Senegalese Association for Family Welfare (ASBEF) has an active program of family planning. Many of these organizations have shown interest, and a few have already been involved in family planning. This list of organizations is only illustrative and not complete. Neither the GRS nor USAID has any implied or formal a priori commitment to any group. The GRS and USAID wish to promote appropriate involvement by any non-governmental group. Yet experience is limited to judge precisely the degree and kind of involvement these institutions can have in providing family health information and/or service. With the number of institutions potentially to be involved there is likely to be a variety of approaches and a changing cast of characters. It is probably out of this diversity that some of the more innovative approaches can be developed. Thus it is important to have a flexible mechanism to respond to new ideas and new organizations in a way that does not stiffle initiative and prevent these or any other organization from being a maximally effective partner of the MOH in Senegal's quest for Santé pour Tous. The following mechanism is suggested to provide selective assistance in a simple fashion catalizing the kind of activities in the non-governmental sector which will be consistent with and supportive of government health policy and the objective of the family health and demographic project.

STRUCTURE AND FUNCTION

1) Non-governmental Project Review Committee:
A non-governmental projects review committee (comité d'étude) (NGPRC) will be formed to establish and review policy in this area to assure complementarity between governmental and non-governmental actions, review and approve projects, monitor project progress and evaluate performance. The committee will be composed of:

1) Respected private citizen (chair person)
2) Representative of the MOH
3) Representative of the MSD
4) Representative of the Project Technical Assistance group
5) Representative of USAID

2) Technical Assistance Implementing Group (TAIG):
A technical assistance group will be assigned responsibility to carry out the policy and program as determined by the Project Review Committee. They will:

a) Develop necessary bureaucratic procedures (i.e., simple project request format, simple project agreement and report forms).

b) Explore project possibilities in the non-governmantal sector and assist organizations to develop projects.

c) Present proposals to the committee.

d) Revise proposals as necessary and prepare project agreements to be signed by review committee chairman and the organization. Make funding arrangements.

f) Provide technical assistance in implementation

g) Monitor progress and report to review committee.

h) Prepare agenda for review committee.

The technical assistance implementing group will be composed of the members of the project technical assistance contract team:

1) Senegalese professional
2) Health systems management expert
3) Nurse midwife
4) IEC specialist
5) Representative of the financial management contract firm (local pulic accounting firm).

3. Financial Management Firm (FMF):

A local public accounting firm will be contracted by the project to manage the financial aspects of the non-governmental sector activities of the project. The role will be to:

1) Review budgets and projections of project proposals.

2) Establish appropriate financial procedures satisfactory to USAID for managing funds and paying costs of individual projects.

3) Report on fiscal matters to TAIG.

4) Carry out audits as necessary.

C. PROCEDURAL STEPS

1) Solicitation of interest by TAIG and NGPRC. Publication of availability of this assistance.

2) Technical assistant (TA) - (member of TAIG) visit to project site of non-governmental organization. (At the initiative of the organization or the TA).

3) Preparation of project request by organization and TA.

4) Review of proposal by TAIG and FMF.

5) Revision of proposal by organization if required.

6) Distribution of project proposal to members of NGPRC by TAIG two days in advance of meeting.

7) Presentation of proposal to NGPRC by TA.

8) Review of proposal and decision to approve/disapprove during meeting of NGPRC - (meetings to be held at least bi-monthly).

9) Preparation of project agreement by TAIG and FMF.

10) Signing of project agreement between the responsible person of the organization and the chairman of NGPRC and the responsible person of the FMF.

11) TA and FMF work with organization to clarify financial and reporting procedures.

12) TA works with organization to secure training, equipment, commodities, personnel and technical assistance requirements.

13) Simple reports prepared by organization and TA (quarterly and final).

14) Evaluation report by TA to NGPRC.

D. PROJECT CRITERIA

1) Requesting organization or association must be duly registered with an appropriate ministry of GORS (e.g., MOH, MSD, MOE, or MOI).

2) Requesting organization must be in the non-governmental sector. (For purposes of this project this is interpreted to include semi-public or parastatal institutions).

3) Activities for which support is requested must be in the public interest and in support of the objectives of the Family Health and Population Project of USAID and the GORS. Preferance will be given to activities which serve to:

   a) Provide family planning information to the community

   b) Expand service delivery systems for integrated family planning.

   c) Provide training for family planning and family health providers.

   d) Carry out research on ways to improve service delivery, evaluate community or client satisfaction, or analyze relevant demographic variables.

4) Initially, projects will not generally excede $10,000 nor will their first stage excede two years. Self-sufficiency will be encouraged, but follow-on projects will be considered. As experience is gained with this process, larger projects will be considered by the NGPRC.

E. PROJECT EXAMPLES

The following illustrates the kinds of activities that may be developed. The example are neither exhaustive nor definitive. They do not represent proposals from any organization or assiciation.

1) An industry or parastatal public service institution has a clinic including PMI for its workers and their families, It may request assistance to expand family health services to include family planning. It may request equipment, IEC materials, training and contraceptives.

2) An organization of health care professionals or workers (e.g. physicians, nurses, pharmacists) may request the project to provide training for its members in family planning IEC or service delivery.

3) A non-governmental organisation with a network of maternity and PMI clinics such as the Red Cross may wish to provide family planning as part of its health service, The project may be requested to supply equipment, contraceptives supplies, informational materials and training.

4) A local (or regional) health committee may request assistance to employ a community health worker to assist with nutrition surveillance, immunization and identification of high risk mothers and provision of family planning information and referal.

5) A womans organization may request technical assistance, training or materials to organize family life education programs.

6) A university or professional association may request assistance to undertake research in the area of user satisfaction with family health services, causses of infertility, improving service delivery in under-served areas, or carry out a survey of pharmacists', physicians' or nurses' opinions and practice in relation to family planning

7) A professional organization may request assistance to provide family life education and/or contraceptive supplies to such organizations as police, unions, military or service organizations.

8) An organization may request assistance to add training and informational materials on natural family planning to their services.

9) A non-governmental organization may be formed to serve as a clearing house or coordinating agency for industries or non-governmental clinics requiring a supply of contraceptives or informational materials. They could require organizational assistance, personnel, office equipment and a supply of contraceptives.

F. PROJECT PERFORMANCE

It is expected that in the first year 10 projects could be approved at a value of approximately $80,000. With project progress there will be some growth in the number of projects but perhaps more in the size, impact and cost of individual projects. The expectation is that nearly half a million people will be touched by the educational efforts of tese activities over the life of the project and about 30,000 will be receiving family planning services by the end of the 7th years.

	1985	1986	1987	1988	1989	1990	1991
PROJECTS	--	10	12	15	15	15	15
COST ($000)	--	80	120	300	500	500	500

APPENDIX I

FIELD TRAINING TEAM FOR HEALTH CENTER PERSONNEL

FIELD TRAINING TEAM FOR HEALTH CENTER PERSONNEL

Summary

In order to maximize the integration of family health services (family planning, and treatment of MST and sub-fertility), a field training team will be formed to visit each health center in the program to provide training at the health center for three or four days. The team will be composed of representatives of the national planning cellule of family health (PSF) the technical assistance contract personnel and regional personnel of the ministries of Health and Social Development. The objectives will be to:

a) provide theoretical training and practical experience in the health team approach to the delivery of integrated family health information and services at the health center.

b) improve the coordination of the Sante Familial project (PSF) activities with those of the regional health team and the actions in support of family health by the Ministry of Social Development.

c) develop the basis for improved supervision, continuing education and material support to the health center by the PSF in coordination with regional health personnel.

d) provide for improved feed back from the health center to the regional and national levels, and vice versa.

Before initiating this training there will be a training seminar for national and regional team members with assistance from Santa Cruz, Columbia University or the American College of Nurse-Midwives. Team visits will be carried out at least once a month so that all centers can be visited at least once during the project.

Detailed suggestions are made for demonstration and practical training with health center clientele in the morning, discussions and presentations in the afternoon and community outreach.

FIELD TRAINING TEAM FOR HEALTH CENTER PERSONNEL
(Equipe de formation sur le terrain)

These suggestions are made in response to the Ministry of Health concerns that family planning be well integrated into the ongoing activities at the health center level.

I. The team

A multi-skilled travelling team would be formed to provide training at the health center level in the delivery of integrated health services (maternal and child health, primary health care or family health services, including family planning, prevention and treatment of infertility and sexually transmitted disease (MST). This team would include personnel from the national planning cellule for family health (PSF), the technical assistance contract personnel, regional personnel of the Ministry of Health (MOH) and Ministry of Social Development (MSD).

II. Objectives of the training

It is assumed that the health center is reasonably well staffed with personnel already trained in most elements of primary health care. The center will also have one or two nurse mid-wives (sage-femmes) who have received special training in family planning. Thus it is not the objective of this field training team to provide skill training in primary health care to the health center team or family planning skills to the sages-femmes. Rather, the new element being introduced is how the centers can integrate family health (Santé familiale) activities (including child spacing, infertility management and prevention and treatment of MST) into the ongoing activities of the health center. Attention will be given to how the center can be organized and staff responsibilities assigned to encourage a health team approach in the delivery of these services. There will be some aspect of supervision in the team's work since those who normally will provide the ongoing health service supervision (regional health officers) and the PSF supervision will be part of the team. However, the primary objective is training and coordination. This is not a substitute for the ongoing supervision by the MOH and PSF. The objectives can be stated as follows:

a) Provide theoretical training and practical experience in the health team approach to the delivery of integrated family health information and services at the health center.

b) Improve the coordination of the Sante Familial project (PSF) activities with those of the regional health team and the actions in support of family health by the Ministry of Social Development.

c) Develop the basis for improved supervision, continuing education and material support to the health center by the PSF in coordination with regional health personnel.

d) Provide for improved feed back from the health center to the regional and national levels, and vice versa.

III. Composition of the Training Team

a) Co-team leaders

1) PSF Deputy Director, Technical Director or regional coordinator.

2) Representative of the Regional Health team - (Médecin-chef, Regional Supervisor of Primary Health Care or Regional Supervisor of Maternal and Child Health)

b) PSF logistics supervisor or assistant (will generally only remain at the center for one of the traing days).

c) Regional or local representative of the Ministry of Social Development

d) One of the Technical Advisors to the PSF, Health systems management advisor, Nurse midwife, Information, education and communication expert, or Senegalese professional.

IV. General Approach

a) A two week training/planning seminar would be organized by the PSF to prepare team members for their participation. Technical assistance would be secured from Columbia University, Santa Cruz and/or the American College of Nurse Midwives. Personnel from CESSI, the National School of Sages-Femmes, the Research, Planning and Training Division of the MOH (DRPF) and the MSD would assist with specific parts of the training. Those in attendance would be the technical personnel and regional coordinators of Santé Familiale, the Project Technical Assistance Contract team including short-term contractors, for the purpose, one or two representatives from each of six regional offices of the MOH and one from the MSD from each of the six regions in the project (about 30 in all).

b) During the training session national level personnel would be assigned to each of two teams on which different regional personnel would be assigned depending on the regions in which the clinics to be visited would be located. (In effect this might be considered six teams).
Visits to individual health centers would be scheduled with one or two centers to be visited each month for the next 18 months.
This would require national personnel to serve at the maximum once a month and regional personnel once each three months at most.*
In scheduling the visits priority would be given to those centers just beginning to provide family health services. However during the course of the project it is expected that all centers would receive training from this field team at least once.

If decisions are made to develop a more rigorous schedule by fielding more teams, national level participation could by augmented by additional short-term Senegalese professionals provided under the project technical assistance contract.

c) The schedule would be transmitted to the MOH and the MSD, the regional health team and local centers. The PSF would reschedule as necessary and request the health center to prepare its personnel and the community in advance for the training. PSF should also solicit requests from the health center for any special assistance required. If the center has been in the PSF program for some time a report of performance will be prepared by PSF in advance.

d) Team travel would be arranged and financed by PSF with the team arriving at the health center in time for a planning meeting with the health team in the afternoon of the first day. The following three days would be used for the training. PSF would bring to the training session all IEC material, drugs, contraceptives etc to be provided to the center by the project.

e) Following the training at the health center the PSF would be responsible for the preparation of a report to the health center team summarizing conclusions and recommendations.

f) During the time of this training process, various operations research activities will be carried out by the MOH and PSF to test variations of the service delivery model. The training team will coordinate closely with those doing this research so results can be incorporated quickly into the training.

g) At the end of twelve months this process would be evaluated by PSF, the project technical advisors, the MOH and MSD to determine if continuation was warranted or modifications required. A second training/planning seminar would be required after 18 months.

V. The training at the health center

In the mornings practical training would involve actual demonstrations by the training team and training team participation with the health center team in the provision of services to health center clientele. The afternoons would be reserved for discussions with the health team of technical matters in integrated health service delivery, a review of the practical demonstrations, and discussion of the implications for developing the health team approach to service delivery. At least one evening during the training period should be used for a meeting with the local health committee or for holding a community health education event or open forum for community members.

Flexibility should be maintained for responding to particular interests of the health center personnel. The following subjects are suggested from which the actual training outline could be developed:

A) <u>Examples of subjects for demonstration or practical participation in the morning session</u> (members of health team affected)

1) Formal and informal IEC activities with health clinic clientele on such subjects as breastfeeding, child spacing, understanding subfertility, prevention of MST. Materials used will be those which can be produced at the health center or those available to the health center from the PSF (all members of the health team).

2) Post-partum evaluation of the mother and examination of new borns including counselling on child spacing (nurses and sages-femmes).

3) Demonstration of ORT (nurses and auxilliaries).

4) Plotting and interpreting growth charts, demonstrating their use in nutrition surveillance and as a basis for introducing child spacing concepts (nurses and auxilliaries).

5) Counselling clients on advantages of child spacing; - the advantages, disadvantages and use of various contraceptives (nurses or others who will assist the sages-femmes in family planning activities).

6) Taking history, clinical exam, insertion of IUD (sages-femmes).

7) Dispensing of contraceptives and management of user problems. (Nurses or others who assist sages-femmes).

8) Demonstration of the use of the project records-keeping, filing and logistics systems, preparation of the monthly statistical report, and use of these reports for self evaluations.

9) Counselling clients in infertility (nurses, sages-femmes, social workers).

10) Screening patients for MST, treatment and referral (nurses, sages-femmes and social workers).

11) Developing job descriptions, specific functions and tasks of staff, space utilization, patient flow and scheduling of services (médecin-chef and staff).

12) Projecting utilization of services and coverage targets, planning ways to involve the community (médecin-chef - nurses - auxilliaries)

B) <u>Examples of subjects for presentation or discussion in afternoon.</u>

1) Implications of integration - tug of war or team of health? What do these concepts mean to the personnel present?

2) The impact of child spacing on maternal and child health

- mortality and morbidity associated with age of mother, birth interval and parity;
- traditional views on child spacing in relation to health;
- identification of high risk mothers and prevention of high risk pregnancies;
- health benefits of contraceptives other than child spacing - protection against some types of cancer, reduction of PID and MST -, reduction of anemia;
- prevention of abortion;
- health risks and contra-indications of various contraceptives - means of screening through more careful histories

3) Screening for MST, counselling and methods of treatment available - at the clinic or through referral.

4) Counselling sub-fertile couples - services available for treatment at the clinic - or through referral.

5) ORT in the treatment of diarrhea dehydratation.

6) Review and commentary on morning demonstrations.

7) Case review from morning, especially as related to family planning, MST or sub-fertility.

8) Ways to involve the health center in more community outreach - and collaboration with other development workers.

9) Review of health center service goals and coverage implications.

10) Review of staff roles and responsibilities.

11) Feedback of ways regional and national program can better support the health center team.

VI. Check List for Report to Clinic

The PSF will coordinate the preparation of a report on the training session which will serve as a record of conclusions drawn and a report of clinic needs and recommendations. It will provide recommendations to the clinic for procedural or programmatic changes and be part of the supervisory record.

The kinds of questions to be reviewed are as follows:

(1) Have planned renovations been completed and is proper space, equipment and staff available to deal efficiently with the clients in providing family health services.

(2) Are family health materials and supplies (IEC, contraceptives and MST drugs) available in adequate supply, stored carefully and recorded according to project procedures?

(3) Are family health client records maintained and filed properly and reports accurately completed?

(4) Have job descriptions and role assignments been developed to provide for appropriate integration of family health services with other health services of the clinic?

(5) Is there evidence of mutually supportive effort on the part of health center personnel working as a team to provide service both in the health centers and in the community? Has appropriate coordination been accomplished with MSD and other development agents?

(6) Does the center have service goals and client service levels consistent with public health coverage objectives for its catchment area?

(7) Are there knowledge or skill gaps noted in the health center team for which additional training should be provided?

(8) Are there particular program areas where additional support or effort is required eg. growth monitoring, community outreach, health and family planning information and education, MST or infertility screening or counselling, family planning.

(9) What decisions were reached by the health center team as to any changes in health center organization, objectives or emphases?

(10) What recommendations or requests were made by the health center team for more or different kind of support from the national or regional offices?

(11) What are the recommendations of the field training team growing out of this visit either for the health center operations or for regional or national policy change?

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APPENDIX J

EVALUATION PLAN

EVALUATION PLAN

Summary

The plan calls for three evaluations during the life of the project. The first evaluation at the end of year 2 will be done internally by PSF, MOH, MSD and USAID personnel. This evaluation will review whether all procedures and institutional arrangements are in place for the proper administration and implementation of the project, for example: have arrangements been secured for technical assistance, commodity procurement and financial management; is there coordination between PSF, MOH, MSD and regional health officers; what health center renovation is completed or planned; has there been on-going evaluation in the various sub-sections of the project, etc. Some performance evaluation can also be included, since some service delivery, training, IEC, and demographic data collection will have been initiated.

The second evaluation, will be carried out in year 4 with a local project team and external assistance. The evaluation will continue to review mamagement and administration but will focus more on performance in the areas of service delivery, IEC, training, policy development and demographic data collection. At this time some of the broad issues of program management policy and strategy can also be addressed.

The final evaluation in year 6 will be carried out with more external assistance. It will address performance issues as well as make some initial review of project impact in birth spacing and reducing the percentage of high-risk mothers exposed to undesired or high risk-pregnancy. It will address broad issues of the degree of institutionalization achieved, project sustainability and needs for future assistance.

The evaluations will be based on an initial and fifth year contraceptive prevalence/reproductive health survey, the 1987 census, service statistics of client use and contraceptive flow, quarterly progress reports on government and non-government actions, interviews with government personnel, community leaders and trainees, operations and bi-medical research reports, internal evaluation reports of sub-sector activities, and visits to clinic and project sites.

Evaluation Plan

I. Introduction

The evaluation plan will have elements both of impact and process evaluation. From the outset we know that this project continues a slow evolutionary process helping the GORS make family planning more widely known and acceptable to the population and providing family planning services in a conservative clinic based approach. This will initially have little widespread impact on birth rates and consequently little on the patterns of mortality and morbidity. At this stage exogenous factors, difficult to predict and measure, may indeed have more effect on these variables than the direct impact of the project. Nevertheless it will be important to attempt some measure, however difficult, of the initial impact.

The primary objective of the project is to improve the health of mothers and children through child spacing and other family health interventions.

However, it has been found in other health projects that measuring reductions in infant and maternal mortality and morbidity is difficult and costly. Measuring the differential impact of various health interventions on these variables is nearly impossible. Thus intermediate measures will be used as surrogate indicators of project impact. The number of couples using family planning methods will be one intermediate measure. Other indicators of reproductive health will also be used. Early in the project, a contraceptive prevalence survey with a reproductive health module will include a measure of the percentage of women who have high risk pregnancy. Such indicators will be used as the mothers age less than 16 or more than 35, a pregnancy interval of less than 24 months, parity over 4, or a pregnancy following a previous pregnancy with a poor outcome or without proper health care. The percentage of these "high risk" mothers who know about and have access to family planning methods will be measured. At the end of year five of the project a similar survey will be carried out to determine the percentage of births which are to high risk mothers, and the percentage of these high risk mothers who now know about and have access to family planning methods. Both these surveys will measure the level of family planning knowledge, access and use in the general population and in the regions served by the project.

Those who design the survey will review possibilities of including indicators associated with the interventions in treatment and prevention of sexually transmitted diseases. However, we suspect the cost effectiveness of attempting such measurement will rule this out.

In the area of demographic data collection one measure of project impact will be objectively verifiable - was the census carried out and published in a timely fashion and did a post census survey verify reasonable accuracy and completeness. This information should be available in time for the final evaluation in the sixth year of the project.

Measures of impact in the policy development area will be more subjective and the differences may be more subtle. There may be such evidence of policy change as more forthright statements by government leaders of the importance of demographic factors to socio-economic development. There may even be the articulation of a more formal Population Policy. Welcome as these may be, more important will be indications of budgetary allocations, public information programs and changes in family planning service delivery which demonstrate actions toward implementing a positive Population Policy (or a series of population policies).

Given the nature of the project and its objectives the evaluation must place relatively more emphasis on the process than the impact. This will be especially true of the initial and mid term evaluation but will be the case in the final evaluation as well.

II. Initial Evaluation

The first evaluation, at the end of year two, will be an internal evaluation carried out by representatives of the MOH, MSD, PSF, BNR, Project Technical Assistance contract and the USAID. This will largely be an assessment of the start up process but in this period some specific accomplishments should be measurable. The evaluation will be based on interviews with approriate project leaders, service statistics, supervisory reports and visits to selected clinic sites.

Major emphasis should be placed on such organizational preparatory actions as:

a) Has the resident technical assistance team been posted and established a satisfactory office complex serving the needs of the project? Has the appropriate liaison been established between the team, the PSF and the USAID? Has the team begun to work effectively in providing technical assistance to Senegalese governmental and non-governmental agencies? Has adequate provision been made for logistics support for other contractors/consultants and for trainees? What are the constraints and how can they be minimized?

b) Has the short-term technical assistance and training planned for the BNR been provided on schedule?

c) Have commodities been ordered and received on time? Are procedures for customs clearances, inventory, onward shipment to receipient agency and property control in place and effective?

d) Have satisfactory financial procedures been developed for expeditious transfer of grant funds to cover project costs. Have financial management and reporting procedures been clarified to grantees?

e) Have trainees been selected and enrolled in the appropriate overseas training programs? Are the procedures for handling this process adequate?

f) Have adequate office space and a full complement of personnel been maintained for the PSF?

g) Are adequate personnel made available by the MOH for service delivery at the health centers, as trainers and as trainees in order to achieve the project objectives?

h) Has adequate time been made available on national radio and TV for appropriate informational programs on family health?

i) Have procedures been established for approval and implementation of the "small accompanying projects" of the MSD?

j) Has the project review committee for the non-governmental sector been established and functioning smoothly?

k) Have the field training teams (for health centers) been trained and begun to make clinic by clinic training visits?

l) Is there evidence of appropriate coordination between PSF, DRPF, Health Education Division of MOH, MSD, Regional Health Committees, etc?

m) Are procedures for health center renovation operating eficiently?

n) Have plans been made for operations and bio-medical research?

o) Have the appropriate continuing evaluation procedures been built into the various component parts of the project (i.e. service delivery, IEC, training, treatment of MST and infertility, demographic data collection and policy development)?

There will also be some actual project accomplishments that should be reviewed such as:

a) Timeliness, completeness and accuracy of monthly reporting from health centers in client use and contraceptive flow.

b) The trend in family planning users in centers already in the program.

c) The results of planned PSF training for mid-wives.

d) The number of additional centers renovated and added to the program.

e) The additional training carried out for IEC.

f) The number of IEC materials developed and distributed. The use of mass media.

g) The first contraceptive prevalence/reproduction health survey which should have been carried out analyzed and results published.

h) The provision by BNR for a properly conditioned computer room.

i) The schedule of activities preparatory to the census and the finances being made available by the GORS and other donors.

The review of the kinds of questions listed above should lead to recommendations for remedial actions as necessary.

.CID.

III. Mid project evaluation

The mid project evaluation (year 4) will have external consultants to assist an internal review board composed as indicated for the first evaluation. Assistance will be required for (a) review of service statistics and contraceptive supply (CDC), (b) clinical practice (ACNM), (c) census (BUCEN).

While still a process evaluation and still concerned with procedures this evaluation can focus much more on performance. This evaluation will be based on:

a) Interviews with project leaders, national and regional officials of MOH and MSD, community leaders, and trainees;

b) Review of quarterly progress reports;

c) Review of service statistics and commodity flow;

d) Review of self-evaluation of training courses and other components such as IEC, MST/infertility, and demographic data collection.

e) Review of progress reports from operations and bio-medical research;

f) Review of program and evaluation reports of non-governmental sector projects;

g) Review of short-term T.A. consultant reports;

h) Visits to selected clinics and to non-governmental organization project sites.

An initial review will be made of progress in implementing the recommendations of the previous evaluation which largely dealt with establishing proper procedures. Some of the same issues will no doubt require further review.

The major objective of the evaluation will be to review progress in achieving the service delivery, training, IEC, census and policy development target as outlined in the P.P.

Questions of a more general, program policy nature will also be addressed such as:

a) Does the program strategy of consolidation in six regions followed by expansion to the other four regions with a growing emphasis on making family health services available at the health post and health "case" still seem valid?

b) Has there been appropriate review of modifying the protocols for family health delivery to involve nurses and auxiliary workers more directly in dispensing contraceptives?

c) Does the existence of a separate "national cell" for PSF still serve a valid function? Is this an effective adjunct to the MOH and MSD in stimulating and supervising project performance?

d) Is the relative emphasis on governmental and non-governmental sector activities appropriate?

e) Is the level and kind of technical assistance planned still appropriate?

f) Do the results of project performance and/or operations research indicate the need for changes in the kind of training, supervision, personnel levels, IEC activities?

The recommendations of this evaluation should address both the broad issues of program policy and specific elements of project performance.

IV. Final evaluation

The final evaluation will be carried out early in year 6 in time to give recommendations to the GORS and external assistance agencies for ways to respond to future needs of the population in terms of family health information and service.

The evaluation will be carried out by the same kind of team as the mid-project evaluation. The technical assistance contract team, however, will not participate and a consultant in the area of the planning and organization of population/family planning programs will be added to the team.

The same tools will be available to the evaluation team as at mid-project. In addition there should be results from operations research projects and the results of the 5th year contraceptive prevalence/reproductive health survey.

As noted in the introduction, elements of impact analysis can be introduced into this evaluation, However, there will still be considerable emphasis on performance in reaching the specific project output targets as outlined in the Project Paper.

Several broad issues will need to be addressed in addition to the questions noted above:

a) Has this project produced the institutional strength (especially in training institutions and clinical facilities) capable of carrying forward an effective program of family health in the future - What additional assistance is required?

b) Has the service delivery protocol evolved sufficiently to assure the population is provided easy access to appropriate quality service? For the future what additional service delivery models should be considered?

c) For future activities, is any reorganization of the inter-ministerial cooperative action required?

d) For any future activity could any different emphases between the governmental and non-governmental sector be required?

APPENDIX K

RECOMMENDATIONS FOR CONDITIONS PRECEDENT AND COVENANTS

April 1, 1985

HPNO, Sara Seims

RECOMMENDATIONS FOR CONDITIONS PRECEDENT AND COVENANTS

Recommendations for Conditions Precedent and Covenants

1) Conditions precedent

I recommend you include only the standard bureaucratic requirements about signatures required, bank accounts to be opened etc. The Program Office and Controller can stipulate what they should be.

2) Covenants

I suggest the following covenants be included in the agreement, they be called to the attention of the GORS in the first project implementation letter and that progress in carrying out these covenants be reviewed and commented on as appropriate in suceeding project implementation letters. Wording should conform to the format of other grant agreements but the substance is as follows:

(a) The government of Senegal will detach the requisite numbers of personnel from the Ministry of Health, Ministry of Social Development or other to appropriately staff the National Planning Office of the Project Santé Familiale.
The full-time personnel required are a director, a deputy director, a director and deputy director of IEC, a director and deputy director of clinic service, an accountant and assistant and a logistics supervisor. An obstetrician-gynecologist will be provided part-time
Notwithstanding the fact that the project will pay the salaries of these personnel for the first two years, their salaries will be paid by the Government of Senegal in subsequent years.
The project will pay the cost of travel and per diem whenever these personnel travel in Senegal or outside the country to carry out agreed upon project functions.
The Government of Senegal will continue to provide office space for this team and two technical assistants contracted by the project.
The National Planning Office of the Project Santé Familiale will be maintained throughout the life of the project or until USAID and the GORS agree that a different management organizational structure would be more effective.

(b) The GORS, through the Ministry of Health and the Ministry of Social Development, the School of Sages-Femmees and the School of Nursing, will make requisite personnel time available to carry out the training, supervision, family health service delivery and informational programs planned in this project. New personnel are not required and the activities will be integrated into the ongoing work of training institutions, regional health teams, health center health teams and motivational/educational personnel of the Ministry of Social Development. However, clear directives should be promulgated by these two ministries to their several administrative levels clarifying the requirement that personnel fulfill the expected role in family health. Additionally, lead persons will be identified at each of the participating health centers and health posts who will receive the requisite training to supervise the provision of family health service by the center or post health team and carry out the special logistics and service statistics requirements of the project. In most cases this means that two nurse midwives in each health center will have this responsibility part-time as will one nurse in each health post.

(c) The Ministry of Health, through its relevant technical offices, will continue to review its procedures and standards for the provision of different kinds of contraceptives. This review should assure that appropriate medical standards are maintained while making contraceptives readily available in a way to minimize inconvenience to clients. The Government of Senegal will covenant that none of the funds provided by AID will be used to perform abortions or to promote abortion as a means of family planning. The government will further covent that there will be no coercion of any kind and that all use of family planning methods will be voluntary action of the persons involved. The Ministry of Health by Dec. 1, 1986 and Dec. 1, 1988 will provide a report to USAID of its review of these matters.

(d) The Government of Senegal, through the Ministry of Information and Culture, the Ministry of Health and the Ministry of Social Development will make time available on national and regional radio or TV for government or non-government organizations to provide informational programs on family health and to inform the public of the locations where family health service is available.

(e) The Government of Senegal, through the Ministries of Health and the Ministry of Social Development, will name two representatives to the non-governmental project review committee of the Family Health and Population project. These representatives will be named before Jan. 30, 1986 or another date agreed to in writing by USAID. They will be empowered to represent these ministries in developing policy for this committee and in voting on project approval during bi-monthly review meetings.

(f) The Government of Senegal, through the Ministry of Health and the Ministry of Social Development, will select trainees for the training programs sponsored by the project from among those persons who are or will be working in the regions or centers where project activity are or will be carried out. These trainees will continue to receive government salary during their training program and will be continued in their present or a more responsible position where they can put to use the skills obtained.

(g) The Government of Senegal through the BNR, will provide climatized space before the computers are delivered for the project.