M ENT
3530A
PD-AAW-733
ISN 53062

VOLUME I

PROJECT PAPER AMENDMENT NUMBER 1

RURAL HEALTH SERVICES DEVELOPMENT PROJECT

(NO. 685 - 0210)

USAID/SENEGAL
BP 49
DAKAR
September 1980

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE: C (A = ADD, C = CHANGE, D = DELETE)

PP

2. DOCUMENT CODE: 3

3. COUNTRY/ENTITY: SENEGAL

4. DOCUMENT REVISION NUMBER: 1

5. PROJECT NUMBER (7 digits): 685-0210

6. BUREAU/OFFICE: A. SYMBOL: AFR; B. CODE: 06

7. PROJECT TITLE (Maximum 40 characters): Rural Health Services Development

8. ESTIMATED FY OF PROJECT COMPLETION: December 31, 1982 FY 83

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY 77; C. FINAL FY 80; B. QUARTER (Enter 1, 2, 3, or 4)

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1 –)

A. FUNDING SOURCE	FIRST FY B. FX	FIRST FY C. L/C	FIRST FY D. TOTAL	LIFE OF PROJECT E. FX	LIFE OF PROJECT F. L/C	LIFE OF PROJECT G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	(226)	(268)	(494)	(1,248)	(2,071)	(3,319)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S. 1. Peace Corps	12		12	81		81
OTHER U.S. 2.						
HOST COUNTRY		60	60		1,535	1,535
OTHER DONOR(S)						
TOTALS	238	328	566	1,329	3,606	4,935

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 77 F. GRANT	E. 1ST FY 77 G. LOAN	H. 2ND FY 78 I. GRANT	H. 2ND FY 78 J. LOAN	K. 3RD FY 79 L. GRANT	K. 3RD FY 79 M. LOAN
(1) SH	590	510		494		999		949	
(2)									
(3)									
(4)									
TOTALS				494		999		949	

A. APPROPRIATION	N. 4TH FY ___ N. GRANT	N. 4TH FY ___ O. LOAN	Q. 5TH FY ___ R. GRANT	Q. 5TH FY ___ S. LOAN	LIFE OF PROJECT T. GRANT	LIFE OF PROJECT U. LOAN
(1)		877			3,319	
(2)						
(3)						
(4)						
TOTALS		877			3,319	

12. IN-DEPTH EVALUATION SCHEDULED: MM 11 YY 81

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 = NO
2 = YES

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: David Shear

TITLE: Director USAID/Senegal

DATE SIGNED: MM DD YY

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (3-78)

PROJECT PAPER AMENDMENT OUTLINE

VOLUME I.	PAGE
I. SUMMARY AND RECOMMENDATIONS	1.
II. PROJECT DESCRIPTION	3
A. BACKGROUND	3
B. GOAL AND PURPOSE OF REDESIGNED PROJECT	7
C. PROJECT OUTPUTS	8
D. SUMMARY OF AID INPUTS	9
E. DESCRIPTION OF REVISED PROJECT	11
1. PROJECT STATEGY	11
2. GEOGRAPHIC SCOPE	12
3. TRAINING	13
4. TECHNICAL ASSISTANCE	16
5. PROJECT STAFFING AND TRANSPORTATION	17
6. MEDICAL RESUPPLY SYSTEM	17
7. FINANCIAL SELF SUFFICIENCY	18
8. EVALUATION AND HEALTH SURVEY DATA	19
9. PROJECT MANAGEMENT	19
III. PROJECT ANALYSIS	20
A. TECHNICAL ANALYSIS	20
B. SOCIAL ANALYSIS	23
1. SUMMARY AND CONCLUSION	23
2. VILLAGE PARTICIPATION	24
3. SOCIO-CULTURAL CONSIDERATIONS	24
4. SPREAD EFFECT	26.
5. BENEFICIARIES	27
C. ADMINISTRATIVE ANALYSIS	28
1. BACKGROUND	28
2. ADMINISTRATIVE WEAKNESSES OF PROJECT	29
3. PROJECT ADMINISTRATIVE CHANGES	30
4. ROLE CLARIFICATIONS	31

.../

D. ECONOMIC ANALYSIS 37

1. PROJECT COSTS 37
2. PROJECT BENEFITS 37
3. PROJECT COST-EFFECTIVENESS: COMPARISON WITH POSSIBLE ALTERNATIVE 39

E. ENVIRONMENTAL ANALYSIS 46

IV. FINANCIAL PLAN 47

V. IMPLEMENTATION PLAN 56

A. COORDINATION OF ACTIVITIES 56
B. PROCUREMENT PLAN 57
C. SCHEDULE OF ACTIVITIES 58
D. PROJECT IMPLEMENTATION REPORT OUTLINE 63

VI. EVALUATION PLAN 66

VOLUME II

ANNEX

1. LOGICAL FRAMEWORK MATRIX 1 - 1
2. STATUTORY CHECKLIST 2 - 1
3. WAIVER JUSTIFICATION 3 - 1
4. TRAINING PLAN 4 - 1
5. SCOPE OF WORK 5 - 1
6. MOH AUTO-FINANCEMENT GUIDELINES 6 - 1
7. PRIMARY HEALTH CARE PROJECT IN SENEGAL 7 - 1

SUMMARY AND RECOMMENDATIONS

A. Country : Senegal

B. Project : Rural Health Services Development (685-0210)

C. Funding : 3,319,000 life of project funding fully obligated $ 1,600,000 being reprogrammed.

D. Life of project : Project Assistance Completion Date extended to December 31, 1982.

E. Waiver : 1) Purchase of mobylettes and replacement vehicles from Code 935 for $ 187,000

F. Conditions : Continuing Government of Senegal provision of personnel and policies for supervision and establishment of drug resupply system.

This Project Paper Amendment (PP) reprograms $ 1.6 million in undisbursed funds remaining out of the $ 3.3 million life of project funding obligated for the Senegal Rural Health Services Development Project (N° 685-0210). By postponing the expansion of the project into the Department of Kaffrine and reprogramming the remaining project funds for continued and new technical assistance, training, commodities and operating support to the existing system in the Departments of Nioro, Kaolack, Gossas and Foundiougne, this amendment makes major managerial and structural changes in the project in accordance with the recommendations of the Project Impact Evaluation Report of April 1980. All changes recommended by this amendment were reviewed with the Government of Senegal during a series of meetings which included the Ministry of Public Health, the Secretariat d'Etat à la Promotion Humaine and the Governor of the Region of Sine Saloum. Thus, this amendment provides a technically sound revised project and a clear implementation plan which is understood by all USAID and Government of Senegal project personnel.

This amendment will assure the achievement of the Project purpose (which is to assist the Government of Senegal to develop a delivery system for the provision of health services to the rural population of the Sine Saloum Region) by making the network of village health huts financially viable and self-sustaining and by improving the Government system of technical supervision and medicine resupply for the health huts.

.../

The major elements of the redesigned project are :

A. A new management structure including better (1) delineation of responsibilities and coordination of activities among USAID, the Ministry of Health and other technical services ; (2) improved and more regular supervision of health huts by health post nurses, sanitation agents and Promotion Humaine agents and; (3) closer monitoring and better reporting on project activities.

B. Additional training for village management committees and retraining for village health workers;

C. Improvements in the drug resupply system

D. The gradual phasing in of several new preventive health measures concerning malaria prevention, measles vaccinations, and environmental health.

E. Evaluation of project activities after one year and two years of implementation.

A waiver is requested for the amount of $ 187,000 to permit the purchase of replacement vehicles and mobylettes from Code 935 (Special Free World) sources.

A revised Project Agreement shall be signed by AID and the Government of Senegal. The Government of Senegal will convenant to establish certain policies for supervision and medicine resupply and to provide in-kind project support of personnel and operating costs necessary to successfully complete the project. The disbursement of AID project funds will be conditioned upon the provision of this support./-

II. PROJECT DESCRIPTION

A. Background

The Sine Saloum Rural Health Project was initiated by a grant of $ 3.3 million from AID to the Government of Senegal in August 1977 and had as its stated objectives to :

1. Establish a network of 600 village health posts staffed and supported by 1800 community level personnel in 6 departments of the Sine Saloum Region.

2. To improve and strengthen the support infrastructure of the Government of Senegal for services to health centers.

The health huts were to be equipped with basic drugs needed to treat the major illness of the region. Medicine and services were to be paid by the villagers. The health huts were to be built by villagers through a network of management committees and rural community councils.

At the start of the project, the health delivery system was described as suffering from a number of serious constraints :

1. Inadequate numbers of trained MOH and Promotion Humaine personnel;

2. Lack of supervision troughout all levels of the health delivery system;

3. Inadequate numbers of rural health posts;

4. Inadequate supply of essential basic drugs and long delays in their procurement;

5. A generally weak logistical system;

6. Poor system of transportation for supervision, monitoring and patient referral;

7. Inadequate funding allocated in general to the health sector by GOS.

To eliminate these constraints, the Sine Saloum project was to provide the following :

1. Construction, Equipment and Supplies;

. Renovation of 58 existing health posts, construction of 15 new health posts,

.../

and renovation of the Khombole School of Sanitation.

. Equipment for 79 existing and new health posts,

. Equipment and initial medicine stocks for 600 health huts,

. Financing for 17 vehicles, 76 horses and buggies, audio-visual aids, literacy manuals and teaching materials.

. Financing of cement and materials for construction of 600 health huts.

2. Training

. In service training program for village health workers and their supervisors.

. Literacy training by Promotion Humaine for Rural Community Council Members.

. Short term technical assistance in training designs , extension work and curriculum development at Khombole School.

. Training stipends for 40 sanitation students at Khombole School.

. Expenses for Village Health Workers (VHWs) during training.

3. Evaluation

. Baseline data survey for subsequent project evaluation.

. Funding of independent evaluation team.

4. Technical Assistance;

. Funding for long term public health advisors in nurse/midwife training health education, and public health administration.

5. Logistics (travel)

. Funding of expenses for travel for supervision, literacy training and animation activities.

[illegible] through the intended life of the [illegible]ect

and AID joint responsibilities were not established". In the area of management, concerning the selection and remuneration of health workers, the provision of adequate transportation and adequacy of the records system, there were problems yet to be resolved. However, the evaluation report concluded that a reasonably efficient medical supply system was emerging and that "if management and supervision problems can be overcome, the project could have a profound effect on health".

A project redesign team assembled by AID in July-September 1980, addressed the issues raised by this evaluation. Through study of project documents, prior reports and evaluations, on-site interviews with health administrators and workers at all levels, visits to health facilities from regional level to village huts, the redesign team confirmed the conclusions of the impact evaluation team.

They cited as major problem areas of the project :

1. Planning and Implementation

   a. Project too ambitious in scope and size

   b. Poor selection of sites for village health huts.

   c. Pace of implementation too rapid to properly organize and train village health committees and to develop health infrastructure that would adequtely support the system.

   d. Health huts currently not financially viable.

2. Management and Supervision

   a. Lack of AID management and control

   b. Lack of supervision and technical support for Village Health Workers,

   c. Baseline health survey not done at project inception resulting in inability to adequately evaluate health services provided.

3. Training and Personnel

   a. Inadequate training for MOH and Promotion Humaine staff especially with regard to :

      a. community organization for village health,
      b. function of village committees;
      c. skills required of VHWs.

.../

b. Inadequate preparation and training of villagers and health committees and lack of training materials.

c. Poor selection of VHWs who are often not committed to the project and to the community.

d. Pooly defined roles and responsibilities of key project personnel AID and MOH.

e. MOH delays in providing agreed upon personnel (Health Post Nurses, Sanitation agents).

f. Hygienist underutilized, not respected and represents a financial drain on the villages.

4. Logistic Support

a. Inadequate transportation for supervision and support of village health workers.

b. Lack of functional medical resupply system reaching down to the village level.

5. Coordination

a. Lack of coordination and communication between MOH and Promotion Humaine at national level to guarantee necessary support for the animation/ community development efforts at regional and departmental levels.

The culmination of the redesign efforts was the establishment of a joint redesign team of USAID, MOH, Promotion Humaine and CILSS (Permanent Interstate Committee for Drought Control in the Sahel), officials which reviewed the preliminary proposals for the redesign project and presented final recommendations to the Minister of Health and USAID Mission Director. A principal aspect of the redesign project limits the project to the four existing departments of Kaolack, Foundiougne, Nioro and Gossas, specifically, the project will focus on 20 Rural Communities and selected villages in those rural communities..Significant revisions will also be made in the arrangements for staffing, training and supervision; in selection, compensation and motivation of village health workers; in data collection and reporting mechanisms; in the development of medical treatment protocols; in the drug resupply system; in the provision of transportation; and in external technical assistance. It also seeks to improve overall coordination of the project particularly between AID and the Ministry of Health and between the Ministry of Health , Promotion Humaine and the field project headquarters staff.

.../

Additional specific recommendations for the revised Sine Saloum Rural Health Project are stated in the following detailed description.

B. Goal and Purpose of Redesign Project

1. Goal. The project goal remains essentially the same i.e., to improve the level of health among the rural population and to establish a prototype health care delivery system appropriate to the social and economic conditions of the rural population of Senegal.

2. Purpose. The project redesign will facilitate achievement of the original project purpose which is to : a) establish a network of village health huts which are staffed and supported by community level personnel in the region of Sine Saloum and b) to improve and strengthen the support infrastructure of the Government of Senegal (GOS) for providing support services to the village health system.

The thrust of the redesign project will continue to be the development of a self-sustaining village-based health care delivery system. To eliminate many of the constraints revealed by recent evaluations of the project :

- A new time-frame for the project which assumes a scaling down of the quantitative outputs anticipated;
- An improved data collection and reporting system;
- A training system which begins with improvement of the capacity of trainers of all health personnel to provide skills specifically related to the major health problems of the Sine Saloum region and which also prepares the village health committees to plan and manage health services;
- A streamlining of the functions of village-level health workers with the emergence of only two types of workers, the traditional midwife or matrone for maternal and child programs and a first aide-sanitation worker or secouriste-hygieniste to provide general primary health care, preventive health services and environmental sanitation to the village population;
- A sounder logistics system for drug resupply ;
- More appropriate means of modern transportation for supervision, support referra- and project monitoring;

.../

. A carefully delineated . network for supervision and project management which depends upon careful structuring of the coordination role at the Ministry level, improvement in external technical assistance and frequent convening of health professionals at various levels of the regional health network and periodic evaluation of the project ; the initial network will be concentrated for training and intensive support activities in selected villages of 2C rural communities;

. The introduction of preventive health measures against primary health problems of malaria, measles and childhood diarrhea, which will be integrated into the existing primary health care structure after village health committees are prepared to manage such efforts.

C. Project Outputs

At the end of the project period, the following conditions will indicate progress toward achieving the purpose of the project :

. A health management information system will be in place that will facilitate on-going monitoring of the accomplishment of health objectives.

. A village health committee will be operating in selected villages in 20 designated rural communities, in the departments of Nioro, Kaolack, Gossas and Foundiougne.

. Each such village health hut will ahve a trained secouriste-hygieniste and a matrone.

. Approximately 1200 village health workers (VHWs) will have received preliminary training and refresher courses.

. Approximately 600 VHWs will have been cross-trained to serve as combination secouriste-hygieniste.

. Approximately 50 Ministry of Health, Promotion Humaine and Peace Corps personnel including health post nurses will have received special training in community organization, health services management, supervision, primary health care, and pedagogic principles.

. Approximately 40 graduates of the Khombole School of Sanitation will have received orientation and retraining in primary health care, health education techniques and community organization.

.../

. A Senegalese Project Coordinator will be trained in all aspects of project Management, including planning, organizing and evaluation.

. Basic protocols will be developed for malaria suppression, vaccination, oral rehydration, basic sanitation and miscellaneous health education activities.

. A total of 8 new health posts will have been constructed, staffed and equipped.

. A total of 51 health posts will have been renovated.

. Departmental drug storerooms will have been constructed in the four departments.

. An adequate transportation system, including vehicles, mobylettes and horses and buggies and provisions for adequate maintenance will be supporting continuing supervision, retraining and medicine resupply.

. A medical and drug resupply system will be servicing all the health huts; a supplementary supply of medicine and drugs will have been provided from the U.S. and stored for distribution as needed to assure adequate stocks in health huts.

. A streamlined data collection and reporting system, including a health surveillance system, will have been established.

D. Summary of AID Inputs. (from original project conception to end of project)

. Construction, equipment and supplies

1. Financing of renovation of 51 existing Health Posts,

2. Construction of 8 new health posts

3. Renovation of the Khombole School

4. Equipment for 59 existing and new health posts.

5. Equipment, initial stock of medicines and resupply stock for 400 health huts.

6. Financing of purchase of 21 light vehicles.

7. Financing of purchase of horses and buggies.

.../

8. Financing of purchase of 78 mobylettes

9. Financing of 4 small boats

10. Financing of purchase of audio-visual kits

11. Financing of publication of 3,000 VHW manualsand 1,200 Village Health Committee manuals.

12. Financing of literacy and teaching manuals

. Logistics and travel

13. MOH and PH expenses for training trips

14. Transportation of equipment and medical supplies.

. Training

15. Expenses for orientation, in-service and retraining program executed by MOH, Promotion Humaine, Peace Corps and AID Technical Advisors for Village Committees, Village Health Workers, MOH and other training staff and Khimbole Shool graduates.

16. Training stipends for 40 students at Khombole.

. Evaluation

17. Financing of management information system, including health surveillance mechanisms.

18. Costs of independent evaluation team.

. Technical Assistance

19. Public Health Advisor (nurse/midwife training specialist) based in Kaolack

20. Public Health Advisor (community organization and health education based in Kaolack.

21. Public Health Advisor (administration) based in Dakar.

.../

22. Short-term technical assistance in community development and organization, data analysis and management, drug resupply administration, design of training methodologies and materials, development of clinical protocols and other as needed.

E. Description of Revised Project

It is apparent that villagers do not understand the self-financing concepts that are critical of the survival of the health huts. Village committees have not been trained to organize and involve the community nor to plan and manage a self-governing, self-supporting health service. Improvements must be made in the selection and training of health workers, in their supervision and in their support through an improved drug resupply system and more appropriate transportation. In depth training in health hut management and community organization must be provided to key project staff, who perform the sensitivization or the village organization effort who train the Village Health Committees, and who prepare the village health workers for their primary health care tasks. This staff includes personnel from MOH at regional, departmental and health post units, Promotion Humaine, the AID-funded project office and Peace Corps Volunteers.

1. Project Strategy

The strategy of the revised program is to thoroughly prepare the major agents of change to perform their intended functions. Therefore, the emphasis is on training and retraining of existing MOH, Promotion Humaine and AID project staff and Peace Corps Volunteers to equip them with the skills and capabilities required and to understand what each level in the health pyramid is intended to accomplish. In the following pages the specific changes in the project are discussed. The key ingredient in all of these in closer cooperation and collaboration among AID, the MOH, and Promotion Humaine.

The revised project inputs are designed to achieve three vital objectives which were cited by the recent AID Impact Evaluation Team report. The report concluded that for the project to survive :

a. Health huts must be financially viable;
b. The Government and AID must deliver adequate support and supervision;
c. An efficient medicine resupply system must be organized.

Under this proposed redesign, villages will be more thoroughly prepared through a process of making the villagers aware of their potential for participating in the development of health services. They will be taught to assume substantial role in planning and managing a self-governing, self-supporting health service. Each village health hut, ideally, will become an autonomous, financially independent entity, and will maintain its working capital established initially by the "seed funding" given in the form of resources for certain materials, drugs, and training assistance.

.../

2. Geographic Scope

Assessment of the present quality of project implementation indicated that an overly ambitious program was launched within an unrealistic time frame. Consequently, the project failed to produce the planned services to develop the necessary health infrastructure. To remedy this, the redesign project places limitations on the expansion of the project to other departments of the Sine Saloum region. Until village level health services are viable in the present of departments of Kaolack, Nioro, Foundiougne and Gossas, USAID will not finance any primary health activities in the Department of Kaffrine. However, renovation of health facilities in Fatick, called for in the original project design, will be completed; this action is not dependent upon the quality of services achieved elsewhere and will assist in the development of a viable project in Fatick, which is primarily financed by Holland.

To achieve project objectives, it is planned to make the most of the existing situation. The task is to analyse the distribution of existing health huts into manageable units and focus available resources following the approach of more successful projects in other Senegalese locations including the Belgian project in Pikine and the Dutch project in Fatick. The project will select 4 or 5 villages in each of 20 rural communities in which to concentrate activities during the first year of the revised project. Intensive orientation training and supervision will be given these selected villages, while some level of support for the others will be maintained. Concentrating project efforts in a limited number of villages makes the job of strengthening health services more achievable.

One Khombole School graduate will be placed in each of the twenty rural communities and will receive intensive training, support and supervision from the project staff and local MOH and Promotion Humaine technicians. These Khombole graduates will work with the health post nurses and devote their effort to :

1) developing sanitation projects,
2) training the health workers,
4) training the village management committee in health hut management and
5) providing health education.

As the health huts in each rural community reach a level of effectiveness and gain the confidence of the villagers, new health services can be introduced through the health posts and health huts, including the provision of preventive health measures such as the vaccination of children against communicable diseases and malaria suppression.

.../

One half of the rural communities will receive intensive support during the first year because of the limited manpower available. The remaining half will receive improved support and management training during the second year, through the addition of twenty new Khimbole graduates.

It is evident that many health huts have failed or faltered due to their location. Some are too close to other huts or to the health post where free care has been provided. As a result, many health huts have not attracted nor maintained an adequate patient load. Others are serving too small a population and have insufficient revenue for this reason. This factor of location is to be reviewed to attempt a more rational distribution scheme. In the process some huts will be eliminated or moved to more favorable locations.

3. Training

In the revised project, four levels or training and education activities will be provided.

a) the training and/or recyclage of the VHWs. The first aid man and the sanitarian will be combined into one skilled health worker, a secouriste-hygieniste.

b) the training of members of the village health committee in the administration and management of the health huts.

c) The training of Ministry of Health, Promotion Humaine, AID and Peace Corps Volunteers in community organization and the management of village health huts.

d) the orientation and supplementary training of the Khombole School graduates who will be assigned to work in the region of Sine Saloum.

Some of this training has already been done during the first three years of the project. An assessment of the village health services system in the region indicates that the villagers are not sufficiently knowledgeable of the operation of a village health hut. Therefore, modifications in the existing training program and the development of new training components will be added. The major emphasis of the training component will be on community development and management of the health hut (see training plan in Annex 4).

.../

a. Training of VHWs

Initially three types of health workers, a first aid person, birth assistant and sanitarian, were trained to work with each health hut. Experience over the past two years has shown that (1) Villages cannot support three full-time health workers and that (2) the impact of the sanitarian has been minimal, resulting in a significant attribution rate among sanitarians.

As a part of the retraining of VHW's in Nioro, Kaolack, Gossas and Foundiougne, the project will retrain the first aid men in sanitation activities and sanitarians in first aid.

Required cross-training will be done through both on-the-job experience and formal retraining sessions. It is anticipated that VHW's will also attend day long refresher courses at the health post at least four times per year.

Included in this on-going supplementary training will be :

- problem solving
- clarification and simplification (in some cases) of VHW tasks
- introduction of an improved data retrieval system
- basic preventive health protocols and work plans

b. Training of the Village Health Committee.

A major weakness of the project to date is the lack of village participation in the health care system. To encourage this participation, the project will finance an extensive community development effort. A major component of this community development effort is training. Members of the village health committees will be trained in the management and administration of the village health hut. A few of the topics which will be covered in the training curriculum are :

- the role and responsibilities of the village health committees.
- Village health needs assessment; that is, what are the major health problems at the village (s) and how can they be addressed.
- Record keeping
- Simple accounting procedures
- Financing of health services. That is, how to determine fees, reimbursment mechanisms for the health aides, and methods for the collection of revenues and disbursement of funds.
- Drug resupply
- Health education for the village.

.../

Course materials, on the management of a village health hut, similar to the aide-memoires and training guides used to train the VHWs will be written in Wolof.

c. Training of Promotion Humaine and Ministry of Health Personnel

Individuals responsible for training the village management committees will come from Promotion Humaine and the Ministry of Health and will be assisted by the USAID technical advisers. They will work together in a team in these organization and training activities.

The training of the GOS departmental officials will be given by the USAID technical advisors and GOS Health and Promotion Humaine. The curriculum for this training course will include :

- Community organization
- Role and responsibilities of the village health committees.
- Technical aspects of managing the village health huts including simple accounting and bookkeeping, determining fees, collection of revenues and disbursement of funds, reimbursement mechanisms of VHWs, hours of service, drug resupply system, and maintenance of the health hut.
- Primary health care
- Health Education
- Political and administrative institutions developed by the Administrative Reform;
- Principles of Pedagogy
- Supervision and follow-up

The training program will include both classrooms and on-the-job training. Course materials will be financed by USAID.

d. The Orientation and Retraining of the Sanitarian Graduates from Khombole.

Additional manpower for this project will come from the forty sanitation graduates of the Khombole School who will be assigned to the region of Sine Saloum. These graduates will be assistants to head nurses of the health posts.

.../

They will assist in the training and supervision of the village health workers in health hut, management practices and development of projects to improve environmental sanitation. The Khombole curriculum has already provided them with the knowledge of rural sanitation. To assist the nurse and the departmental staff of Promotion Humaine, however, the Khombole graduates will receive additional training in health education, and community organization, and health hut management.

This retraining will be done in two phases. The first phase will consist of a general orientation to the Sine Saloum Rural Health Project. After the orientation, the Khombole graduates will spend several months working directly with the health post nurses and VHWs while living in the rural community. This will provide the Khombole graduates with an understanding of the village primary health care system. A supplementary training session will be given at the end of several months. This training program will include both community development and primary health care components, including the administrative and financial management of a village health hut. All of the Khombole graduates will be trained together at a central location.

5. Technical Assistance

Criticism of the present adequacy of AID technical assistance concentrates on the failure to respond appropriately to technical requirements and to integrate advisor services into the staff requirements at all levels. Specific assistance is required in three new areas : (1) training in data gathering and analysis, (2) community organization and (3) drug resupply (see Annex 5 for scopes of work for technical assistance). In the first area, assistance will focus on the area of health and management statistics where expertise is needed at each reporting unit level to collect,collate, analyse and present vital statistics and program information in formats which will assist in monitoring the progress of the project, relate project inputs to outputs, and enable more effective decentralization of project management.

In the second area assistance will focus on improvement of training activities and the development of relevant training aids and manuals. A major form of this assistance will be designing and providing direction for the development of a training effort to train trainers. This is necessary for not only improving health care but also for the development of village organization activities to improve village participation in the health system.

For the third areas, technical assistance will be provided to help design and organize a medical supply system, reaching to the health hut level.

.../

6. Project Staffing and Transportation

As part of the revised project MOH has appointed a project coordinator in Kaolack. A senior Ministry technician had also been assigned to collaborate with USAID program officer and to monitor the project at the national level. With the creation of these positions, the input of 20 graduates from the Khombole School and the staffing of understaffed and unstaffed health posts in the region, the Ministry of Health should have the capacity to provide effective project supervision and support.

To enable this supervision and support to work effectively, the redesign calls for the provision of a mobylette to most health posts in Kaolack, Nioro, Gossas and Foundiougne to increase the capability of health post staff to support the village workers through more effective monitoring and supervision. MOH or Health Post staff will provide for maintenance and operating costs. These mobylettes will supplement the horses and buggies earlier given to each rural community to support project activities. During the evaluation and subsequent follow-up of finding by the redesign team, the suitability of horses and buggies for transportation of health post nurses was frequently questioned. Most supervisory personnel were in favor of the provision of mobylettes, as appropriate, economical and sustainable means of transportation in all but the island zones of the region.

7. Medical resupply system

A systematic review of both public and private drug resupply systems at all levels will be performed and an improved system recommended in the redesigned project. Short term technical assistance will be employed to perform a study which will result in a simplified inventory control and reorder cycle which can be managed by village health committees. It is suggested that a revised list of drugs may be needed, using more economical drugs, which are produced in Senegal and which are more appropriate to the actual health problems of the Sine Saloum.

Certain characteristics of an ideal drug distribution and resupply network are already evident and should become part of the new system. It is clear that AID should more closely control the initial distribution of drugs and provide technical assistance in such areas as design of new forms for purchase orders, inventory controls, etc. Any drug resupply system must be kept simple; the experience of the Dutch project at Fatick is to be used as a model for methods of record-keeping appropriate for illiterate workers.

.../

A network of Government drug depots at regional and departmental levels is to be constructed.

It will be necessary for AID to purchase a new supply of drug under the revised project to recapitalize depleted health hut inventories. This should be done for all huts, not just for the failures.

8. Financial self-sufficiency

In addressing the problem of financial viability, and self-sufficiency, it is critical that village committees and rural community councils understand the true costs of drugs and services (including purchase price of replacement drugs, transportation charges, inflation rates, mark-up due to overhead and subsidies incurred by providing care for the medically indigent). The village health committees will be made aware of the available financial options during training and follow-up visits.

The concept of "self-sufficiency with self-support" is not intended to independence of the health huts from the rest of the regional health delivery While self-financing (auto financement) is an ideal administratively, and in fact stic accomodation to the scarcity of outside resources, the village health st depend on close linkages with the rural community and the health posts ide the professional and technical support to assure quality services. ly scheduled supervisory visits of higher level health personnel and the ice training must be sustained for the health hut system to survive. Likewise health committees are dependent upon the combined efforts of MOH and on Humaine trainers to teach them how to plan and manage their own health .

9. Evaluation and health survey data

A major emphasis in the project design will be the installation of an internal evaluation system. On-going monitoring of the project will be based on a work plan to be drafted by a binational project team and keyed to the revised logical framework for the project. Principal points to be covered in the evaluation plan will be the development and attainment of project objectives; a plan for supervision and the assignment of responsibility for specific project components; provision for evaluating personnel performance; and the development of baseline data which will permit evaluating the impact of the project on specific health indices. One of the first implementation tasks on the redesigned project will be to implement health surveillance mechanisms in those areas where data are lacking.

.../

These data along with data from the project monitoring system will be used as a basis to evaluate the impact of the project on the health status of the rural population. It is not expected that the evaluation system will be a perfect instrument given the scarcity of program data. It should, however, provide sufficient guidance at the end of another year to enable a decision to be made by MOH and AID whether or not to expand the project to other areas of Senegal.

10. Project Management.

Steps have been taken at AID to strengthen the project management capability and insure greater day to day involvement in the coordination and implementation of the project.

In the project redesign, the following is recommended :

a. the development of work plans with clearly defined objectives, a time frame designated and accountability assigned to specific personnel;
b. monthly reports from health post nurses and Khombole graduates;
c. bi-monthly reports on progress against stated objectives; problems encountered, major events, action planned for next reporting period, etc, will be completed by the project staff.
d. regular meetings:

   1. Regional coordination meeting on a monthly basis to include : AID Health Officer/Project Coordinator/AID Technical Advisors/ Promotion Humaine counterpart, Regional Medical Officer and the regional and, departmental supervisors.
   2. National Coordination meeting in Dakar to include : USAID representatives, Project Coordinator and representatives from MOH.
   3. Monthly departmental coordination meetings to include : the departmental Medical Officer, the departmental health supervisors, Promotion Humaine representatives, health post nurses and sanitation agents. The Project Coordinator and USAID technical advisors will attend these meetings whenever possible.

c. Clearly defined responsibilities of health post nurses and sanitation agents which include routine supervision, support and training of VHWs and Village Health Committees.-

III. PROJECT ANALYSIS

A. Technical Analysis

The technical component of the Sine Saloum Health Project has been carefully assessed and it is recommended that it be revised on a phased incremental basis. During the next two years of the revised project, preventive health measures will be integrated into the existing primary health care structure. The initiation of new or revised technical interventions within the village will commence only when the Village Health Committees (VHC) are organized, trained and clearly understand and agree that the tasks involved are of value to them. The implementation of the management and financial component of the Village Health Committee will have been completed prior to introducing new technical tasks.

The Project will however, commence the development of specific technical protocols which define interventions for priority health problems. Malaria, measles and childhood diarrhea complicated by malnutrition are the priority problems most amenable to prevention using available technology. Hence, priority attention during the next year of the project (1980-81) will be given to designing interventions for these problems, in an appropriate and timely fashion.

Current interventions which are ongoing and supported by the population and the health workers in the Sine Saloum such as the treatment of conjuntivities and helminthiasis will be contined.

The clearly expressed wishes of the VHW, if not the population, to have a medicine for belly pain, diarrheas and an antiseptic will be honored. During the course of the project the USAID technical advisors will examine the senegalese use of soap and water as an effective substitute for alcohol in preventing wound infections. The Senegalese preference for paragoric will be included in the formulary. Specifically technical protocols during the next year will be developed collaboratively with the MOH for :

1. Village level chloroquin suppression of malaria in children under 5 years of age and in pregnant females.
2. An infant diarrhea and rehydration program.
3. Immunization of children for DPT and measles between the ages of 9 months and three years. Tetanos toxoid antenatally will administered to pregnant women. The initiation of this effort is dependent upon the project working out the technical protol as part of the GOS Expanded Immunization Program (EIP). The establisment of a "cold chain" will be required prior to commencing this activity.

.../

4. The program will continue to make available:

   a. Iron tablets for pregnant females on demand.
   b. Antibiotics ointments for eye diseases.

In every instance the technical interventions defined will be simple enough to be effected by a briefly trained villager. The project redesign anticipates an expansion of re-training of activities for the VHW's including the new technical interventions outlined herein. Another guilding principle should be that any technical element of a program must be consistent with the national primary health care policy. That still evolving policy in Senegal appears to require that the community pay for all of its own health services. In this context their introducing a vaccination element or a program designed to distribute chloroquin on a periodic basis to a particular target group requires that group either be sufficiently motivated to pay for the vaccine or medicines themselves or that the village agree to underwrite these costs through a system of taxation and pricing of services at the level of the health hut.

5. Health education related to infant feeding.

The project will research and adapt existing material available through WHO, UNICEF, the GOS and others and include them in the village-based health educational VHW training.

6. The project during the next year will utilize the twenty Khombole graduates assigned to Sine Saloum region.

They will work with designated Village Health Committees and health/sanitation workers to develop specific village-based projects to improve water and sanitation. An agreement or "contract" will be developed between the project and the village which specifies what each will do and when to carry out the agreed upon improvement. The USAID and the GOS project staff will monitor and periodically review the progress of these village-based improvement projects.

7. A management information system will be designed and implemented which quantifies the village-based activities.

The system will track drug usage, major problems, costs, revenues, resource allocation and distribution, utilization and productivity. As the technical protocols are defined, the information system will collect longitudinal data for the total targeted populations.

For example, the chloroquin program is planned to include all children under five years of age in each village. The village information system will therefore provide a complete registration of all children under five, a record of their chloroquin dosage, and compliance with the protocol agreed on.

8. The data collected and recorded by the village health workers to data will be analyzed.

Tables will be developed for :
a. drug utilization by problem
b. drug and consultations costs and revenues and trends.
c. problems/diagnosis treated.

On the basis of this analysis an ongoing surveillance system for tracking priority problems will be revised and implemented. The surveillance system will provide the GOS and USAID project management and technical advisors data on an ongoing basis for periodic assessment and evaluation. The project will schedule regular sessions including the staff of GOS, Ministry of Health, Promotion Humaine, USAID and other interested parties to review the project's progress. The quantified data produced by the system and reviewed in these sessions will allow those responsible for the project's execution to assess performance against projected goals and objectives. The following table is illustrative of the type of tables/reports that will be prepared on a regular basis:

	NUMBER PROJECTED	TRAINED AS/OF			
		1/1/80	1/3/80	1/6/80	Y.T.D.
1. Village Health Committee organization training	200	17	35		
2. Village management committee in place	200	8	12		
3. Village Health Workers re-trained	800	216			
4. Drugs available at villages on schedule	100%	35 %	40 %	NO%	
5. Supervision of village workers carried out as planned	100%	60%	65%	80%	

As the technical materials for the specific problems are completed, similar tracking of progress toward implementation will be collected, analyzed and reviewed by those responsible.

B. SOCIAL ANALYSIS.

1. Summary and conclusion.

The village primary health care system, as redesigned, is an effective way of providing for the health needs of the rural poor of the Sine Saloum Region. The project provides an opportunity for testing training methodologies, medical techniques and service systems which may have broader application to other regions of Senegal which have similar social and economic conditions. The project provides the vital linkage between rural village participation in a national system established to provide broad public health services. This linkage uses the existing local structures and an appropriate accomodation of traditional and modern practices and beliefs. This system has the potential to be expanded throughout the country as the Ministry of Health (MOH) continues to expand the rural primary health care system.

2. Background.

Experience with prior Government efforts to affect the economic structure of the Sine Saloum region, primarily based on cultivation of the groundut and to provide other Government services has developed a negative attitude among rural peoples toward Government created structures, and toward Government bureaucrats in general. Since the colonial era, numerous schemes and projects purporting to benefit the farmers of Sine Saloum have been undertaken. Most have failed to attain their social objectives and even their economic production goals. Virtually all these schemes neglected to consider genuine participation of the rural people in the improvement of their lot. Subsequently, much suspicion of intent exists as a backdrop to any present and future efforts in that direction.

However, when genuine efforts to give the villagers not only tangible improvements but also a greater voice in the management of their own affairs have been attempted, they have been met with interest and respect. The GOS Administrative Reform, based on the creation of relatively self-governing and partially self-supporting "Rural Communities", is well underway in Sine Saloum. These units of local government, each grouping a number of villages in contiguous zones, are the focus of the redesigned project.

3. Village Participation.

Data indicate that the people of the Sine Saloum Region to varying extents, are not only open to change, but are desirous of change in the direction of their aspirations: better health, education, training, higher income, and improved housing.

There exists widespread evidence that the rural population is seriously concerned with health and wants to participate and finance efforts to improve its health. Villagers have already financed and built numerous rural maternities, contributed toward purchase of drugs, and established village pharmacies.

The recent evaluation of the Sine Saloum Rural Health Project found that to date the villagers have not actually participated in the development of the village health program. The project appears to have been imposed on many villagers without seeking their participation in the project. Particular problem areas of community participation the evaluation cited are:

- Inadequate preparation and training of villagers and village health committees.
- Inadequate training of MOH and Promotion Humaine training staff in regard to community organization and the functions of village health committees.
- Pace of implementation was too rapid to adequately organize and train village health committees.

Recognizing the importance of the participation as opposed to simply the cooperation of the villagers in the development of their health delivery system, the redesigned project will emphasize the participation of the community in the planning and implementation of the project. To do this more effectively self-organizational and community development efforts must be made. Project staff and trainers must be trained to develop in villagers the understanding that they have the ability to solve many of their health problems themselves and that the control of the village health hut rests with them. Villagers will be involved in the planning, selecting training and supervising of Village Health Workers (VHW) and responsible for the planning and management of the village health huts.

4. Socio-cultural considerations.

Another finding of the evaluation is that the village sanitarian is underutilized, often not respected, and a financial drain on the village. Therefore, the functions of the first-aid man and the

sanitarian will be combined into one Village Health Worker who will be responsible for both functions.

Village Health Workers will be encouraged to serve voluntarily. Hopefully, they will do so because the prestige of having been chosen by their own kinsmen and neighbors carries with it sufficient rewards. Villagers will have twe option of paying the VHW, in cash or in kind, or if they so desire, by assisting him till his fields during the agricultural season. These methods of compensation are compatible with the accepted social transactions of this region and in fact are being used now in health hut locations. The VHW is a link between the village and the National Health system. But, he is not a government employee. He serves at the discretion of the villagers and the type of reimbursement he receives, if any, is decided by the village health committee.

The village health care system does not conf''ct with traditional village health care. Since many villagers [illegible] iate disease incidence with supernatural causes they continue to [illegible] n traditional curers to intervene for them. Nevertheless, [illegible] modern medicine is well accepted by the population. T[illegible] emand on governmental medical facilities and the large stock[illegible] tern medicines in the local markets testify to this. In the eyes of the villager the Village Health Worker is one more curing agent which he can use, in addition to the traditional curers.

In every village there is a traditional matrone who has been assisting village women in the delivery of their babies. Villagers are encouraged to select this traditional matrone or another woman who is hightly respected by the women of the village and has had experience in delivering babies. Villagers understand that by undergoing training the traditional matrone will become even more effective. The role of the matrone is firmly entrenched in village life.

There have been some difficulties encountered in the Sine Saloum Project Thus far in the choice of matrones young, unmarried women have been trained and assigned as matrones but not accepted by the village women who want a mature, married mother with children to assist them in birthing and child care. This recruitment flaw has been noted by the project managers, who have resolved to select only those workers who will be accepted by the village women as their traditional matrone has been in the past.

This same problem of acceptance of young people in general as

dispensers of health care has troubled projects of this type elsewhere. Representation on the village health committee of the Village Chief or other respected elder, preferably as President of the Committee, and the careful orientation of the Committee in the nature of health care requirements and the appropriateness of training given to Village Health Workers and the Sanitation Agents will often improve relationships between villagers and young health workers. This careful preparation of the villages to receive and use younger workers provided in the redesign should minimize this issue.

5. Spread Effect.

The evaluation also criticized the project for being too ambitious in size and scope. Therefore, to insure that the project is successfully installed in the four departments where it has already been introduced, project activities during the following two years of the project will be selective and focus on twenty rural communities in these departments. During the first year special attention will be given to those rural communities where the Sanitation Agents, the graduates of Khombole School, are placed. In the second year, after it is evident that the villagers in those rural communities have operating health huts and that the villagers are managing their health huts, the project will move into the remaining rural communities.

Villagers want very much to have a village health hut in their village. Their recognition of the effectiveness of modern medicine was mentioned above, and they would like to have medicines and basic treatment readily available. For remote villages, travel to a health post is too difficult. What is lacking in the project to date is the participation of the villagers in the operation of the health hut. Through the selection of a limited number of rural communities, the project team can work more closely with the villagers in community organizations. Project benefits should be visible after a short period of village health hut operations. After the project is successfully operating in the Departments of Gossas, Kaolack, Nioro, and Foundiougne it may be possible to expand the project to Kaffrine but this will depend on the findings of the second impact evaluation to be done in late 1981.

The Project focus is the Region of the Sine Saloum because this prototype health project structure could be implemented only in a region that has gone through the process of administrative reform. Moreover, Sine Saloum contains an important Wolof population which constitutes a test population for extension of the program to other

regions with predominantly Wolof populations. Spread to other regions will occur if the GOS, convinced of the efficiency of the project, chooses to extend it to other regions.

6. Beneficiaries.

The intended beneficiaries of the Project as presently conceived are the rural population of four departments of the Sine Saloum Region who reside at some distance from the health posts; that is some 55% of the population in the western part of the Region, and some 85% of the population in the eastern part, or some 600,000 people in all. The ultimate target group is the rural population of other regions of Senegal, equally deprived of access to medical care, estimated at 2.8 to 3.2 million people.

The villagers are not passive recipients but actively benefit from the village health hut opearion through local participation. Village Health Workers are villagers themselves who are nominated by the villagers and are likely to remain in the village. Villagers exert control over the VHWs to insure that they perform their duties responsibly.

Villagers also exert some control over the distribution of medicines. Assisted by the Project Team they determine the fee structure. If during his supervisory visit, the health post nurse finds a shortage of funds taken in, then he informs the village health committee, which is responsible for the financial and administrative management of the health hut. In this way the Project encourages responsible participation at the village level to insure that villagers receive their medicine and health care they paid for themselves.

The role of women in this Project and its implementation is obvious. Almost one-half of the people to be trained and to do training will be women. There will exist many opportunities for skills improvement for women and an increase in their local stature through the international , inter-regional and inter-departmental contact. Moreover, many women will receive additional training in medical program management practices, particularly those women who are designated as women's representatives on the village health committees. The effect upon women in the region will be multi-faceted because of the services offered: maternal and child health care, mid-wifery family planning, nutrition and hygiene. This is not to mention the increased amount of time available to women bacause of the nearer location of the health facilities. Women spend a great deal of time now traveling for health care for themselves and for their children; a reduction of this time represents a potential for other activities and uses of productive energy.

C. Administrative Analysis.

1. Background.

The rural health project depends upon a complex administrative system involving the Ministry of Health at four governmental levels, national, regional, departmental and rural community (see Exhibit II-A) plus health committees and health workers at village level.

Minister of Health
The Minister of Health makes all policy decisions whith the advice of his cabinet. He is directly responsible to the President and Prime Minister regarding all health matters.

Regional level
At the regional level, the Regional Medical Officer supervises all health activities in the region, including the regional hospital, the departmental health center and the health posts. He is also responsible for the distribution of medicines and supplies to health huts. The Regional Medical Officer is assisted by a team of regional supervisors and regional pharmacist. He is responsible to the Minister of Health at the national level and to the Governor at the regional level. The Governor's executive committee has authority for regional budget allocations.

Departmental level
Health services at the departmental level are organized into Departmental Health Centers (circonscriptions médicales). Each Health Center has a Chief Medical Officer, usually a Medical doctor, who directs the health center. The health center is a small hospital with 20 to 30 beds of which 10 are maternity beds. The Departmental Medical Officer is assisted by several nurses and midwives. Most health centers have facilities for maternal and child health with clinics for children, nutritional demonstrations, and parental care. Each health center usually has at least one maternity, staffed by midwives who are responsible for all deliveries and who supervise the village matrones.

Rural Communities
Health Posts are rural dispensaries located in the main villages of the rural communities. In principle each rural community has one health post. Health posts are usually two to three-room buildings staffed by one nurse. The twenty Khombole graduates who are sanitation agents, will be placed at the health posts. They will assist the health post nurse in areas of sanitation and in the training and supervision of the village health committees.

Village Health Committees

The village health committes will be composed of responsible villagers or notables, including men and women, and youth who are selected by the villagers. This committee is responsible for the administration and management of the health hut. They will also collaborate with the medical authorities in addressing the health problems of the village and, where appropriate, support the VHWs in their work. A subcommittee or village management committee, composed of a President, Treasurer, and two individuals representing youth and women, respectively, will be responsible for the daily management of the village health hut.

Village Health Worker (VHW)

The Village Health Workers are the men and women who are selected by a village to serve the health needs of the village. There are two types of health workers in each village: 1) a village health worker (VHW), or secouriste-hygieniste, who is a multi-skilled worker trained in first aid and sanitation, and 2) a birth assistant or matrones.

In addition to the health infrastructure, the project is accountable to the regional governmental authorities, at four levels: the Governor and his executive council, Prefet, Sous-Prefet and Rural Community Council.

The supervision, support and coordination of project activities is complicated by the fact that the above mentioned administrative units all suffer from deficient communications, transportations, staffing and administrative infrastructures and systems.

2. Administrative Weaknesses of the Project.

The Project Impact Evaluation conducted in April 1980, focused on the administrative weaknesses of the project. Specifically, these weaknesses included:

- inadequate supervision and support of village health workers;
- lack of AID and MOH project management;
- poor financial controls of the project;
- lack of functional drug resupply system;
- failure of MOH to provide necessary personnel to staff the health posts;
- poorly defined roles and responsibilities of key project personnel,
- inadequate communication at all levels of the project.

3. The Changing Administrative Environment.

The Ministry of Health is in the process of implementing nationwide a "fee for service" structure to replace the present system of free

health care (guidelines for this system are presented in Annex 6). As outlined elsewhere in the paper, this will ultimately have a positive effect on the village level health services delivery system which utilizes a fee-for-service system. In the short-term, however, it will further complicate an already cumbersome administrative structure. What this new system of self-financing (auto-financement) means is that people will have to pay for treatment and medicine they receive at the health posts and health centers. There will be a period of readjustment before this policy is fully executed. Villagers may balk at paying for something that previously was free. However, if the system is managed well there should be an inflow of funds into the system from the receipts of health services at the health posts and health centers. This could enable the MOH to improve existing services.

The second factor which will effect the health services delivery system in Senegal is improved grass roots management. It is planned that each village will establish a village health committee and management subcommittee to organize and manage village health services. Thus, the village health huts will eventually be self-managed and self-sustained entities. Members of the village health committees will receive appropriate training in the administration and management of village health services. As a result, villagers will be able to actively participate in the planning and implementation of village health services, and in the overall development of the rural areas.

4. Project Administrative Changes.

The Sine Saloum rural health system is now two years old with approximately 200 functioning health huts in the Departments of Nioro and Kaolack, and another 175 soon to become operational, in the Departments of Foundiougne and Gossas.

The success of the system will depend on careful coordination between the MOH and AID Project personnel. It is anticipated that effective administration of the project is feasible with the following planned actions:

a. Appointment by MOH of a Project Coordinator with clearly defined responsibilities and authority who will coordinate all activities at the Regional level and control local currency project funds.

b. Improved AID/MOH project management through implementation of work plans with specific objectives, time frame and accountability assigned; bi-monthly reports on progress against stated objectives: and administrative procedure manual, and key personnel changes.

c. Simplification of the GOS administrative structure by reducing the direct role of the Governor and civil administrative authorities and increasing coordination and participation of MOH personnel at the Regional (Medecin Chef), Departmental (Medecin-Chef and supervisors) and rural community (Chef de Poste and Agent Itinérant) levels. (see attached revised Organizational Chart, Exhibit II-A).

d. Improved Communication at all levels through regular staff meetings, expanded training and supervision, and clearly defined lines of authority and responsibility.

e. Placement of necessary personnel into the system: 40 sanitation agents (over two years), nurses for new health posts, and nurses assistants for those posts lacking them, to provide necessary training supervision and support to village health workers.

f. Timetable for project expansion will be delayed to allow time for necessary training and development of health infrastructure to support the system in the existing four departments.

g. Technical assistance will be provided to improve the drug distribution and data gathering and reporting systems.

h. Project outputs will be based on more realistic expectations of the Ministry of Health and Promotion Humaine.

i. New and/or revised technical interventions will be introduced on a phased incremental basis only when the village health committees clearly understand and agree that the tasks involved are of value to them.

j. Monitoring and evaluation mechanisms will be set up to enable routine measurement of project and personnel performance against stated objectives, work plans and assigned accountability.

5. Role Clarifications.

A principle factor of a successful project is strong leader-ship from both MOH and USAID. It is important that all the actors in the project understand their roles and responsibilities. The project has been hindered from the beginning by a failure to clearly define the role of key project personnel. Following are outlines of the functions and roles of these key personnel/groups as they relate to the Sine Saloum Village Health Project:

- Regional Medical Officer
- Project Coordinator
- AID Technical Advisors and Health Officer
- Regional Supervisors
- Departmental Supervisors: MOH and Promotion Humaine
- Health Post Nurses
- Sanitation Agents
- Peace Corps Volunteers
- Village Health/Management Committee
- Regional Pharmacist for Sine Saloum Rural activities.

Regional Medical Officer:
The Regional Medical Officer is responsible for all health activities and health personnel in the Sine Saloum Region. As such, he supervises all project activities. In addition, the activities of all health personnel of the regional, departmental and health posts level come under his supervision.

Project Coordinator:
The Project Coordinator is the assistant to the Regional Medical Officer for rural primary health care. This project coordinator ia a liason with the central administration of the MOH in Dakar, and works under the direct supervision of the Regional Medical Officer. He performs administrative, and supervisory functions related directly to support of the village health huts. At the regional level, he directs the project office, supervises the bookkeeper and office support staff and coordinates project activities of the AID technical advisors and other GOS agencies, including Promotion Humaine, Alphabétisation and Public Works, Below the regional level, he coordinates the supervision and support of the village health system through the MOH and Promotion Humaine departmental supervisors and health post nurses. He is also the financial manager of local project expenditures. He verifies that all expenditure requests are properly justified and have been approved by the Regional Medical Officer. He signs the checks prepared by the project accountant. To exercise his coordination role he will develop criteria for supervision including monthly workplans and reports on the project activities to be used by himself, the departmental supervisors, and the health post nurses. These workplans must be approved by the Regional Medical Officer and submitted to the Governor. To assure proper resupply of health hut medicines he will monitor the drug resupply system including village pricing policies and coordinate medicine resupply in cooperation with the Regional Pharmacist.

AID Health Officer and Technical Advisors

The USAID Health Officer is the AID Project Manager who directs all AID project inputs. His overall project direction includes supervision of the AID technical advisors, approval of all AID project documentation, liaison with the GOS and other donors, financial planning and monitoring, and project administration. The AID Technical Advisors work under the technical direction of the USAID Health Officer within the regional supervisory framework established by the Project Coordinator and agreed to in advance by the USAID Health Officer.

The Technical Advisor for Health Training assists in organizing and executing the health training and retraining programs. This advisor assists the departmental supervisors and health post nurse in the orientation and training activities and helps them monitor and improve the performance of the village health workers.

The Technical Advisor for Community Development assists in organizing and executing the training programs for village health committees. This advisor assists in village organization and orientation activities, coordinates the work assignments of Peace Corps Volunteers in the project, and helps monitor and improve the village health management committees.

The Technical Advisor for Administration assists the AID Health Officer and GOS Project Officials in project management implementation and evaluation. This advisor assures general logistical support, including facilitating the transportation system, monitors regular project reporting and documentation, and assists in data collection and evaluation activities.

Since all these administrative activities involve assistance to and coordination with MOH project officials in Kaolack as well as with the AID Health Officer in Dakar, two administrative positions have been established. One is a general support and administrative assistant to the Health Officer in Dakar and a second is an assistant project manager and technical advisor for health administration to the Regional Medical Officer and the Project Coordinator.

Regional Supervisors

This team has consisted of three types of personnel: a senior nurse who supervises departmental and health post nurses, a midwife who supervises the midwives at the departmental and the communauté rurale levels, and a hygienist who supervises sanitation workers at the departmental level. These regional supervisors work under the

supervision of the Regional Medical Officer. They assist in the training and supervision of the project trainers (Health post nurses, sanitation agents, and departmental supervisors).

The MOH Departmental Supervisors
These supervisors work under the direction of the Departmental Medical Officer at the health center. They monitor the functioning of the Health Posts and the quality of performance of the health post nurses. They assist in training and supervision of the health post nurses and the village health workers, and they assist Promotion Humaine agents in implementation of the village health committee management training activities.

The Departmental Promotion Humaine Supervisors
These supervisors collaborate closely with MOH staff as part of the departmental supervisory team and give special attention to the community organization aspects of the project. The supervisors provide a general orientation to the villagers on the project and assist the villages in the organization of a village committee which will develop and manage locally supported health services. The Promotion Humaine agents also assist in the training of the village health management committees.

Health Post nurses
The health post nurse is the MOH official in charge of the health post. He is responsible for the supervision of health post staff including the sanitation agents, but also for the supervision and training of village health workers. The health post nurses participate in the orientation of members of village health committees on local health issues and primary health service management, and they assist Promotion Humaine staff in the organization and training of villagers to establish and to manage their own health services. The nurses are responsible for collecting appropriate health data on village health activities and submit monthly reports to departmental health centers and the Regional Medical Officer. They also monitor the status of medical supplies and drugs to encourage timely reordering of necessary supplies.

Sanitation Agents
These agents serve as an assistant to the Health Post nurse for sanitation activities and are delegated responsibility for training and direct supervision of village health committees. They provide technical assistance to the VHW in the field of sanitation and hygiene and assist the departmental Promotion Humaine agents in their village organization efforts.

The Peace Corps Volunteers (PCVs):
The Peace Corps Volunteers are supervised by the Regional Representative of Promotion Humaine. The PCVs assist the departmental MOH and Promotion Humaine supervisors with the implementation, supervision and evaluation of the Sine Saloum Rural Health Project. Project work assignments for the PCVs will be coordinated by the USAID Technical Advisor for Community Development within the regional supervisory framework established by the ProjectCoordinator. Specifically their activities involve programming, in coordination with the MOH and Promotion Humaine departmental supervisors, regular visits (e.g. two rural communities per week) to the Health Hut villages to discuss (depending on the phase of the project) the following issues:
- goals of the project,
- construction of the health hut
- selection of VHWs
- training of VHWs
- creation of a Village Health Committee
- training of Village Health Committees
- methods of bookkeeping
- selection and/or replacement of VHWs
- logistics of medicine and material supply
- problems encountered by the villagers.

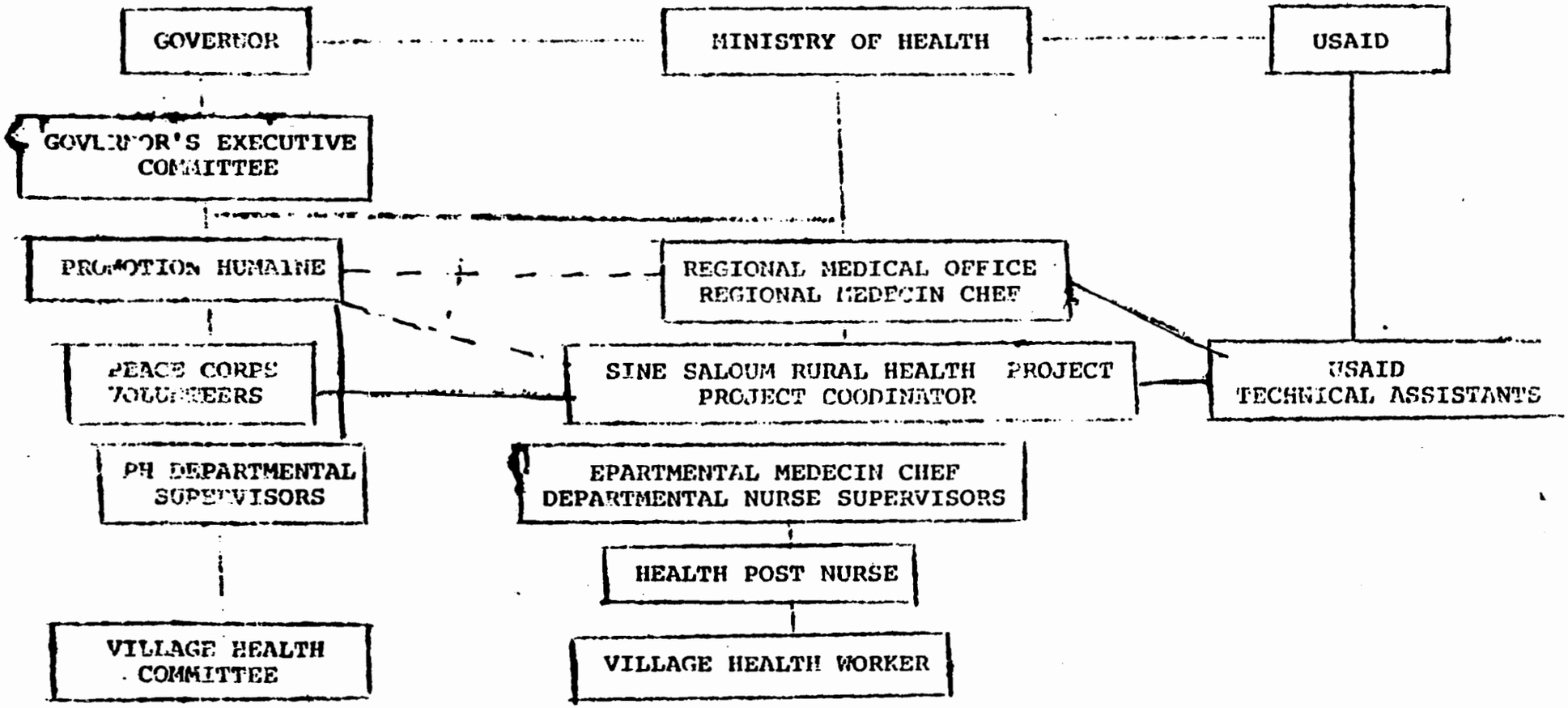
These visits are programmed in collaboration with the Project Coordinator, the Health Post nurse, President of the Rural Community, Village Chief and notables, and women and youth representatives in the village.

The PCV also functions as a liaison between Regional AID technical advisors and departmental officials, disseminating logistical information to better insure broad communication to and from the field.

The role of the PCV requires a through comprehension of Wolof and French as both are essential to effective communication of Project goals.

The Assistant Regional Pharmacist.
This person works at the regional level to assist in the development of an effective drug and medical supply system which support the village health huts. He would maintain a stock inventory and reorder system which monitors drug usage at all operational levels and anticipates in advance the need to procure replacement supplies. He develops pricing policies for medical supplies that assure sufficient revenues from drug sales to villagers to permit replacement of drugs without subsidization from MOH. The Pharmacist also conducts regular visits to the village health huts to assist and train the village management committee in the reordering of medicines and supplies.

ORGANIZATIONAL CHART FOR THE SINE SALOUM
RURAL HEALTH PROJECT



D. ECONOMIC ANALYSIS.

1. Project Costs.

The time frame for the project has been extended through December 1982. The USAID financing of $3,320 remains the same but the scope of the project has been changed as described previously. Approximately 375 health huts (each serving approximately 600 persons for a total of 225.000 beneficiaries) will be established in four departments rather than 600 huts in six departments. Total project costs will be reduced to $4.935.877, a result of a reduction in GOS costs. Project investment per beneficiary is increased to $21.95. U.S. contribution will now be $15.1 per beneficiary.

Recurrent costs for the project in the Sine Saloum region (1) are reduced to $657,615 per year, or $2.92 per beneficiary per year, a result of the reduced scope of work and a lesser degree of required MOH support than originally estimated. Of this cost, 36% or $1.04 per beneficiary will be contributed by the MOH. The balance of $1.88 per beneficiary per year ($11.28 per family of 6) will be contributed by villagers through purchase of medicines and compensation of the VHWs.

An AID agricultural survey for the groundnut basin gives an annual production figure of 45,000 CFA (about dol.200) per agricultural worker, i.e. dol.600 per family including 3 economically active persons. Thus, the cost of medical services to the family through the Project will be 1.9% of the family income.

This is within the economic possibilities of the villagers, as indicated by their willingness to purchase even more expensive medicines through private pharmacists wherever available and by their participation in the construction of village pharmacies in the Region.

2. Projects Benefits.

It is inherently difficult to assess the benefits of a rural health project in terms of increased production; however, some estimate is given in the following.

---

(1) Excluding the recurrent costs of the Khombole School which is a national level undertaking, but whose annual operating expenses are outlined in Table III 0-2.

The AID agricultural survey has shown that the income of $200 per agricultural worker quoted above requires about 180 workdays, mainly on millet and groundnut. Of these 180 days, 120 days during the rainy season earn $150, or $125 per day, while the other 240 days of the year will produce $50, i.e. $21 per day, or $ 50 for 60 full workdays, i.e. $83 per day of actual work.

In fact, the contrast between the value and the significance of workday (or the loss caused by an illness) in the rainy vs. the dry season is probably greater because of the consequences that an illness just after a rain can have on the whole harvest, while a disease during the dry season will mean merely postponement of a non-urgent task.

The study "The Impact of Malaria on Economic Development" (G.N. Conly, Sc. Publ. No. 297, PAHO/WHO, 1975) has demonstrated that absences from the fields can have disastrous consequences for those crops which demand a good deal of care at a precise time (2),(in this case, millet and groundnut), and that, when disease strikes repeatedly, farmers shift to less exacting crops such as cassava, a change which does take place in some areas of Senegal.

Consequently, bringing into the villages those few drugs that can prevent or cure common and incapacitating illnesses such as malaria and diarrhea can have significant economic returns. In fact, an adult may be provided with annual requirements of malaria and diarrhea pills for 57 cents; or the value of less than a half day's work during the rainy season. The total annual cost of Project medical services to the villagers in cash and in kind ($11.28 for a family of 6) may be compensated by avoiding 3 days of illness per adult during the rainy season - an effect which seems well within the Project possibilities. Statistics regarding frequencies of illness before and after the project, to be gathered for Project evaluation, will help quantify the economic effects of the Project.

---

(2) The study "Les Paysans du Senegal" (Paul Pelissier, Ed. Fabregue, 1966) maintains the following: "The two main cultures, millet and groundnut, have a cycle of 100 to 200 days. Seeding takes place from the end of June to mid-July. Groundnut can be seeded only in wet soil; each heavy rain is followed by 3 days of intense activity: this constitutes the perilous challenge of rain season agriculture". Such a situation requires physical fitness during the rainy season.

Furthermore, estimating that the 940 village health workers will spend 25% of their time in health activities, and will be compensated in kind by the villagers, the Project will in effect create the equivalent of 235 village level jobs.

3. Project Cost-effectiveness: Comparison with possible Alternative.

The most likely alternative to the Project for increasing the rural health services would be to extend the existing system of health posts (one per Community Rurale) by constructing several Health Posts per Rural Community (10-15 villages).

Even if it is assumed that the new Health Posts would be limited to the bare minimum (one Registered Nurse and one orderly per post; no means of transport; no supervision) the investment in construction equipment and training would total $23,020 per Health Post. Assuming that three such health posts will give a satisfactory coverage of each of the 59 Rural Communities, 59 x 2 = 118 new health posts will be necessary at a total Project cost of $6,036,107. This is $1,100,230 more than the cost of the present Project. More importantly, the alternative project will not provide the villages with equivalent access to health care nor as reliable a supply of medicines.

The alternative project would imply for MOH an increased operating cost of $495,600 annually for the salaries of 118 Registered Nurses and 118 orderlies (not counting maintenance of the Health Posts and equipment). Adding this amount to the annual recurrent costs of the revised project would increase the amount by 75%.

The recurrent costs of the alternative project would place additional strain on the already over-bardened MOH financial capacity. For all of the above reasons, the alternative to the proposed model project cannot be considered satisfactory.

TABLE III D-1 SUMMARY COST ESTIMATE AND FINANCIAL PLAN ($ U.S.)

Cost to USAID	FISCAL YEARS 78-80			FY 81	FY 82	TOTAL
A. Training				67,858	40,404	
B. Training materials				37,500	1,250	
C. Misc. materials				3,750	3,750	
D. Equipment and furniture				39,655	18,080	
E. Medicine				200,000	25,000	
F1 Vehicles				147,200	39,350	
F2 Vehicle operation and maintenance				28,675	28,675	
G. Local salaries				40,000	44,140	
H. Per Diem				42,900	54,900	
I. Construction and renovation				79,000	- 0 -	
J. Short-term technical Assistance				120,000	20,000	
K. Long-term technical Assistance				100,000	222,500	
L. Evaluation				25,000	25,000	
Cost to USAID				931,538	522,949	
10% contingency				93,154	52,295	
Cost with contingency				1,024,692	575,244	
Inflation				----	----	
TOTAL COST TO USAID			1,719,000	1,024,692	575,244	3,318,936
Cost to Peace Corps	12,750	17,000	17,000	17,000	17,000	80,750
TOTAL COST TO U.S.	12,750	17,000	1,736,000	1,041,692	592,244	3,399,686
National counterpart costs						
A. Ministry of Health	73,320	93,440	242,720	292,820	334,820	1,037,120
B. Promotion Humaine	10,800	10,800	29,700	29,700	29,700	110,700
C. Community participation	35,600	37,700	58,150	58,150	58,150	247,750
Cost of GOS and communities	119,720	141,940	330,570	380,670	422,670	1,395,570
10% Inflation allowance	11,972	14,194	33,057	38,067	42,267	139,557
TOTAL NATIONAL COUNTERPART COSTS	131,692	156,134	363,627	418,737	464,937	1,535,127
TOTAL PROJECT COST				1,460,429	1,057,181	4,935,877

National participation = 31% of total project cost.

TABLE III D-2 NATIONAL COUNTERPART COSTS (U.S. $)

A. COSTS TO MOH	FY 78	FY 79	FY 80	FY 81	FY 82	TOTAL
Costs already inscribed in MOH budget:						
1. Salary of departmental supervision team of two persons. 1st and 2nd years - 4 people st $220/mo 3rd, 4th & 5th years 8 people at $375/mo	10,560	10,560	36,000	36,000	36,000	129,120
2. Salary of health post nurses of 1st, 2 years - 19 posts at $220/mo.each 3rd, 4th & 5th yrs. 8 people at $375/mo.	50,160	50,160	132,000	132,000	132,000	496,320
Subtotal of costs already included in MOH budget	60,720	60,720	168,000	168,000	168,000	625,440
New costs to MOH:						
1. Salary of Sanitation Agents 1980-81 - 20 Agents at $ 175/mo. each 1982 - 40 agents at $ 175/mo. each	- 0 -	- 0 -	42,000	42,000	84,000	168,000
2. Salary of Regional Supervision team, 3 persons at $350/mo. each	12,600	12,600	12,600	12,600	12,600	63,000
3. Salary of health post nurses of 15 new health posts (Fatick) at $250/mo.each	- 0 -	- 0 -	- 0 -	45,000	45,000	90,000
4. Asst. Regional Pharmacist (1) at $425/mo.	- 0 -	- 0 -	- 0 -	5,100	5,100	10,200
5. Additional operating costs at Khombole School (Annex)	- 0 -	20,120	20,120	20,120	20,120	80,480
Subtotal, new costs to MOH	12,600	32,720	74,720	124,820	166,820	411,680
TOTAL COSTS TO MOH:	73,320	93,440	242,720	292,820	334,820	1,037,120

TABLE III D-2 (Continued)

B. COSTS TO PROMOTION HUMAINE	FY 78	FY 79	FY 80	FY 81	FY 82	TOTAL
Salary of departmental team of animation agents. 78 & 79-2 teams x 2 persons x 190/mo. x 12 plus 1 regional supervisor 1980-82; 4 teams x 2 plus 1Reg.Supervisor x 275/mo. x 12	10,800	10,800	29,700	29,700	29,700	110,700
C. COMMUNITY PARTICIPATION						
1. Value of part-time work of Village Health Workers (avg. 2.5 per village) 1978-79) 2.5x200 at 4/mo. x 12 1980-82) 2.5x375 at 4/mo. x 12	24,000	24,000	45,000	45,000	45,000	183,000
2. Construction of health huts (Labor - local materials at $90 each) 1978-79: 200 x 90 1980-82: 175 x 90	9,000	9,000	5,250	5,250	5,250	33,750
3. Upkeep of health post horse at $100/yr.ea.	2,600	4,700	7,900	7,900	7,900	31,000
TOTAL Community participation:	35,600	37,700	58,150	58,150	58,150	247,750
National counterpart Costs without inflation	119,720	141,940	330,570	380,670	422,670	1,395,570
Inflation (10% annually)	11,972	14,194	33,057	38,067	42,267	139,557
TOTAL NATIONAL COUNTERPART COSTS	131,692	156,134	363,627	418,737	464,937	1,535,127

42

TABLE III D-3 KHOMBOLE SCHOOL - ANNUAL OPERATING EXPENSES

A. Future expenses - School renovated for 40 students.

1. Expenses which can be defrayed by study stipends:

- Alimentation	
40 students x 10 months x 25,000FCFA/month	10,000,000 FCFA
- School supplies	500,000 FCFA
- Washing	300,000 FCFA
Total = $46,960 ($1,174 per student) =	10,800,000 FCFA

2. Overhead expenses

- Services	1,000,000
- Correspondence	100,000
- Printing	200,000
- Maintenance of furniture & building	500,000
- Uniforms for personnel	200,000
- Teaching materials	500,000
- Field work	500,000
- Water analysis laboratory	500,000
- Uniforms for students	1,500,000
- Vehicle operation and maintenance	2,000,000
Total overhead expenses = $30,435 =	7,000,000 FCFA
Total operating expenses = $77,390 =	17,800,000 FCFA
Personnel expenses = $ 76,780 =	17,660,000 FCFA
Total annual costs = $154,170 =	35,460,000 FCFA

B. Present annual expenses.

- Personnel salaries	16,078,000 FCFA
- Honorariums for outside lecturers	500,000 FCFA
- Operating expenses	3,453,000 FCFA
Total present annual expenses $87,090 =	20,031,000 FCFA
Additional expenses required by expansion : $67,080 =	15,429,000 FCFA
Additional expenses, net of study stipends : $20,120 =	4,629,000 FCFA

TABLE III D-4

TOTAL PROJECT RECURRENT COSTS TO SENEGAL ($ U.S.)

A. Annual costs to MOH.	Total $/year	per beneficiary/yr
1. Salaries of existing personnel engaged in project:		
- health post nurses: 44 at 250/mo.x25%	33,000	.15
- Sanitation agents: 40 at 175/mo.x100%	84,000	.37
- Dept. Supervisors: 8 at 375/mo.x50%	18,000	.08
- Reg. Supervisors: 3 at 350/mo.x100%	12,400	.06
- Regional pharmacist: 1 at 425/mo.x100%	5,100	.02
Salary Sub-total	152,700	.68
2. Additional MOH operating costs:		
- Per Diem	42,600	.19
- Vehicle maintenance and operation	28,675	.13
- Maintenance of 15 new health posts, (2% of $26,100 construction cost ea.)	7,830	.03
- Amortization of equipment of 15 new health Posts, $ 900 ea., over 10 years	1,350	.01
- Amortization of 59 water systems, at $100 ea. over 10 years	590	--
Additional MOH costs sub-total	81,045	.36
Sub-total annual costs to MOH	233,745	1.04
B. Annual costs to villagers.		
1. Community compensation of approx.940 VHW's, estimited value of $4/mo.ea. (25% of VHW's annual income)	45,120	.20
2. Maintenance of 375 village health huts at $50/year	18,750	.08
3. Payment of medicines by population; 375 health huts x 400 beneficiaries ea.x $1.60/yr. medicine consumption each	360,000	1.60
Annual cost to villagers	423,870	1.88
TOTAL Annual recurrent costs	657,615	2.92

TABLE III D-5 - COST OF AN ALTERNATIVE PROJECT - CONSTRUCTION OF 173 HEALTH POSTS ($U.S.)

	FY 78	FY 79	FY 80	FY 81	FY 82	TOTAL
Construction of (59x2) = 118 new health posts	460,000	460,000	480,000	480,000	480,000	2,360.000
Equipment and water systems for health posts, dol. 1000ea.	23,000	23,000	24,000	24,000	24,000	118,000
Expanding Khombole School	157,000	--	--	--	--	157,000
Project co-director	60,000	60,000	60,000	60,000	60,000	300,000
Training 118 registered nurses	117,760	117,760	122,880	122,880	122,880	604,160
Salary of new personnel	88,320	176,640	294,000	394,800	495,600	1,449,360
in FY 78 & 79 and 250/mo. in FY 80,.81 & 82	906,080	837,400	980,880	1,081,680	1,182,480	4,988,520
Contingencies, 10%	90,608	83,740	98,088	108,168	118,248	498,852
Sub Total	996,688	921,140	1,078,968	1,189,848	1,300,728	5,487,372
Inflation, 10% annually	99,668	92,114	107,896	118,984	130,072	548,735
Total cost of alternative project	1,096,356	1,013,254	1,186,865	1,308,832	1,430,800	6,036,107

E. ENVIRONMENTAL ANALYSIS.

Provision of the revised project inputs will not have a direct impact on the environment of the area. An initial Environmental Examination was done and Negative Determination was approved by the Assistant Administrator for Africa for the original project. The basis for that determination remains valid and unchanged. Additional environmental analysis is not necessary.

IV. FINANCIAL ANALYSIS.

PROJECT BUDGET

The Project budget resulting from the Project redesign done in September 1980 is extended for 26 months from November, 1980 through December 1982. During the initial three years of the project (which began approximately one year later than scheduled) 1978-1980, approximately $1,720,000 has been expended. Financial needs to complete the redesigned project are approximately $1,600,000 as outlined in Table IVa, which coincides with the $1,600,000 remaining from the original project budget. (After analyzing funds advanced to the Kaolack Project office during the 2.5 years and funds actually expended, it appears the project may have additional funds of approximately $50,000 (over the 1.6 million) available for miscellaneous contingencies.) Detailed project costs for the 1.6 million are contained in Table IVb. An exchange rate of 200CFA/$1 has been used for the calculation.

Expenditures of USAID inputs to the redesigned project are determinated by the revised implementation plan prepared by the redesign team. Expenditures of funds for year two will be subject to an evaluation to be performed in November, 1981 and the resultant workplan.

Assumptions made in the redesign which impact significantly on the budget that follows were:

1. Only 375 health huts will be developed.
2. Because of attrition, some health huts will have one worker and some two (other than the midewife). For that reason, we have estimated an average of 1.5 health workers (plus a midwife) per village health hut.
3. The project will not be able to recruit (through an institutional contract) a management specialist prior to June, 1981.
4. All 40 sanitation agents from Khombole School will be assigned to the project.
5. Project vehicles being replaced include only those of staff who will continue after AID involvement ends.
6. Health prevention programs will be phased into the project as the huts, VHW's, and GOS infrastructure are capable of implementing them. We expect this activity to occur in the second year.
7. Sanitation activities will be introduced into the project on an incremental basis (one simple project at a time) as a method of developing credibility for the sanitation program and of achieving

a limited success in the community, that will hopefully inspire and enthuse the villagers.

8. Drugs are being purchased to restock the approximately 200 health huts in Nioro and Kaolack that have been operating for 1-2 years and are facing insolvency. Huts in Gossas and Foundiougne are just now receiving their initial stock.

9. An Administrative Assistant will be hired to assist the USAID Health Officer in Dakar.

10. The Regional Supervisors role will be reduced to that of training. Supervision (and therefore per diem) have been eliminated from their project related functions.

11. Because of the immediate need for technical assistance to finalize design changes and the absence of a USAID Health Officer until January, 1981, short-term technical assistance will be obtained through an IQC work order.

TABLE IV b - SUMMARY OF PLANNED EXPENDITURES ($ US)

	FY 81	FY 82	TOTAL
A. Training	67,858	40,404	108,262
B. Training materials	37,500	1,250	38,750
C. Miscellaneous materials and supplies	3,750	3,750	7,500
D. Equipment and furniture	39,655	18,080	57,735
E. Medicine	200,000	25,000	225,000
F1. Vehicles	147,200	39,250	186,450
F2. Vehicles operation - maintenance	28,675	28,675	57,350
G. Local salaries	40,000	44,140	84,140
H. Per Diem	42,900	54,900	97,800
I. Construction and renovation	79,000	0	79,000
J. Short-term technical assistance	120,000	20,000	140,000
K. Long-term technical assistance	100,000	222,500	322,500
L. Evaluation	25,000	25,000	50,000
Cost to USAID	931,538	522,949	1,454,487
10% Contingencies (1)	93,154	52,295	145,449
Cost with contingencies	1,024,692	575,244	1,599,936
Inflation (2)	-	-	-
TOTAL COST TO USAID	1,024,692	575,244	1,599,936

1) Includes miscellaneous project costs such as utilities
2) Inflation factor included in individual line item costs.

TABLE IV b - DETAILED PROJECT COSTS TO AID

A. TRAINING COSTS		FY 81 LC	FY 82 LC	TOTAL LC
1. Training of trainers:				
3 Regional Supervisors				
16 Departmental Supervisors				
40 Sanitation Agents	for 15 days at 500CFA/day	3,975		3,975
44 Health Post Nurses				
2 PCV's				
1 Pharmacist				
2. Training of Village Management Committee:				
a. Trainees:				
375 Presidents for 1,5 days at 400CFA/day (1125)				
375 Treasurers for 5 days at 400CFA/day (3750)		12,187	12,18	24,375
375 Women representatives for 3 days at 400CFA/day (9750)				
375 Youth representatives for 3 days at 400CFA/day (9750)				
b. Trainers				
44 health post nurses for 9 5 days at 500CFA/day (1,045)				
40 sanitation agents for 9 5 days at 500CFA/day (950)		2,115	2,115	4,230
16 departmental supervisors for 3 days at 500CFA/day (120)				
3. Training of VHW's				
a. Trainees				
* - Retraining (crosstraining) for multi-skilled VHW 375 huts x Av ql 5 VHW's = 563 VHW for 24 days at 400CFA/day		13,512	13,512	27,024
- Continuing education (new health skills) for 563 multi-skilled workers and 375 matrons for 8 days at 400CFA/day		7,504	7,504	15,008
b. Trainers				
44 health post nurses for 32 days at 500CFA/day		1,760	1,760	3,520
4. Orientation and Training of Khombole graduates				
a. Trainees: 40 individuals for 6 days at 500CFA/day		300	300	600

A. Training Costs (continued)	FY 81 LC	FY 82 LC	TOTAL LC
b. Trainers: 3 Regional Supervisors for 6 days at 500CFA/day	25	25	50
5. Stipends for Khombole Students: 20 stipends at 1,174/year	23,480		23,480
6. Misc.: seminars, workshops for project personnel ...	3,000	3,000	6,000
	67,858	40,404	108,262

* Basic Assumptions: Due to the attr ition of VHWs, there is an average of 1.5 first-aid-men/sanitation workers.

B. TRAINING MATERIALS COST	FY 81	FY 82	TOTAL
1. Manuals for Village Health Committees Training - 1500 copies at $15 each	22,500		22,500
2. Demonstration materials for health posts 50 sets at $50 each	1,250	1,250	2,500
3. Supplementary health protocols ($1000 for 1000 VHW's)	10,000		10,000
4. Health Educat n Materials - 379 health huts at $1000	3,750		3,750
	37,500	1,250	38,750

C. MISC. MATERIALS COSTS	FY 81	FY 82	TOTAL
1. Drug system supplies - Inventory purchase order forms, etc.	1,000	1,000	2,000
2. Forms/Materials for Dept. of Public Works	250	250	500
3. Office supplies - Kaolack project Office	2,500	2,500	5,000
	3,750	3,750	7,500

D. EQUIPMENT/FURNITURE COSTS	FY 81 $US	FY 81 LC	FY 82 $US	FY 82 LC	TOTAL $US	TOTAL LC
1. Audio-visual quipment		3,000				3,000
2. Sanitation equipment for health huts in Gossas and Foundiougne &40 sanitation agents		22,135		3,000		25,135
3. Preventive health equipment	10,000	3,720	10,560	3,720		28,000
4. Salter Portable baby scale (model 235) 50 scales at $25 each plus shipping	750		750		1,500	
5. Tape measures - 50 at $200	50		50		100	
	10,800	28,855	11,360	6,720	1,600	56,135

E. MEDICINE COSTS	FY 81	FY 82	TOTAL
1. Stock of medicines to resupply/recapitalize approx. 200 health huts at $1,000 each	200,000		200,000
2. Medical supplies for preventive health activities		25,000	25,000
	200,000	25,000	225,000

F. VEHICLE COST	FY 81	FY 82	TOTAL
1. Replacement of 12 vehicles	76,000	17,000	93,000
2. Spare parts for 12 vehicles	19,000	4,250	23,250
3. Purchase of 78 mobylettes for 38 health post nurses &40 sanitation agents at 900 each	52,200	18,000	70,200
	147,200	39,250	186,450

VEHICLE OPERATION AND MAINTENANCE COST	FY 81		FY 82		TOTAL	
	$US	LC	$US	LC	$US	LC
1. Gasoline for 15 vehicles (used by AID technical advisors and MOH personnel)		17,575		17,575		35,150
2. Maintenance and repair of above vehicles		11,100		11,100		22,200
		28,675		28,675		57,350

G. LOCAL SALARIES	FY 81	FY 82	TOTAL
1. Kaolack Office Staff			
Bookkeeper (1/2 time)	3,861	3,861	7,722
Secretary	4,000	4,600	8,600
Guardian (2)	6,132	6,532	12,664
Drivers (2)	6,007	7,147	13,154
2. Health Office - DAKAR			
Administrative Assistant	20,000	22,000	42,000
	40,000	44,140	84,140

H. PER DIEM COSTS	FY 81	FY 82	TOTAL
1. MOH dept. supervisors (8) 8 x 1000CFA/day x 10days/mo x 24	4,800	4,800	9,600
2. Pharmacist & at 1000CFA/day x 10 x 24	600	600	1,200
3. Promotion Humaine dept. supervisors (8) 8 at $1000/day x 10days x 24	4,800	4,800	9,600
4. Health Post Nurses 44 at 1000CFA/day x 5days/mo x 24	13,200	13,200	26,400
5. Project Coordinator 1 at $500/mo x 24	6,000	6,000	12,000

H. (Continuation)	FY 81 $US	FY 81 LC	FY 82 $US	FY 82 LC	TOTAL $US	TOTAL LC
6. Sanitation Agent 40 at 1000CFA/day x 12 (2nd year) 20 at 1000CFA/day x 12 (1st year)		12,000		24,000		36,000
7. Misc. Per Diem		1,500		1,500		3,000
		42,900		54,900		97,800

I. CONSTRUCTION/RENOVATION						
1. Renovation of 15 health posts in Fatick at $5000 each		75,000				75,000
2. Construction/Renovation of 4 Departmental drug depots - 4 at $1,000 each		4,000				4,000
		79,000				79,000

J. SHORT-TERM TECHNICAL ASSISTANCE	FY 81	FY 82	TOTAL
1. Management Information System (including development health surveillance mechanism and analysis of data gathered at health huts during project operation)	30,000		30,000
2. Training Methodology and Manuals - Community Organization - Health Hut Management - Health education programs	30,000		30,000
3. Clinic Protocols for - Malaria suppression program - Vaccination program - Rehydration - Sanitation	20,000		20,000
4. Analysis of Private Sector potential with particular emphasis on: - drug distribution - Vehicle maintenance and repair - Cold Chain	20,000		20,000

J. (Continuation)	FY 81 $US	FY 81 LC	FY 82 $US	FY 82 LC	TOTAL $US	TOTAL LC
5. Analysis and development of drug dist. system	10,000				10,000	
6. Project team development, including - Management training for Senegalese Project Coordinator - Task oriented skill development for key Project staff - Training of trainers	10,000				10,000	
7. Miscellaneous T.A.			20,000		20,000	
	120,000		20,000		140,000	

K. LONG-TERM TECHNICAL ASSISTANCE	FY 81	FY 82	TOTAL
1. Public Health Advisor-Education	50,000	100,000	150,000
2. Public Health Advisor Training		22,500	22,500
3. Public Health Advisor-Administration	50,000	100,000	150,000
	100,000	222,500	322,500

L. EVALUATION	FY 81	FY 82	TOTAL
1. 2nd Impact Evaluation	25,000		25,000
2. End of Project Evaluation		25,000	25,000
	25,000	25,000	50,000

V. IMPLEMENTATION PLAN

A. Coordination of Activities

1. Responsibility for Implementation

The Ministry of Health has designated the Director of Hygiene and Environmental Health as the national-level project director. However, the responsibility for implementation of this project will be with the MOH appointed Project Coordinator in Kaolack. He will have direct responsibility for day to day project administration but will report to the national-level director and work under the authority of the Chief Medical Officer (Medecin Chef) of the Sine Saloum Region. The Project Coordinator performs administrative and supervisory functions related directly to support of the village health huts. He also manages local project expenditures.

The successful completion of the Sine Saloum Rural Health Project depends on the timing and sensitivity of the logistical support system. For the GOS this means developing a viable drug resupply system to the village level and assuring that sufficient MOH staff are available and have the means to support the village health service system. For USAID logistical arrangements must focus on proper and prompt procurement of goods and appropriate and on-site technical and training assistance in primary health care and community development. The workload created by the redesigned project does not place additional burden on the health infrastructure. However, the development of a village health service system does depend heavily on a supportive MOH infrastructure.

2. Monitoring

The major responsibility for USAID Health office will be the monitoring of project implementation. This will be done by the USAID Project Manager. The Project Manager will maintain communications between the USAID Regional Health Officer and the Sine Saloum Rural Health Project Office in Kaolack. Formal monitoring will be done through the bi-monthly project implementation reports which will be reviewed jointly at the national-level by the GOS and USAID. A project performance tracking chart will be updated as part of this review. An outline of the project implementation report including a tracking chart is included as Section V D. In addition, regular monthly meetings of relevant project personnel at both the regional and national levels will be held. All project supervisory, and monitoring functions will be improved by developing a management information system. (The terms of reference for developing this system are presented in Annex 5.)

E. Procurement Plan

The primary responsibility for procurement will be assigned to the Administrative Assistant in the USAID Health Office. The commodity list and cost estimate for the vehicles, mobylettes, equipment, and medicines to be purchased under this project are given in the financial analysis. Detailed specificiations for commodities will be finalized in November by short-term technical assistance under the direction of the USAID Project Manager. Project needs may result in some shifts between the line items but these shifts will not be major ones.

The authorized source and origin for commodities financed by USAID under this project is the United States. A source origin waiver to permit procurement of mobylettes and replacement vehicles from Code 935 (Special Free World) is requested for an amount not to exceed $187,000. The justification for this waiver is provided in Annex 3. While maximum effort will be made to purchase all other materials and equipment in the United States, the practicability of the project will require that some items, may not be available in the United States, thus necessitating further off-shore procurement.

Shelf item procurement from Code 935 sources (Special Free World) is authorized for the project for items not exceeding a unit price of $2,500 and not totaling more than 10% of total local currency funding. The price paid for shelf items will be no more than the lowest available competitive prices, and will be in accordance with good commercial practices.

Contracting will be both host-country and direct-AID. The two new major contracts are (1) for short-term technical assistance, provided through an IQC Work Order to finalize design changes, and (2) for long-term technical assistance over the remaining life of project.

SUMMARY OF CONTRACTS

HOST COUNTRY

1. Contracts for Health Post renovation by MOH/GR - all completed except Fatick

2. Contracting for new Health Post personnel (MOH).

3. Contracts for construction of Health Posts by GR/MOH - completed.

4. Contracts for transport of commodities.

AID CONTRACTS

1. Personal Service Contracts for Public Health Advisors in Training, Education, and Administration - will be replaced by No. 4, the institutional contract.

AID CONTRACTS (Continued)

2. Contracts for Evaluation Teams.

3. Contract for short-term technical assistance (through February 1981) for management information system, village health committee training, medical distribution system, and preventive health protocols.

4. Institutional contract for short and long-term technical assistance over remaining life of project.

C. Schedule of Activities

Actions and Agreements at Time of New Project Agreement Negotiation

a. Agreement reached with MOH, MOF, MOI, MPH and the Governor's Office at Kaolack for the redesigned project.

b. Agreement reached with MOH to assign twenty Khombole stipend recipients to the Project area.

c. MOH approve position for Project Coordinator at Kaolack.

d. USAID-financed advisors for community organization and training at work in Kaolack.

September

1. Establish revised management structure and organization chart for the project.

2. Develop job-descriptions for key project staff.

3. Prepare orientation program for Khombole graduates. (Sanitation Agents)

4. Select health posts for Sanitation Agents.

5. Prepare PIO/T for IQC Work Order for short-term T/A to finalize redesign.

6. Develop defined objectives, accountability, and time frame.

7. Revise policy on indemnities.

October

1. Provide orientation to Sanitation Agents.

2. Clarify budgetary activities and financial procedures of Kaolack office.

3. Select villages to participate in intensive community organization, training, and supervision.

4. Begin clarification of policies and procedures for the project.

5. IQC work order executed for short-term T/A for follow-up on redesign.

6. Project Paper approved in AID/Washington.

MONTH 1 - November

1. Sign revised Project Agreement with GOS

2. Develop "Health Hut Management" trainers manual and materials.

3. PIO/C written by USAID for health hut medicine and equipment.

4. Complete Policies and Procedures for project.

5. PIO/C written for 58 mobylettes.

6. Begin analysis of management information system and drug inventory system.

7. Develop system of project control and evaluation.

8. Begin renovation of fifteen health posts in Fatick.

9. Select trainers for village management training.

10. Finalize PIO/T and issue RFP for long-term technical assistance.

11. Finalize specifications for preventive health program.

12. Provide management and team development training to key project staff.

MONTH 2 - December

1. Translation and reproduction of trainers manual and village management committee materials.

2. Begin collection and analysis of data gathered in health huts of Nioro and Kaolack during first two years of project.

3. Begin health education activities by assembling relevant health education materials developed by other Senegalese projects and international organizations (WHO, Hesperian Foundation, etc.)

MONTH 3 - January

1. Select villages to receive resupply of drugs.

2. Select village management committee members to be trained.

3. Begin analysis of private sector potential involvement in project.

4. Begin development of preventive health and sanitation protocols.

5. Training of trainers - Group I, (10 health post nurses, 10 sanitation agents, 3 regional supervisions, MOH and PH departmental staff, eg, Nioro and Kaolack).

MONTH 4 - February

1. Training of trainers Group II, (eg, Gossas and Foundiougne).

2. Selection of VHW's to receive retraining.

3. Develop health education materials.

4. Evaluation of proposals for long-term technical assistant contracts.

MONTH 5 - March

1. Training of village management committee members from 10 rural communities.

2. Introduction of health protocols and health education information to trainers.

3. Introduction of sanitation activity into selected villages.

MONTH 6 - April

1. Training of village health committees from 10 additional rural communities.

2. One day retraining of selected VHW's at health posts.

3. Sign contract for long-term technical assistance.

MONTH 7 - 12

1. Introduction of preventive health programs in selected villages.

2. Begin long-term technical assistance contracts (June).

3. Selection of 20 additional rural communities to receive sanitation agents.

4. One day retraining of VHWs. (July and October)

5. Additional sanitation activity initiated in selected villages.

6. Assignment and orientation of 20 new sanitation agents (October).

7. Equipment and drug supplies for health posts and health huts arrive and stored in Kaolack for redistribution as required.

8. Initiation of cold chain for vaccination campaign.

9. Follow-up and supervision of health activities in those villages which received community organization training.

10. Twelve more vehicles ordered as replacement for project vehicles and purchase twenty mobylettes for new sanitation agents.

MONTH 13 - 18

1. Second impact evaluation team completes report. Decision made to finish project in 1982 or expand it to Kaffrine and other Senegalese regions. (November, 1981)

2. Beginning of Phase II training of trainers.

3. One day retraining of VHWs. (January and April)

4. Training of village health committees from second group of 20 selected rural communities.

5. Introduction of preventive health abd sanitation activities in villages supervised by sanitation agents.

MONTH 19 - 26

1. Follow-up and supervision of health activities in those villages which received community organization training.

2. Retraining of VHW's (July and October)

3. Additional preventive health and sanitation activities introduced.

4. End of project evaluation completed.

.../

D. Project Implementation Report Outline

Project No. 685 - 0210
Sine Saloum Rural Health Developement
Bi-Monthly Implementation Report (Period Covered)

I. Basic Data

A. Project Authorization Date :
B. Project Agreement Date :
C. Date Conditions Precedent met :
D. Project Assistance Completion Date :
E. Cooperating Agency :
F. USAID Project Manager :
G. Cooperating Agency Project Manager :
H. Life of project funding

1. AID :

2. Cooperating Agency

I. Accrued Expenditures :

1. Technical Assistance

2. Commodities

3. Training :

4. Operating Costs :

II. Project Purpose :

(Brief Statement)

III. Major Events during Reporting Period :

(Covers previous two months)

IV. Problems or Delays

V. Remedial Actions

VI. Major Actions Planned Next Reporting Period

VII. Project Performance Tracking Chart

[illegible] TRACKING CHART

PROJECT NAME: SINE SALOUM RURAL HEALTH PROJECT

DATE: _____

PROJECT NUMBER: 685-0210

OMPONENT	PLANNED TIME FRAME			
	1st Year	2nd Year	3rd Year	4th Year
	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D
)TRAINING				
a)Training of Trainers	--- ----			
b)Recyclage of Khombole Graduates	-- ---			
c)Training of village health committees	-----	----------		
d)Refresher training for VHWs	-- -- -- --	-- -- -- --		
)COMMODITIES				
a) Order mobylettes	---			
b) Order replacement Vehicles		---		
c) Order equipment for Cold Chain	---			
d) Order vaccines	---			
) Order medicines to restock health huts	---			
STRUCTION				
Renovation of Fatick Health Posts	---			

PROJECT TRACKING CHART

PROJECT NAME: SINE SALOUM RURAL HEALTH PROJECT (Continued) **DATE:** _____

PROJECT NUMBER: 685-0210

COMPONENT	PLANNED TIME FRAME			
	1st Year	2nd Year	3rd Year	4th Y
	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D
)TECHNICAL ASSISTANCE				
a) Contract USAID Trainer				
b) Contract USAID Community Organizer.				
c) Contract USAID Project Administrator.				
d) Contract USAID Administrative Assistant				
e) Develop community organization manuals				
f) Contract for drug inventory system.				
Contract to develop management information system.				
) Conduct project impact evaluation.				

VI. Evaluation Plan

The Impact Evaluation Team which reviewed this project early in 1980 was handicapped by an insufficiency of project information due to the lack of a management information system. The team was restricted to a critique of implementation and management rather than an evaluation of organized data generated by the project.

It is planned therefore that the revised project will assure that information is available. A management information system will be installed, which will provide information that will enable adequate planning, monitoring and evaluation. This system will furnish project managers with data on the quantity and appropriateness of services provided by village health huts ; the financial viability of the health huts, the quality and frequency of supervision and management ; the population being served (by specific ages, residence, and other characteristics) and with statistics (including births, deaths and pregnancies). In addition, the analysis of sociological data and performance of limited epidemiologic surveys prior to initiating specific preventive health measures will be undertaken. These activities will help complete the body of information needed to perform the planned evaluation.

These data will be maintained and updated for use in November 1981 when a team will perform a second Impact Evaluation. This evaluation will attempt to measure general project effectiveness in reaching the objectives stated in the revised Logical Framework, (Annex 1). It is not feasible to expect that this Impact Evaluation will be able to present reliable conclusions concerning changes in health status of the population attributable to the Sine Saloum Project. To concentrate energy and resources on the development of a complex data system necessary to generate such information is not within the present capabilities of the health workers participating in this project.

The November 1981 evaluation will however provide decisive information for a project review by the Mission and the Ministry of Health to determine whether to expand the project to the Kaffrine department of the Sine Saloum or indeed, whether to expand beyond the Region and apply the principles learned in this project to other areas of Senegal. To assure objectivity, this evaluation team will be contracted with individuals or groups outside of AID and the MOH. Both AID and the MOH will provide resource personnel to assist the team in gathering data and insights from the project areas. A final evaluation is scheduled for December 1982 to serve as the end of project assessment. Funds are also budgeted for the assistance of an external consultant.

During project implementation and before the 1981 evaluation, it is expected that the generation of data from the management information system will

.../

permit project personnel to assess progress in selected areas of administration and management, including attainment of staffing goals, numbers of patients attending health huts, health huts in operation, numbers of personnel trained, utilization of services, primary problems treated, and the on-hand inventory of drug and medical supplies. This style of ongoing project evaluation can be more effective in the long run than an annual evaluation. Project personnel will be trained by the AID Technical Advisor for Health Management to maintain this in-service monitoring system. (See Annex 5 for a more complete description of the proposed management information system).

962 517**

URCINTER64693

0102294 1226 12/29

517 AMEMB SG

364 17.24

URCINTER64693

AMERICAN EMBASSY DAKAR

FOR USAID - DAVID SHEAR INFO PATRICIA DALY

AMEMB 517 SG

SENEGAL

GALLOWAY AND COLEMAN MET WITH JOEL SCHLESINGER AID/W WHO HAS SENT CABLE TO DAKAR RE STATUS OF SINE SALOUM PROJECT REVIEW. WE CLARIFIED ALL OF REVIEW TEAM' S CONCERNS EXCEPT TWO. THEY FEEL THAT:

1. PROJECT NEEDS MORE TIME: PERHAPS ADDITIONAL ONE OR TWO YEARS. WE EXPLAINED THIS WAS MAJOR POLICY DECISION FOR DIRECTOR'S ACTION INVOLVED IN GENERAL REVIEW OF FUTURE OF HEALTH SECTOR ACTIVITIES IN SENEGAL. IT WAS CLEAR HOWEVER THAT SUCCESS OF PROJECT WOULD BE ENHANCED BY EXTENDED TIME FRAME AND LESS INTENSIVE TRAINING SCHEDULE.

2. EXPECTATIONS OF 150 VILLAGES OPERATING EFFICIENTLY AT END OF TWO YEARS PERIOD PRESENT PROJECT REDESIGN TOO AMBITIOUS. WE SUGGEST THAT YOU SEND TELEGRAM IN FURTHER RESPONSE TO THE AID/W TELEGRAM WHICH DESCRIBES CRITERIA FOR EVALUATION OF PROJECT AT END OF ONE YEAR PERIOD TO DIFFERENTIATE DEGREE OF COMPLIANCE WITH EXPECTED GOAL AS FOLLOWS: (NUMBERS AND PERCENTAGES FOLLOWING EACH FACTOR IS LEVEL OF EXPECTATION FOR EACH OF STATED GOALS, [illegible] LEVEL OF SUCCESS WILL CONSTITUTE A PASSING

68

COMPLIANCE WITH THIS LEVEL OF SUCCESS WILL CONSTITUTE A PASSING GRADE FOR THESE FACTORS, YOU MAY WISH TO ADD OTHERS BUT THESE SEEM SUFFICIENT TO US)

(Note: Based on 75 villages per year)

I. AT VILLAGE LEVEL FOR SELECTED VILLAGES

A. HEALTH AND MANAGEMENT COMMITTEES ARE TRAINED (75 VILLAGES OR 100 PERCENT)

B. FUNCTIONING HEALTH AND MANAGEMENT COMMITTEES (10 HUTS FUNCTIONING AT 100 PERCENT, 15 AT 75 PERCENT, 25 AT 50 PERCENT, AND 35 AT 25 PERCENT, USING FOLLOWING SUBCRITERIA:

1. MEET REGULARLY ON MONTHLY BASIS
2. SUPERVISING VILLAGE HEALTH WORKERS (VHWS) AND HUTS
3. USING CAHIER DE GESTION AND ADEQUATE CONTROLLING FINANCES
4. ORDERING DRUGS AS NEEDED
5. INVOLVED IN HEALTH EDUCATION OF HEALTH VILLAGES
6. INVOLVING PERIPHERAL VILLAGES IN HUTS ACTIVITIES
7. UNDERSTAND PROJECT AND RESPONSIBILITIES
8. COMMITTEE OFFICERS ARE FULFILLING THEIR RESPONSIBILITIES

C. SELF-SUFFICIENT HUTS - I.E. RECEIPTS ADEQUATE TO REPLENISH MEDICATION (19 HUTS OR 25 PERCENT OF TOTAL ARE SELF-SUFFICIENT)

D. AT LEAST 2 VHWS RETRAINED AND WORKING AT VILLAGE LEVEL (MATRONE AND SECOURISTE) (56 HUTS OR 75 PERCENT)

E. ONE SANITATION/PREVENTIVE HEALTH PROGRAM INTRODUCED IN VILLAGE (38 HUTS OR 50 PERCENT OF TOTAL)

F. VHWS KEEPING HEALTH HUTS LOGS ADEQUATELY (38 HUTS OR 50 PERCENT)

G. REGULAR MONTHLY MEETING BETWEEN HEALTH POST NURSE OR ITINERANT AGENT AND VHW AND VILLAGE COMMITTEES (~~48~~ 60 HUTS OR 80 PERCENT)

H. INCREASED AWARENESS OF HUTS SERVICES AND PREVENTIVE HEALTH ACTIVITIES BY VILLAGE RESIDENTS (~~48~~ 60 HUTS OR 80 PERCENT)

II. AT HEALTH POST LEVEL - EVALUATION PERFORMED AT 10-15 POSTS WHICH SUPERVISE THE SELECTED VILLAGES.

A. NURSE TRAINED AS A TRAINER (100 PERCENT)

B. ITINERANT AGENT TRAINED AS TRAINER (100 PERCENT)

C. TRAINING CONDUCTED FOR HEALTH AND MANAGEMENT COMMITTEES AND VHWS OF SELECTED VILLAGE (80 PERCENT)

D. QUARTERLY WORKPLANS DEVELOPED (75 PERCENT OF POSTS)

E. MONTHLY ACTIVITY REPORTS COMPLETED (50 PERCENT)

F. HEALTH POST NURSE AND ITINERANT AGENT ATTENDED MONTHLY MEETING AT DEPARTMENT AND SELECTED VILLAGES (75 PERCENT)

G. HEALTH HUT LOG SUMMARIZED INDIVIDUALLY AND BY CR AND DISCUSSED WITH VHWS AND VILLAGE COMMITTEE MEMBERS. COPY FORWARDED TO PROJECT OFFICE (50 PERCENT)

H. REGULAR SUPERVISION AND ONGOING TRAINING TO VHWS AND VILLAGE COMMITTEES (FOR EACH AGENT AND NURSE - TWO VISITS PER MONTH TO SELECTED HUTS PLUS TWO VISITS PER MONTH TO SELECTED VILLAGE COMMITTEES AND ONE VISIT PER MONTHS TO OTHER HUTS AND COMMITTEES (50 PERCENT)

I. MOBYLETTES HAVE BEEN MAINTAINED IN OPERATING CONDITION (50 PERCENT)

J. HAVE INTRODUCED ONE SANITATION/PREVENTIVE HEALTH PROGRAM INTO EACH OF SELECTED VILLAGES (50 PERCENT) OF SELECTED VILLAGES

2 III. ABOVE PROGRAM PROVIDES FOR SCALE DOWN TO 120 VILLAGES (60 EACH YEAR) EVALUATED DURING TWO YEAR PERIOD AND SEEMS TO MEET SCHLESINGER'S CONCERN. PLEASE ADVISE YOUR REACTION TO ABOVE.

Urgent

See letter received 01/07

70