

World Vision Relief & Development Inc.

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Mid-term Evaluation
Thies Extension Child Survival Project
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Acronym List

ADP	Area Development Program
ALRI	Acute lower respiratory infection
AMB	Medical Association
ANC	Ante natal care
<i>Arrondissement</i>	French term for the Senegal geographical and political division of a district
BCG	Bacilli Calmette-Guerin vaccine
BF	Breastfeeding
CDD	Control diarrheal diseases
CFA	Name of the Senegal currency
CHW	Community health worker
CSP	Child Survival Project
CHW/ASV	Community health worker
CERP	Center for the Expansion of Multiple Rural Activities
DIP	Detailed Implementation Plan
DMO	District Medical Officer
EPI	Expanded Program on Immunization
FP	Family planning
GM	Growth monitoring
HIS	Health information system
HP	Health Post
HPN/ICP	Health post nurse
IEC	Information, education, communication
IGA	Income generating activity
IMN	Impregnated mosquito net
KPC	Knowledge, practice, and coverage
LBW	Low birth rate
MC	Maternal child
MOH	Ministry of Health
NGO	Non-governmental organization
OPV	Oral polio vaccine
ORT	Oral rehydration therapy
ORU	Oral rehydration unit
PHC/SP	Primary health care
PVO	Private voluntary organization
REDIBE	Integrated Development Organization
SEATS	Family Planning Service Expansion & Technical Support
TBA	Traditional birth attendant
TS	Technical support
TT	Tetanus toxoid
UNICEF	United Nations International Children's Education Fund
USAID	United States Agency, for International Development
VHC	Village health committee
VHP	Village health promoter
WID	Women in development
WV	World Vision
WVRD	World Vision Relief & Development

Tables

Table 1	Summary of DIP Objectives and Mid-term Achievements	2
Table 2	Summary of DIP Inputs and Outputs and Mid-term Achievements	4
Table 3	Summary of Personnel Linked to the CSPProject	13
Table 4	Summary of Training Activities	14
Table 5	Summary of Self Assessment Results	15
Table 6	Summary of the CSP Supervision Structure	16
Table 7	CSPProgress Towards Sustainability	20

Appendices

Appendix 1	List of Evaluation Team Members
Appendix 2	Schedule of Evaluation Activities - English and French versions
Appendix 3	List of Key Informants
Appendix 4	List of Discussions Groups
Appendix 5	Interview Guides
Appendix 6	KIT Survey Report
Appendix 7	Ministry of Health Indicators
Appendix 8	Supervisory Guides
Appendix 9	Pipeline Analysis

Table of Contents

Executive Summary	iv
Background	1
Mid-term Evaluation Methodology	1
Project Accomplishments	2
Achievement of Project Objectives	2
Project Outputs and Inputs	2
Effectiveness	7
Relevance to Development	9
Design and Implementation	9
Design	9
Management and Use of Data	9
Community Education and Social Promotion	11
Human Resources for Child Survival	12
Supplies and Materials for Local Staff	15
Quality	15
Supervision and Monitoring	16
Regional and Headquarters Support	17
PVO Use of Technical Support	18
Assessment of Counterpart Relationships	18
Referral Relationships	19
PVO/NGO Networking	19
Budget Management	20
Sustainability	20
Recommendations	21
C o n c l u s i o n	2
	1

EXECUTIVE SUMMARY

The Mid-term Evaluation had two distinct phases: the quantitative phase included two 30 cluster KPC surveys, one in the Mékhé District and one in the Bambey District, conducted by World Vision/Senegal staff; and the qualitative phase, included direct observations, focus group discussions with mothers, community health workers, village leaders and members of partner organizations, through key informant interviews with MOH clinic and WV staff, and a review of reports and records carried out by the evaluation team members. The evaluation team spent two days in Dakar for discussions with senior MOH officials and seven days in the field to reach nearly 200 mothers, and others directly benefitting from the project.

The project's major accomplishment is the impact it has made on the health of the beneficiary population through a broad and integrated approach to health development. By coordinating WV/Senegal's ADP program, which focuses on community enhancement activities such as IGAs, improved water sources and sanitation, with the CS interventions, the CSP has made access to health care services possible, and at the same time has enhanced the general well-being of people living in the target villages by meeting some of their most basic needs. The project has accomplished its intended outputs in terms of training VHCs, CHWs and TBAs, rehabilitating or constructing health huts and has effectively combined its resources with those of the MOH to bring health care within reach of the beneficiary population. The CSP has not been as effective in meeting some of the objectives as set out in the DIP. Particularly, objectives concerned with the TT2 immunizations of mothers, exclusive breast-feeding, treatment of diarrhea with ORT, the addition of semi-solid foods to children's diet between ages 4-6 months, and the use of impregnated bednets. These objectives will not likely be met during the one year remaining in the project. These objectives, for the most part, may have been too ambitious, especially for the new expansion areas in the Bambey District

This CSP has completely integrated its activities with those of the MOH and has assisted the MOH in reaching its goal to decentralize health services to the most peripheral level. By bringing health care services close to where people live and by training community health workers to provide some those services, the project has made valuable contributions. It has assisted the MOH in demonstrating that decentralization is possible and that even poor communities are able to generate resources to help maintain health care coverage. The most important lessons learned are that close collaboration with MOH increases the sustainability of efforts, and that combining conventional CS activities with longer lasting development programs creates a synergistic effect that benefits the entire community.

Activities carried out by project staff, such as training and supervision of CHWs and TBAs are of high quality, however, the quality of outreach services provided by HPNs needs to be improved. The evaluation team recommends that more effort is needed to improve the quality of outreach health care activities and that there is an urgent need to diversify health messages delivery

This report was prepared by Helga M Morrow with assistance from the evaluation team members. The content of the report was shared with key stakeholders during the evaluation feedback session held on the 19th of September at the WV/Senegal national office in Thies. Local NGOs, USAID/Senegal, district medical officers, and others were invited to attend this session

BACKGROUND

World Vision's Thies Child Survival Project (CSP) has operated in all three *arrondissements* - Niakhéné, Merina and Dakhar - of the Mekhe District, Thies Region since October, 1991. Then, in 1994, with a three year centrally funded CS grant from USAID, the CSP project activities were continued in the Mekhe District, and expanded into two new *arrondissements* - Meouane and Baba Garage - of the Bambey District which is situated to the east of the Mékhé District in the Diourbel Region.

Both the Mekhe and Bambey Districts had been characterized by low health service coverage and disproportional high maternal and infant mortality rates. Key factors that have limited improvements in the health status of mothers and children include: poverty, very low female literacy rate, consistent droughts, and cultural beliefs and taboos that have a negative impact on health and are difficult to change.

World Vision's approach to improve the overall health and well-being of families and communities in the *five arrondissements* is to strengthen community health services by enhancing the technical skills and knowledge of MOH service providers, training community-based volunteer health workers, and supplying health posts, health huts and the communities with essential supplies and materials. Project staff facilitate and motivate, but do not provide any direct services other than training and supervision.

MID-TERM EVALUATION METHODOLOGY

The Mid-term Evaluation team was composed of individuals from WV/Senegal, WVRD Headquarters, MOH, the CSP, and an external evaluator. The schedule of the activities conducted by the evaluation team was prepared by the external evaluator in consultation with the project management. The evaluation took place in the five *arrondissements* of the Mekhe and Bambey Districts where project activities are being implemented. To obtain the information contained in this report the evaluation team members held discussions with mothers, community health workers, TBAs, health post nurses, village health committees and many others. In addition, they observed supervisory visits, and clinic and community education sessions. The evaluation team was also provided the results of the Mid-term KPC survey conducted in the districts prior to the arrival of the evaluation team leader. (See Appendices 1, 2, 3, 4, and 5)

The Mid-term Evaluation had two distinct phases: the quantitative phase that included two 30 cluster KPC surveys carried out by World Vision/Senegal before the arrival of the evaluation team leader; and the qualitative phase, carried out by the evaluation team through focus group discussions, key informant interviews with mothers, community health workers, MOH clinic and WV staff, village leaders and members of partner organizations, through direct observation, and a review of reports and records. Data from the KPC surveys were available for review by the team and were used to evaluate the effectiveness of some of the project's interventions (see Appendix 6). In total more than 700 people participated in the evaluation, including the KPC survey teams and the 480 mothers interviewed during the surveys.

Table 1: Summary of DIP Objectives and Mid-term Achievements, continued

DIP Objectives	End of Prqject Target	Mid-term Achievement per District
Percent of mother who know what foods prevent anemia	65%	71% -B 74% -M
Percent of mothers who consume more foods than usual during pregnancy	65%	48% -B 55% -M
Percent of pregnant mothers with 2 or more prenatal visits	70%	42% -B 52% -M
Percent of deliveries conducted by a trained health agents	65%	48% -B 58% -M
Percent of women not wanting a child within next two years who are using a modem contraceptive	5%	3% -B 9% -M
Percent of pregnant women who receive weekly malaria prophylaxis	60%	NA NA
Percent of children with suspected malaria who received full course of treatment	60%	NA NA
Percent of households with impregnated mosquito nets	20%	8% -B 2% -M

B = Bambey District

M = Mékhé District

Project Outputs and Inputs

The following table is a summary of project inputs and outputs accomplished by the project to date as compared to the DIP projections. The actual number of village centers included in the project area is 98 and not 129 as stated in the DIP. Therefore, the number of health huts established or rehabilitated and the number of health workers trained reflect the actual number of village centers rather than the number mentioned in the DIP. Each village center is strategically located and serves 4-5 satellite villages. The selection of village centers and their location is based on discussions and collaboration with the MOH and local leadership.

Table 2: Summary of DIP Inputs and Outputs and Mid-term Achievements

Inputs (DIP)	Inputs to-date	Final Outputs (DIP)	Outputs to-date
training of MOH staff	-2 sessions held on EPI at both the Mékhé and BAMBEY Districts	trained MOH staff	-48 nurses and midwives trained in the two districts
establish immunization site at each village center	-1 immunization site established at each of the 98 village centers	- 129 community-based immunization posts established -258 VHPs trained - 129 TBAs trained -129 VHCs trained	-98 immunization points established in the project area -immunization services available one day per month within 5 km for beneficiary groups -224 VHPs trained - 109 TBAs trained -98 VHCs trained
-train VHCs -train VHPs in EPI & surveillance -train TBAs in EPI & surveillance -bt-monthly EPI sessions	-28 training sessions held for VHCs on EPI community organization and management -28 training sessions held for VHPs on EPI communication, education and information -EPINEC sessions carried out by VHPs regularly in each village center and in some satellite village.	-HIS strengthened -improved disease surveillance	-immunization drop-out rate monitored after each vaccination session
-supply HPs with syringes and needles -follow-up defaulters -support during vaccination campaigns	-syringes and needles supplied by UNICEF - district mobile immunization team transported 4 days weekly to vaccination sites to increase accessibility	-reliable cold chain -Increased knowledge of immunization and attendance -improved EPI coverage -decreased drop-out	- in Bambey, mothers' knowledge of when to give measles vaccine increased from 7.5% at baseline to 21.7% Mid-term KPC and that TT protects both mother and baby Increased from 29% baseline to 42% Mid-term - drop-out decreased from 36.5% to 13% cover-age increased from 34% to 64%
-train MOH and project staff on CDD and ORT -train VHPs, VHCs and other development agents	-1 session held for Mékhé District staff -28 sessions held for VHPs -28 sessions held for VHCs -2 sessions held for WV other development agents	-trained MOH and project staff -259 VHPs and 129 VHCs trained -other development agents trained	-23 nurses and midwives trained in Mékhé District -224 VHPs trained -294 VHCs member-trained -46 others WV development agents trained

Inputs (DIP)	Inputs to-date	Final Outputs (DIP)	Outputs to-date
-provide OKU supplies -provide CDD visual aids	- 14 ORU kits supplied -112 images boxes on CDD supplied	-health posts and centers equipped with ORU -each village center has visual aids	- 14 health posts and two health centers supplied with OKU kits -98 village centers and 14 health posts have images boxes
-bi-monthly education sessions -promote hygiene & sanitation committees	-regular sessions held by Ws on hygiene and sanitation promotion in village centers and satellite villages	-129 hygiene & sanitation committees -local artisans trained in latrine and jar construction	-33 hygiene and sanitation committees functioning -69 local masons trained in latrine construction -2 local artisans trained in jar with faucet construction
-train local artisans -provide latrine and jar materials -integrate with ADP water program	- 1410 latrines and 256 jars materials supplied to household -69 village centers have a water pump from ADP water program	-increased # of houses with latrines and jars -all WV hand pumps protected -improved community hygiene -Increased # of diarrhea cases managed appropriately	- 20% Increase in ORT usage, but a 12% drop in the number of mothers who gave the same or more breast-milk during last diarrheal episode - increase of only 1% in the number of houses with latrines increase of 4% in the use of closed water jars. -project area sprayed against cholera which is prevalent in all surrounding zones
-train MOH and project staff on nutrition -train VHPs, VHCs, TBAs, and others on nutrition	-28 VHP training sessions held -9 TBA training sessions -2X VHC training sessions	-trained MOH and project staff -258 trained Ws - 129 trained TBAs - 129 trained VHCs and others	-224 Ws trained -71 TBAs trained -294 VHCs members trained

Inputs (DIP)	Inputs to-date	Final Outputs (DIP)	Outputs to-date
<ul style="list-style-type: none"> -bi-monthly education sessions on initiating breast-feeding -provide weighing scales -cooking demonstrations -monthly GM sessions -community gardens initiated -nutritional status of pregnant women monitored -agriculture, livestock and literacy activities integrated with WID program -provide visual aids for training 	<ul style="list-style-type: none"> -education sessions and cooking demonstration are carried out by VHPs regularly at each village center. -32 weighing scales provided. - community gardens established at each village center and equipped by ADP pumps - 112 image boxes provided 	<ul style="list-style-type: none"> -regular GM sessions at village centers -community gardens established -Increased knowledge -improved weaning practices -increased # children exclusively breast-fed 	<ul style="list-style-type: none"> -GM session carried out in each village center each month -69 community garden established - decrease of 9% in the number of mother who correctly knew when to introduce weaning food.
<ul style="list-style-type: none"> -train MOH and project staff on MC/FP -train Ws, TBAs, VHCs and other on MC/FP 	<ul style="list-style-type: none"> - 1 session held for project and MOH staff -28 sessions held for Ws and VHCs -15 sessions held for TBAs 	<ul style="list-style-type: none"> -trained MOH and project staff -258 trained Ws - 129 named TBAs - 129 trained VHCs and others - 129 health huts for provision of ANC 	<ul style="list-style-type: none"> -23 MOH staff and 4 project staff trained -224 Ws trained - 110 TBAs trained -294 VHCs members trained -98 health huts and 14 health post supplied with ANC provision
<ul style="list-style-type: none"> -establish health huts at each village center MC/FP -bi-monthly education sessions 	<ul style="list-style-type: none"> -98 health huts established -maternal care and family planning education sessions carried out by Ws in each village center and some satellite villages 	<ul style="list-style-type: none"> -improved referral of high risk pregnancies -improved antenatal care -Improved postnatal care -Improved emergency transport system 	<ul style="list-style-type: none"> - increase of 15% in mothers with TT2. - increase of 10% of mothers with at least 2 prenatal visits and 10% in at least one post-natal visit
<ul style="list-style-type: none"> -distribution of condoms -promotion of home-based maternal cards 	<ul style="list-style-type: none"> -condoms are distributed by health post nurses -mothers provided with maternal cards 	<ul style="list-style-type: none"> -increased use of modern contraceptives 	<ul style="list-style-type: none"> - increase of 5% of use of modern contraceptives -increase of 12 % of mothers who were assisted by a trained agent
<ul style="list-style-type: none"> -supply TBA kits 	<ul style="list-style-type: none"> 98 TBAs kits supplied 	<ul style="list-style-type: none"> -Increased knowledge of importance of and attendance at pre and post natal care services 	<ul style="list-style-type: none"> -increase of 10% of mothers with at least 2 prenatal visits and 10% in at least one post-natal visit.

Inputs (DIP)	Inputs to-date	Final Outputs (DE')	Outputs to-date
-train MOH and project staff on malaria prophylaxis -train VHF's, TBAs, VHCs and other on malaria prophylaxis -train women's groups to make and treat bednets -provide nets and insecticides -bi-monthly health education -provide chloroquine -provide visual aids	- 1 session held for MOH and project staff -28 sessions held for VHPs -9 sessions held for TBAs - 14 sessions held for women's groups - 14 10 nets and enough insecticides for treatment supplied -268 chloroquine cans with 1000 tablets each provided -12 images boxes provided	-trained MOH and project staff -258 trained VHPs - 129 trained TBAs - 129 trained VHCs and others -women's groups trained -improved home and facility management of malaria -decreased incidence of LBW babies -increased # of houses with bed-nets -improved knowledge of causes and means of protection against malaria	-224 VHPs trained -71 TBAs trained -98 VHCs trained -48 leaders groups trained on bed net treatment - increase of 6% in the use of bed nets.

EFFECTIVENESS

Progress in meeting objectives and yearly targets

It has already been noted that the DIP does not contain yearly targets and that the end of project objectives are not different for the expansion area and the refunded area. In any event, it is the conclusion of the evaluation team that the CSP has already had a considerable impact on the health of infants, children and families in the target areas. The overriding response of the villagers interviewed when asked the question, "What is your observation regarding the health of the community since the introduction of the Child Survival project in your village?" was, "Our children are no longer dying?" Other direct evidence of the positive health impact on the communities occurred during the recent cholera epidemic in Senegal. No cases of cholera were reported in the CSP target areas, whereas the epidemic killed scores of people in neighboring villages. Villagers also reported that compounds are much cleaner, that water sources have improved, latrines have been built, and that health services are now accessible. Antenatal services at the health huts have improved considerably, and mothers are more aware of the need to seek the services of a trained attendant

Nevertheless, the clear positive impact that the project has in terms of improving the health status of the beneficiary population is not reflected in the progress made towards meeting the objectives as outlined in the DIP. Substantial progress still needs to be made toward meeting many objectives except for the objectives related to contraceptive prevalence, a reduction in the immunization drop-out rate in the Mekhe District, and mothers' knowledge of what foods are "good" when they are pregnant. Moreover, the two objectives related to malaria prophylaxis for pregnant mothers and treatment of children 0-59 months of age are not appropriate and can not be measured by the KPC survey as stated in the DIP. One of the recommendations made by the evaluation team is that those two objectives be dropped from the list.

There are several reasons for the gap between the DIP stated objectives and the current status of the project. First, it is not clear how the targets for the combined DIP objectives were derived, as they appear to be unrealistically high for some activities, especially considering the Bambey baseline data. Even with the best intentions, it is unlikely that a three-year funded project can dramatically change culturally ingrained practices and behaviors, such as the value placed on having many children because of economic and social reasons, introduction of exclusive breast-feeding and weaning practices and the use of impregnated bed-nets are difficult, especially with the high illiteracy rate among the population. Secondly, in some villages visited by the evaluation team, none of the persons present could read nor write. Finally, the project staff does not provide any direct services; rather they rely on MOH staff to conduct immunization and pre- and postnatal care outreach sessions. The same impediments that hinder adequate health service coverage, such as shortages of health post staff, supplies and inadequate transport, also impact on the ability of the project to reach objectives.

Other major developments that impact on project activities include prolonged periods of droughts (and the nutritional and economic consequences of such droughts), and the continuing problem with lack of water. Furthermore, the government has embarked on an ambitious decentralization policy that is based on the Bamako Initiative. All health care services offered by the MOH are fee based. Part of the money is used to maintain stocks of medications and pays for expenses, other than salaries, and a certain percentage is for use by central government. The districts are experimenting with a new approach to extend health care coverage. Village centers that do not have services can request health care coverage if they initiate the construction of a health hut and pay for the maintenance of the services, including the salary of a nurse. The MOH will also support the nurse, who will continue to retain the level of a “state nurse”.

Progress in reaching “high-risk” groups

The CSP has concentrated its resources on strengthening the capacity of both MOH personnel and communities to provide mothers and children with accessible health care services. The dominant mechanisms used to accomplish this is training. The project has successfully trained CHWs and TBAs to provide services at the health huts which have been strategically located in village health centers. Secondly, the project has assisted in the construction of 98 health huts by providing materials and supplying them with TBA kits and a limited stock of medications. Before the implementation of the CSP in Mékhé there were 4 health huts functioning in the district - now there are 71. In Bambey there were 11 non-functional health huts - now there are 27 functioning health huts. With the construction and maintenance of these huts, no village is further than five km from a village center with a health hut.

Mothers participating in the focus group discussions reported that they prefer now to deliver in a health hut with a trained TBA rather than at home because, “It is safer there.” One mother related what happened to her two months ago when she had a miscarriage and bled profusely. She went to the health hut, but the TBA recognized her condition and transported her by horse and carriage to the nearest health post. Her condition deteriorated and she was finally transported to Dakar 100 miles away where she received two blood transfusions that saved her life. However, there was no doubt in the mother’s mind that the trained TBA had saved her life.

Similarly, village leaders reported that they wanted their wives to have their babies in a health hut with a trained TBA because they had seen the difference it had made in their wives and children's health.

Each of the village centers is serviced regularly by a health post nurse. Such visits are scheduled monthly, however the periodic shortages of vaccines and lack of adequate transport may prolong the time between visits. The project supports health center personnel through the provision of transport whenever possible, but the project does not supply the vaccines.

The beneficiary population is also reached through other project activities, such as the construction of latrines, improved and more accessible water sources, IGAs, and the availability of bed nets. All the project's activities are fully integrated with those of the MOH, local organizations (providing, for example, agricultural services), and WV/Senegal ADP activities. The WV/CSP is located in an area where WV has ADP activities. It is anticipated that the ADP projects will remain in progress for 10- 15 years as they are funded by World Vision International with contributions from private and corporate sources.

RELEVANCE TO DEVELOPMENT

The CSP in the Mékhé and Bambey Districts is integrally woven into the overall development plan for the area, both as a component of WV's other developmental projects and other governmental developmental efforts. For example, WV/Senegal was asked by the government to take on the responsibility for Literacy Day this year. A number of activities were carried out very successfully and generated much publicity for WV. Other activities implemented by WV through their ADP program include: village level literacy programs - 19 literacy centers have been established in the project area; well drilling and rehabilitating traditional wells - 5 14 wells have been drilled; training of "bush" veterinarians, literacy agents, village water committees, CHW nutritionists, and "bush" agriculturalist; providing seeds and insecticides; working with local development organizations; and developing IGA activities for women and training them to carry out the activities, such as operation of oil presses and grain mills. WV/Senegal also works with local groups on reforestation projects and on the protection of the environment.

DESIGN AND IMPLEMENTATION

Design

Since the start of the CS project, there have been no changes made in the target area nor in the beneficiary population.

Management and Use of Data

Qualitative data collection - Project staff has developed a supervision guide for each activity, which is used during supervisory visits with CHWs, VHCs, and TBAs. These guides mainly serve as reminders of the essential elements of supervisory visits, such as a review of the content of TBA kits, important topics for discussion, and observation of the status of equipment and

materials, such as water jars and latrines. Information from the guides is used to provide immediate feedback to the community health workers and is also used during the quarterly feedback sessions held at the village centers with the health post nurses, the VHCs, and the CHWs and TBAs. The value of such meetings has been recognized by the director of Primary Health Care services, who wants to institutionalize them at the district level for district personnel in collaboration with VHCs

Health post nurses are required to fill out a monitoring guide every six months that contains information from the health posts on the quality of services offered, such as the percentage of adequately treated illnesses according to type of complaint. Health post nurses forward the completed guides to the district monitoring supervisor, who compiles the information and forwards it to the central MOH office. At the health post level, the evaluation team was told that the information is used for the quarterly feed-back sessions, but that no feed-back is received from the central government. Completing the monitoring guide is extremely time-consuming and the process has only been in operation for less than two years. During the key informant interview with the director of Primary Health Care, he mentioned that he will request the assistance from WV to revise the monitoring guide, which was originally developed by UNICEF, since it is too cumbersome and contains information that is not useful.

Other qualitative data collection methods are periodic evaluation of the project staff and direct observation of project staff as they carry out their duties.

Quantitative data collection - The CSP did not develop their own health information forms for project personnel; rather all data is collected on standard government forms. At the village level, the trained health care workers, who are almost all illiterate, are to record the number of women who come for ante- or post natal visits, the number of deliveries conducted in the health huts or assisted in homes, the number of latrines and water jars in the village center and satellite villages, the number of educational sessions held and the number of bed nets used and impregnated. Project staff record the number of training sessions held, the number of supervisory visits made, the number of water sources installed or improved, the number and type of materials and supplies distributed, and the number of health committees formed, trained and supervised.

Health post nurses are responsible for collecting data generated at the village centers, such as number of vaccinations given by antigen, number of children weighed, and the number of ante - and post natal consultations. Information is marked on growth cards, in village registers and in record books. Data from the village centers is collated at the health posts, recording and send on to the district. Data collection at the health posts is extremely detailed, time demanding and difficult. Huge recording books need to be filled out monthly and then forwarded to the district health office. The district medical officer commented on the uselessness of the health information system and the need for a dramatic overhaul. He also asked for the assistance of WV with the design of a new system that was more user friendly. (Appendix 7: List of MOH Indicators)

Neither the project nor the MOH has a record keeping system for use by illiterate workers. In some of the villages the CHWs and TBAs ask for assistance from villagers who can write, but often they have to memorize numbers and present oral reports. During several of the meetings, comments were made about the competency level of the community health workers and the problems such workers present. For example, it was noted that CHWs can not help the health

post nurse with weighing because she can not read. The CSP has used male CHWs with a higher literacy rate for other CS projects, but has found that their attrition rate was very high. The attrition rate for the CHWs currently working with the project is very low. Nevertheless, the project does need to concentrate efforts on developing or adapting an adequate record keeping systems for the CHWs and TBAs.

The major lesson learned and institutionalized is the quarterly feed-back meeting held with the health post nurse and the village health center workers and VHCs. As VHCs are composed of community members, there is a direct line of communication between the project, the health post and the community.

Community Education and Social Promotion

Balance between health promotion, social mobilization and service provision - Project staff do not carry out any direct health care services, other than periodically to help the health post nurse with outreach activities. All activities at the health huts are carried out by trained CHWs, TBAs and health post staff. CSP staff are responsible for training, coordination, supervision and providing specific resources, such as TBA kits, transport, and materials and supplies for the health huts. MOH staff is responsible for monthly or bimonthly outreach services, and the CHWs and TBAs are responsible for providing day to day health care services, mobilizing the communities for health education, and ensuring, with assistance from VHCs, that water sources are maintained, compounds are clean, and latrines maintained.

Because of the government's decision to decentralize to the village level, there is an infrastructure in place that supports health hut activities. In most of the villages visited, a system had been established for the monthly collection of fees to support health hut activities, pay the CHWs and the TBAs a small stipend, as well as health hut improvements. For example, through the fees collected, several village centers already had constructed health huts out of cement or had bricks made for the hut. All the labor for the construction of health huts is donated by the community.

Activities carried out in the community - The government's decentralization policy to bring health care services, as close as possible, to the village level supports community-based activities. The CSP coordinates its activities with those of the MOH at the village and village center level, and reinforces other development efforts. Virtually all CS interventions directly impact villagers most in need of the services.

Approach to community education - CHWs and TBAs are trained to use what the project calls an "image box". The wooden box contains a series of pictures depicting a particular situation, such as a child with diarrhea, a pregnant woman, or malaria control. During outreach sessions, while mothers wait, CHWs use the boxes to present a particular message. Mothers are asked for feedback and to repeat the message. Twice a week the project staff also goes out with a portable generator and video equipment to show relevant videos. This is a particularly popular communication method and attracts men as well as young boys to the village centers.

Non-traditional or participatory educational activities used - The project has just started plans to develop theater groups. A director has been contacted and themes have been developed. There is an urgent need to diversify educational approaches and bring some "life" into the way messages

are delivered. The evaluation team observed several educational sessions and concluded that the project must make a greater effort to be more creative and to better involve the community.

Assessment of learning - As all the CHWs and TBAs are illiterate, project staff does not use pre- and post tests to assess knowledge gained. Staff, through supervisory visits and return demonstrations assess topics that need reinforcing or behaviors that require further interventions. Mother's knowledge is assessed through feedback while messages are delivered. None of these methods are adequate to truly assess what learning has taken place or what practices have changed as a result of the messages delivered. A more objective methodology is the KPC, which actual shows changes in coverage and practice and the direct feedback from the community on the changes that have taken place in the health of mothers and children since the project was began.

The evaluation team has no doubt that messages have had an impact, because they have gone hand in hand with the provision of accessible services.

*The way the **messages** are developed* - The messages are consistent with those supported and developed by the MOH. The project does not develop its own messages, nor does it test them. The project does adapt messages according to specific needs, but as the messages are mainly those based on the pictures in the "image box," there is very little variation.

Assurance of consistency of messages - During a supervisory visit, project staff will observe the presentations of the CHWs and TBAs at an outreach sessions. If needed, corrections are made during the presentations. There is a need to change the malaria message, as the MOH has changed its approach to the use of chemo-prophylaxis for pregnant women and children and also its approach to the treatment of malaria in young children. The new approach is necessary because of an increased resistance to chloroquine and the wide spread and indiscriminate use of this drug.

*Development, pretesting **and** distribution of printed materials* - The project does not develop and distribute printed materials, as the population is largely illiterate.

Human Resources for the Child Survival Project

Roles, functions, numbers and categories of persons linked with the CSP are summarized in Table 3 below.

Table 3: Summary of Personnel Linker to the CSP Project

Category of Personnel	Type	Roles	#
W/CS staff	Nurse-midwife, nurse, sanitation agent, tramer	-supervise and train TBAs, VHPs, VHCs, and others WV ADP agents -data collection and feed back to community -project action plan follow Up	4
WV/CS staff	Project manager - senior nurse with PHC background	-project action plan, financial management and follow up -project staff supervision and training -project activities and ADP activities integration -project design, monitoring and evaluation	1
WV/CS staff	Drivers	-drive vehicles and maintenance	3
WV staff	ADPs staff	-ADPs activities follow Up	6
MOH staff	Health post nurses and midwives	-health care services - Ws, VHCs and TBAs training and supervision -data collection and analysis	20
MOH staff	District supervisors	-health post nurses and midwives supervision -data collection and analysis	5
MOH staff	District medical doctor	-distract health system management -data management	2
Community volunteers	TBAs	-MC community services and IEC	109
Community volunteers	CHWs	-community information and education on project technical components -community involvement, awareness and social mobilization for project activities	224
Community volunteers	VHCs	-community project activities management and community involvement	98
Community volunteers	ADPs volunteers. hush techmcians .bush consultants .literacy facilitators	-community ADP activities integrated into project activities	50

The actual number of project staff compared to number of volunteers is small. As noted in the table above, the project employs five professional staff, compared to 333 community health volunteers. All the volunteers are in place, trained and functioning actively.

The drop-out rate for the volunteers is very low - <3%. The following factors contribute to the low attrition rate for the CHWs and TBAs:

- they are reimbursed for their services through fees paid by villagers
- they are illiterate women who have little opportunity to leave the village and find other means of employment

- they are trained to perform specific functions, which increases their status
- they are selected by the VHC and are trusted by the people they serve
- they are included in regular feed-back meetings at the health posts.

Type, method and duration of training for each category of health worker.

Table 4 Summary of Training Activities

Group with # and dates	Topics	# of hours	Training Method
MOH and project staff (27) 04/16-04/19, 1996	malaria prophylaxis	20 hours	discussions demonstrations
MOH and project staff (48) 05/09-05/11, 1995 1104-1118, 1995	vaccinations	40 hours	discussions exercises
MOH and project staff (27) 06/11-06/15, 1996	diarrhea disease control	30 hours	discussions exercises
MOH and project staff (27) 08/07-08/11, 1996	maternal care	30 hours	discussions exercises
TBAs (110) 07/24-08/23, 1995 09/04-08/10, 1995 11/15-12/15, 1995 03/12-04/12, 1996 05/13-06/13, 1996 07/108-07/123, 1996	maternal care	480 hours each session for initial training and 15 hours for CE	demonstrations discussions
VHPs (224) 01/21-01/24, 1995 02/04-02/07, 1995 01/10-01/13, 1996 02/106-02/108, 1996	maternal care and family planning vaccinations growth monitoring and nutrition malaria control diarrhea diseases control and sanitation	30 hours for each session	role play discussions demonstrations
VHCS (98) 03/109-03/113, 1995 4/121-04/125, 1996	community health activities management	12 hours for each session	discussions
Bush technicians Bush consultants (25) 11/104-11/09, 1995 04/10-04/14, 1996	health topics in ADP development activities	12 hours for each session	discussions
Masons (69) 05/12-05/13, 1995	latrine building	6 hours for each session	demonstrations and practice
Tailors (14) 07/12-07/13, 1996	bed net sewing	6 hours for each session	demonstrations and practices

Supplies and Materials for Local Staff

The project staff is responsible for supplying certain materials for the construction of latrines and health huts, the sewing of bed nets, the development of water jar, and supplying health huts with limited number of medications and TBA kits. They assist health posts by supplying needles and syringes. The project does not provide vaccines, nor does it ensure that the health posts are adequately supplied. With the government's decentralization policy, most supplies have to be bought by funds generated at the health posts and health huts.

According to the local staff, there have been no shortages of any supplies and materials since the project started. When shortages do occur, such as the shortage of certain vaccines, for example, BCG and yellow fever, it is beyond the control of the project. Other shortages that occur periodically that are beyond the control of the project relate to transport for health post staff due to frequent break-downs of vehicles and "motos".

Quality

The following table reflects the results of an exercise carried out during the evaluation with project staff. Staff was asked to self-assess their knowledge and skills related to each of the CSP's major interventions and then to assess the knowledge and skills of the community volunteers and mothers. The table confirms the KPC results, i.e., an adequate level of knowledge does not necessarily translate to an adequate level of practice and that repeated educational sessions with mothers must be reinforced through other health education activities, and an active follow-up and support system.

Table 5: Summary of Self Assessment Results

Intervention	Project Staff		CHWs/TBAs		Mothers	
	Knowledge	Practice	Knowledge	Practice	Knowledge	Practice
Immunizations	good	average	average	-	average	good
CDD/ORT	very good	good	very good	good	good	passible
Nutrition/BF	very good	average	good	passible	good	passible
Malaria	very good	passible	good	good	very good	very good
Maternal Care/FP	good	average	average	passible	passible	passible

The evaluation team had the opportunity to observe health care services carried out in the health huts and health posts and noted that in many instances the quality of services needed improvement. During immunizations sessions, vaccines were not returned to the cold box, syringes were used for multiple vaccinations, the skin was not adequately cleaned, immunizations were not appropriately given, and mothers were not counseled on follow-ups. Weighing sessions were not useful since the weight of the baby was rarely compared to previous weights and the mother was not counseled when the baby's weight dropped or the gain was inadequate. The

nurses responsible for these outreach sessions often worked alone and under tremendous pressure to see all mothers and children that had come for the services. The evaluation team was told that well over 100 mothers come with their children per session for services, and that the support provided by CHWs and TBAs is minimal. The evaluation team feels strongly that effort needs to be made to improve the quality of health care services at the health posts and the health huts and that this is made a high a priority. During the final debriefing session, several recommendations were made that could improve the quality of services.

Supervision and Monitoring

The following table reflects the line of supervision of each category of worker associated with the project. As can be noted from the table, project staff although very involved in the training of MOH staff, do not have supervisory responsibilities for them, and, therefore, do not have the direct influence needed to change practices. Project staff are, however, responsible with MOH personnel for the quality of services carried out during outreach sessions and as such, has channels of communication open to them to affect changes

Table 6: Summary of the CSP Supervision Structure

Health Worker	Supervisor	Method	Frequency	Length
CHWs TBAs	HPN Project staff Mobile team	Visit health huts Visit during activities	Bimonthly	1-2 hours
Village health committees	HPN Project staff	Visits	Bimonthly	1-2 hours
HPN	Medical officer District supervisor Midwife	Coordination meetings On site visits	Every 3 months	3 hours
		On site visits	Bimonthly Bimonthly	4 hours
District supervisors or Midwives	Regional supervisors District medical officer National supervisor	Coordination and feedback meetings On site visits Consultations at office	Quarterly According to need	4 hours 3 hours
Project staff	Project manager	Regular meetings On site visits	Every 15 days According to need	1 day
		Evaluation	Yearly	1 hour
Project manager	National director Regional health advisor	Meetings on site visits	Weekly According to need	4 hours
		Evaluation	Yearly	1 hour

Ratio Of supervisory personnel to worker at all levels and the adequacy of ratios - The project staff has an adequate supervisory ratio as can be noted from the table above. However, the ratio between CHWs and TBAs and MOH supervisors is 20:1, and 107: 1 for project staff. The ratios are based on 431 community workers, which includes 109 TBAs, 224 CHWs and 98 VHCs, and

20 health post nurses and midwives and 4 project staff. As the work of the community volunteers is minimal in scope, (CHWs do mainly health education and social promotion, TBAs are responsible for uncomplicated obstetrical services and with extra training for minor ailments), their supervisory ratio is probably not unreasonable, especially because project staff are conscientious about their regular feedback sessions with these groups. Of greater concern is inadequate supervision of MOH staff, who are mainly responsible for delivering outreach services and providing acute and preventative services in the health posts, There is recognition that quality of those services needs enhancement and it may possible for the project to assist the MOH in carrying out those enhancement activities.

Supervisory techniques - Most supervision is done through observation and feedback. Project staff visit the different village centers on a monthly basis and interact with the community volunteers at that time. The supervisory guides are used to test knowledge and to review health hut equipment and supplies. Feedback is provided on the spot, The supervisors observe CHWs in action as they conduct health education with the waiting mothers. Project staff also supervise the construction of latrines and the installation of water jars.

Supervision and monitoring requirements till end of project - The project's supervision and monitoring requirements for its own services are appropriate and there are no changes are needed till the end of the project. If project staff acquire the means to have a greater input into the delivery of MOH health care services, then other supervisory guides and methods need to be developed. The DMO is aware of the need to improve services and their close collaboration with project staff may make it possible for the CSP to more closely supervise outreach activities.

Description of supervisory tools developed for the project - Appendix 8 contains the collection of supervisory guides used by the project. They include guides for the supervision of CHWs on vaccination activities, ORT, nutrition, malaria and maternal care. There is also a guide for the supervision of TBAs. The tools include observation guidelines for: assessing the condition of the health hut, adequacy of the medication stock and other supplies, review of records kept by the CHWs, and TBAs, simulation or actual observation of care given to a client, review of essential knowledge of specific conditions, such as danger signs of pregnancy, and questions concerning any difficulties encountered. During a visit, the supervisor sits with the CHW or TBA on a mat on the floor in the health hut and it is quite obvious that the atmosphere is relaxed and supportive.

Regional and Headquarters Support

Administrative monitoring and technical support from PVO regional office - WV's West Africa Regional office is located in Senegal and this has enhanced direct technical and monitoring support for the project. The regional health coordinator, also located in Dakar although he was recently transferred to Mali, has provided support during the preparation of the DIP, the KPC survey and the writing of annual reports. The staff feels that the support received from the regional office has met their needs.

Backstopping staff by headquarters - According to the staff, backstopping by headquarters staff has also been adequate. Support was received with the training for Epi Info and with the preparation for the Mid-term Evaluation. WV Senegal recently hosted a Child Survival workshop on family planning and received adequate support in the preparation for that workshop.

PVO Use of Technical Support

As has been observed in other African countries where infant mortality and morbidity was very high and families expect that only forty percent of their children might reach their fifth birthday, major demographic changes are occurring. Children are no longer dying of immunizable diseases. Child survival is a reality, but children are not thriving. There is a general awareness among most communities contacted that child spacing has become a necessity and the desire to limit families is openly expressed. One of the major areas that the project has expressed a need is family planning. Particularly in a society where cultural and religious beliefs have a powerful impact on family issues, the channels used to deliver messages and provide the services must be carefully researched and tested. The project has little experience in this area and has requested technical support if it is to become more deeply involved in providing family planning services, as an integrated part of maternal health care.

The project has also requested support for the development of a community based health information system that can be easily used with non-literate CHWs and TBAs. Further technical support that the project may need is with the development of tools and techniques to help the MOH staff to provide higher quality services, and in delivering health messages in more diversified and creative ways. The staff also expressed a need to find ways to increase the technical skills of the CHWs and TBAs so that they can be used to assist the nurse during immunization sessions and with weighing the children. In summary, the staff is looking for assistance with how better to make use of illiterate community health workers.

Assessment of Counterpart Relationships

Chief counterparts and activities that have taken place - The project's chief counterpart is the MOH. Nurses from the health posts carry out all outreach services and staff the health posts. They are responsible for the supervision of community health workers, and actively participate in their training. In the agreement signed by the MOH and WV, the responsibilities of each party in the agreement are clearly spelled out. It is stated, for example, that the MOH is to ensure that the CSP is totally integrated with activities of the two districts. The MOH also accepts the following responsibilities: assist WV with administrative and technical support necessary to carry out the project's strategies and evaluation; promote and encourage WV's presence in the area; focus on decentralization of the CSP at the community level; offer tertiary services where needed; assist the project with supervision activities in the field; and assist WV with the integration of their health activities with their water and agricultural programs.

Other collaborative activities include agriculture and water projects. The construction of health huts was accomplished with the collaboration of the MOH, as was strengthening and rehabilitation of the village centers. WV's CSP is totally integrated with governmental services in the two districts and their services are complementary.

Technical and managerial capacity of the counterpart staff - One of the weakest part of the CSP is the quality of services provided by MOH staff. Whether the problems are due to inadequate technical and managerial capacity or whether other factors such as work overload play a role, was not determined by the evaluation team. World Vision Senegal project staff recognize

that actions need to be taken to upgrade the technical skills of their counterparts and that this is an urgent matter. The project is planning to focus future training activities on upgrading the skills and knowledge of MOH staff.

Communication between the counterpart and the PVO - The CSP staff hold regular meetings with their counterparts and together they provide feedback every three months to the communities, A comment made during key informant interviews was that the health activities at the community level are identified as WV services rather than MOH services. This at times creates a sense of frustration on the part of nurses who feel that the MOH should be given more credit. Other issues that appear to frustrate counterparts was insufficient time provided for meetings or training sessions. Although the project holds regularly scheduled meetings, counterparts want at least three to four days advance notice when and where the meetings will take place. A recommendation was made by the staff to remind them of this request.

Relationship between the counterparts and the community - The MOH has very good relationships with the community. Communities are aware that decentralization health services are now within their reach, even though they are paying for those services. Communities recognize that the change in their health status is directly linked to immunization coverage, access to clean water and better sanitation. Although they more closely identify WV as the primary source for those services, they are aware that the MOH is ultimately responsible.

Referral Relationships

CHWs and TBAs are trained to refer clients to the nearest health post as the first entry point to advanced health care services. There are 13 health posts/maternity centers in the target area and one health center. Patients with severe complications are transferred by ambulance to Dakar 100 miles to the south of the project area. It appears that the referral is working. There was a consensus that mothers are no longer dying in the villages, and with the training of community health workers, emergency care was now within reach of most people. Nevertheless, transport remains a serious obstacle. Many of the villages visited by the evaluation team can only be reached by four-wheel drive, especially during rainy seasons. The major mode of transport is by horse and carriage and for a woman with an obstetrical complication, this is not an ideal way to travel.

PVO/NGO Networking

There are no other PVOs working in the project area; however, the project works with many local NGOs. The project collaborates with many organizations and groups on different development issues. For example, the project works with local women's groups on income generating activities, agricultural groups on crop protection, planting and seeding, the Association of Bush Doctors on transport and supply issues, local farm associations on live stock breeding and protection, and local government groups on the selection of sites and the coordination of services.

The only complaint heard from some members of the associations was that WV could do a better job of informing the associations of training sessions so that they could better plan to contribute or to participate and to provide adequate advance notice of meetings and training sessions.

Budget Management

According to the pipeline analysis, the project is underspent (see Appendix 9). The project manager and the country finance director gave the following reasons for the under-expenditure: when the budget was prepared at the time of proposal writing, the country was anticipating a major devaluation of the currency. This did occur and the value of the CFA was reduced by 50% in 1994. There was a change in project staffing with the original project manager leaving mid-way through the first year of the project. The salary of the current manager is considerably lower than the salary that was anticipated. By integrating the CSP with WV's ADP program actual costs were lower than expected. For example, the CSP shares with the ADP office the rent of the building, some personnel and equipment costs. This considerably reduced overhead costs at the field office in Mékhé. There is little doubt that with the remaining funds the project should be able to make adequate progress towards meeting many of the objectives,

SUSTAINABILITY

Table 7: CSP Progress Towards Sustainability

Goal	End of project objectives	Steps taken to date	Mid-term measurements	Steps needed
Fully integrate project activities with those of the MOH	Integration of project activities with plans of health districts MOH staff will supervise and provide refresher training for village volunteers	MOH staff responsible for health care provided at community level MOH staff trained and share in supervisory responsibilities Regional and local MOH staff involvement in project implementation	MOH staff in project area trained in EPI, maternal care, malaria, control diarrheal diseases control and provide outreach services MOH district staff involved in project implementation and management	Phase-out monetary support for field activities. Improve quality of services provided by MOH staff through enhanced supervision and improved training HPNs to hold feedback meeting quarterly VHCs to be involved in health post activity monitoring
Assist MOH with decentralization scheme	Communities maintain health huts and generate funds to maintain huts	VHCs develop costs recovery system and income generating activities	Cost recovery scheme and income generating activities developed by VHCs are in place and functioning	Monitor the cost recovery systems at village levels and ensure integrity of the system Improve the training and the selection of VHCs and CHWs to Increase the efficiency of health services.

RECOMMENDATIONS

Recommendations for W/Senegal's Child Survival Project:

1. Hold meetings every two months with project and MOH staff to better coordinate and monitor CS and MOH activities in the target area.
2. Hold a meeting every 15 days with district personnel to better inform counterparts and collaborating agencies of project activities.
3. Provide invited partners with an agenda at least three days prior to a scheduled meeting.
4. Re-evaluate the efficacy of the supervisory program.
5. Increase supervisory responsibility over CHWs, TBAs and health post nurses as requested by the MOH.
6. Disperse money available in the budget for communications for the improvement of communication services at the field office.
7. Disperse money available in the budget for capital expenditure for the improvement of electrical services at the field office.
8. Develop in collaboration with the MOH, a "model" health hut, to be staffed by "model" staff in order to set a role model for quality in health service coverage.
9. Seek appropriate technical assistance to diversify the channels by which messages are delivered and to make the presentations more creative in order to better achieve some of the objectives.
10. Seek appropriate technical assistance to increase the effectiveness of illiterate community workers and to provide them with HIS tools adequate for their levels.
11. Develop more efficient ways to assist the health post nurse during an outreach session so that the quality of their services are not compromised.
12. Assist the villagers with establishing a reliable transport system via horse and carriage for emergency obstetrical cases and for other villagers in need of emergency care.

Recommendations for USAID:

1. Increase awareness that with successes achieved through the Child Survival program, children are now surviving, but they are not thriving, and that emphasis must be placed on integrated child development and providing families with easily assessable family spacing choices, and that funding for PVOs reflect such changes in approach to development.
2. Give approval to eliminate two malaria objectives from the lists as these are not measurable given the activities of the project and not appropriate given the beneficiary population surveyed through the KPC.

CONCLUSION

WV/Senegal Child Survival project has had a major positive impact on the health status of the population it serves in the two districts. By combining a long-term development program with shorter-term child survival activities, and closely integrating these with other developmental and health activities, the project has been successful in improving the lives and well-being of families in Mékhé and Bambey Districts.

LIST OF EVALUATION TEAM MEMBERS

Helga Morrow	Team Leader, Consultant
Milton Amayum	Medical Coordinator, World Vision Washington
Jane B laxland	Director, World Vision/Senegal
Gal10 Cissé	Area Coordinator, World Vision/Senegal
Lamine Diedhiou	Ministry of Health - Supervisor - Mekhe
Elimane Dieng	Ministry of Health - Supervisor - Bambey
Abdou M'Bengue	Area Coordinator, World Vision/Senegal
Fatou Niang	Area Coordinator, World Vision/Senegal
Banda N'Diaye	Project Manager, World Vision/Senegal
Elizabeth Ndjone	Secretary, World Vision/Senegal
David Sy	Area Coordinator, World Vision

SCHEDULE OF EVALUATION ACTIVITIES

Date	Activity	Place
8 Sept, 96	Arrival in country of consultant	Dakar, Senegal
9 Sept, 96	Meeting with evaluation team Discussion of USAID guidelines Identification of essential evaluation topics Identification of groups to contact for each topic Development of questionnaire guides for each group/person to be interviewed	Dakar
10 Sept, 96	Continuation of development of guides	Dakar
11 Sept, 96	Revision of evaluation guides Interview with director of Primary Health Care Division Development of Agenda for field evaluation Interview with Director, National Health Education & Communication Office Interview with Medical Advisor, Family Planning Service Expansion and Technical Support (SEATS) Travel to site	Dakar
12 Sept, 96	Field work	Thies Mekhe, Merina, K.O. Kane
13 Sept, 96	Field work	Ndioudiouf, Gouye Dock
14 Sept, 96	Field work	Baba Garage, Gollobe
16 Sept, 96	Field work	Mekhe, Diamatyl, Merina Thylmakha
17 Sept, 96	Field work	Mekhe, Keur Madiop, Lack Ndiayene, Bambey
18 Sept, 96	Field work	Mekhe, Thies
19 Sept, 96	Summary of findings Development of recommendations Debriefing	Thies
20 Sept, 96	Departure	Dakar

PROGRAMME DE CALENDRIER

PROGRAMME	HEURE	LIEU	EQUIPE
<u>LE 11/09/96</u>			
- Entretien avec le project manager	10 H	Dakar	
- Entretien avec SN.EP	10 H	Dakar	
- Prise de contact avec Dr. S.P	15 H	Dakar	
- Prise de contact avec SEATS			
<u>LE 12/09/96</u>			
- Entretien avec le project staff	8 H 30	Mékhé	HELGA
- Entretien avec Medecin Chef	10 H	Mékhé	H./ B./ J /F.
- Discussion avec ICP Merina	14 H	Merina	EQUIPE 3
- Discussion avec comite de santé	14H	Merina	EQUIPE 3
- Discussion avec le comite de Sante de K.O.K	15 H	K. 0. Kane	EQUIPE 1
- Discussion avec leaders villageois	15 H	K. 0. Kane	EQUIPE 2
- Observation d'une promotrice	15 H	”	EQUIPE 1
- Observation moustiquaires, latrines, canaris,.	15 H	“	EQUIPE 2
<u>LE 13/09/96</u>			
- Observation seances de soins ICP	10 H	Ndioudiuf	EQUIPE 1
- Discussion avec comite de santé	10 H	Ndioudiuf	EQUIPE 1
- Discussion de groupe avec ASV	10 H	Ndioudiuf	EQUIPE 2
- Discussion avec les meres	12 H		EQUIPE 3
- Supervision matrones	15 H	Gouye DOCK	EQUIPE I
<u>LE 14/09/96</u>			
- Rencontre avec REDIBE / AMB	10 H	Baba Garage	EQUIPE 1
- Rencontre avec CERP	10 H	Baba Garage	EQUIPE 1
- Supervision matrones	10 H	Gollobe	EQUIPE 2
- Discussions avec les meres	10 H	Gollobe	EQUIPE 2
- Focus groupe, discussion avec ICP BBG	10H	Baba Garage	EQUIPE 3
- Observation moustiquaires, latrines	10 H	Gollobe	EQUIPE 2

<p align="center"><u>LE 16/09/96</u></p> <ul style="list-style-type: none"> - Entretien avec WV staff - Observations seances de soins - Discussion avec les meres - Discussion avec les ASV - Observation seances de CPN - Entretien avec les CERP 	<p>8 H 30</p> <p>10 H</p> <p>10 H</p> <p>15 H</p> <p>10H</p> <p>15 H</p>	<p>MCKhC</p> <p>Diamatyl</p> <p>Thylmakha</p> <p>MCKhC</p> <p>Merina</p>	<p>HELGA</p> <p>EQUIPE 1</p> <p>EQUIPE 1</p> <p>EQUIPE 2</p> <p>EQUIPE 3</p> <p>EQUIPE 3</p>
<p align="center"><u>LE 17/09/96</u></p> <ul style="list-style-type: none"> - Discussion avec ICP District Mekhe - Discussion avec les GPF - Discussion avec les comites de santé - Observation promotrices - Discussion avec les leaders - Observation latrines et canaris a robinet - Rencontre avec les Medecins chef Bambey - Discussion avec les comites de santé 	<p>9 H</p> <p>10 H</p> <p>10 H</p> <p>10H</p> <p>10 H</p> <p>10H</p> <p>16H</p> <p>10 H</p>	<p>Mékhé</p> <p>Keur Madiop</p> <p>Ndiayene L.</p> <p>“</p> <p>”</p> <p>Bambey</p> <p>Ndiayene</p> <p>Lack</p>	<p>EQUIPE 1</p> <p>EQUIPE 2</p> <p>EQUIPE 2</p> <p>EQUIPE 3</p> <p>EQUIPE 3</p> <p>EQUIPE 3</p> <p>H./J./B./</p> <p>MBENGUE</p> <p>EQUIPE 3</p>
<p align="center"><u>LE 18/09/96</u></p> <ul style="list-style-type: none"> - Rencontre avec les leaders ou organisations locales (UPDM-LAKE GROVE-APAZONE 1 & 2) - Rencontre Directeur Financier - Reunion de mise au point 	<p>8 H 30</p> <p>14H</p> <p>15 H '0</p>	<p>Mekhe</p> <p>Thies</p> <p>Thies</p>	<p>EQUIPES 1, 2, 3</p> <p>HELGA</p> <p>EQUIPE 1, 2, 3</p>
<p align="center"><u>LE 19/09/96</u></p> <ul style="list-style-type: none"> - Reunion a Thies - Synthese et Recommandations 			<p>EQUIPE 1, 2, 3</p>

COMPOSITION DES EQUIPES

EQUIPE 1

1. HELGA
2. DAVID
3. MBENG7JE

EQUIPE 2

1. FATOU
2. BANDA
3. ELIMANE
4. MILTON

EQUIPE 3

1. JANE
2. GALL0
3. DIEDHIOU

LIST OF KEY INFORMANTS

World Vision/Senegal

Ms. Jane Blaxland	National Director, World Vision/Senegal
Mr. Gallo Cissé	Area Coordinator, World Vision/Senegal
Mr. Abdou M'Bengue	Area Coordinator, World Vision/Senegal
Mr. Banda N'Diaye	Project Manager, World Vision/Senegal
Ms. Fatou Niang	Area Coordinator, World Vision/Senegal
Mr. David Sy	Area Coordinator, World Vision/Senegal
Mr. Charles Ossey	Finance Director, World Vision/Senegal

MOH Personnel

Dr. Name Cor N'Dour	Chief, Primary Health Care Division, MOH
Dr. Talla Idrissa	District Medical Officer, Bambey
Dr. Fulgence	District Medical Officer, Mékhé
Mr. Mamadou Ngom	Health Post Nurse, Nésina Dakhar
Mr. Mamadou Mouastpha	Health Post Nurse, Baba Garage
Mr. Papa Sall	Health Post Nurse, Dinguiraye
Mr. Baye Diop	Health Education Officer, Dakar
Dr. Sra Mety Bé	Chief, Health Education, Dakar
Mr. Diebril	Health Post Nurse, Diallo
Mr. Abdoulaye	Health Post Nurse, Diallo
Mr. Abdousahuse	Health Post Nurse, Ndiayene Lack
Ms. Cheickle	Health Post Nurse, Thylmakhe
Mr. Lamine Diedhiou	Ministry of Health - Supervisor - Mékhé
Mr. Elimane Dieng	Ministry of Health - Supervisor - Bambey

Others

Dr. Binyange Martin	Medical Advisor, Family Planning Service Expansion & Technical Support, John Snow Inc.
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LIST OF DISCUSSION GROUPS

Group	# Persons	Place
Members of CERP	2	Mérina Dakhar
Members of CERP	6	Baba Garage
Community Health Workers and TBAs	3	Gollobé
Community Health Workers and TBAs	3	Ndiayéne Lack
Community Health Workers and TBAs	7	Ndioudiouf
Community Health Workers and TBAs	10	Gouye Dock
Community Health Workers and TBAs	13	Thylmakha
Mothers	10	Ndioudiouf
Mothers	12	Diamatyl
Mothers	15	Gollobé
Mothers	14	K.O. Kane
Village Health Committee	4	Ndioudiouf
Village Health Committee	4	Keur Madiop
Village Health Committee	4	Ndiayene Lack
Village Health Committee	3	Thylmakha
Village Health Committee	5	K.O. Kane
Village Leaders	12	Ndi ayene Lack
Village Leaders	7	K.O. Kane
Women's group	12	Keur Madiop
Members of Redibe/AMB	10	Baba Garage
Memmbers of UPDM, APAZONE	3	Mékhé