

World Vision Relief & Development, Inc.

WV/Senegal **FY91**
FINAL EVALUATION REPORT
TRIES CHILD SURVIVAL PROJECT
MEKHE HEALTH DISTRICT, SENEGAL
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TABLE OF CONTENTS

	<u>#page</u>
LIST OF ACRONYMS	ii
I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED	1
A. Project Accomplishments	1
B. Project Expenditures	2
C. Lessons Learned	2
II. PROJECT SUSTAINABILITY	3
A. Community Participation	3
B. Ability and Willingness of Counterpart Institutions to Sustain Activities	6
C. Attempts to Increase Efficiency	9
D. Cost-Recovery Attempts	10
E. Household Income Generation	11
F. Other	11
III. EVALUATION TEAM	12
 APPENDICES	
Appendix 1 Pipeline Analyses	
Appendix 2 Summary of Baseline and Final Survey Results	

LIST OF ACRONYMS

CSP	Child Survival Project
FY	Fiscal Year
HIS	Health Information System
IGA	Income-Generating Activity
MOH	Ministry of Health
NGO	Nongovernmental Organization
PHC	Primary Health Care
PNC	Prenatal Care
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency -for International Development
VHC	Village Health Committee
VHP	Village Health Promoter
WV	World Vision
WVRD	World Vision Relief & Development

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

- A1. The objectives of the project as outlined in the Detailed Implementation Plan (DIP) and as revised later are shown in section A2.
- A2. The accomplishments of the project by objective are shown in the tables on the following pages.
- A3. Most objectives of the project were reached or exceeded. Some of the circumstances which aided the project in reaching the above objectives include the following:
 - a. World Vision (WV) and the national office of the Ministry of Health (MOH) signed a formal letter of execution at the beginning of the project which clearly defined the roles and responsibilities of each.
 - b. Baseline data collected using the standardized KAP survey were used to set specific and realistic objectives and to define strategies for the project.
 - c. From the inception of the project, effective community mobilization ensured the active participation of the beneficiary population, particularly women. Major preventive and promotive health activities undertaken in the field were the responsibility of trained, village-based project volunteers, including female village health promoters (VHPs), traditional birth attendants (TBAs), and village health committees (VHCs).
 - d. The project increased the management capabilities of the WV and Mekhe district health agents through the organization of seminars concentrating on designing, planning, implementing, and evaluating programs in essential drugs, health information systems (HIS), maternal care, and nutrition improvement.
 - e. Regular management team meetings held between WV staff, the nine health post chiefs, the community health workers, and VHC members were used as a tool to monitor the project progress, identify constraints, and propose potential solutions.

Circumstances that hindered the project in reaching some of its objectives included the following:

- a. The centralization of the local MOH family planning program at the Mekhe district health center hindered the project's ability to adequately promote and facilitate use of modern contraceptives at the village level.
- b. Local MOH agents, who are members of different health professional unions, were frequently on strike in 1993 to protest working conditions. A recent devaluation of the local currency in January 1994 further decreased the motivation of local MOH staff.
- c. The high illiteracy rate among the project's rural populations (estimated at 70 percent) constrained the transfer of health knowledge and practices to mothers.
- d. The project area is affected by chronic drought conditions (see section II.C2).

A2a. Immunization

General Objective: To reduce morbidity and mortality due to vaccine-preventable diseases among children under 24 months through immunization against the seven childhood diseases targeted by Senegal's EPI.

Specific Objectives Written in the DIP	Revised or Updated Objective	Baseline Survey Jan. 82*	Midterm Survey July 93	Final Survey Aug. 94
1. Ensure the complete vaccination of 85% of children between 0-23 months	85% of children 12-23 months will have been fully immunized by their first birthday	32%	33% (N) 37% (M+Me)	80% (N) 68% (M+Me)
2. Ensure that 70% of pregnant women receive two doses of tetanus toxoid (TT) vaccine	70% of pregnant women will receive at least 2 doses of TT vaccine	58%	52% (N) 39% (M+Me)	80% (N) 78% (M+Me)
3. 80% of mothers with children 0-5 years will know that their children need 5 visits to be fully immunized by the age of 12 months	80% of children with children 0-5 years will know that their children need 4 or 5 contacts to be fully immunized by the age of 12 mos.	29%	34% (N) 50% (M+Me)	50% (N) 43% (M+Me)
4. 80% of mothers with children 0-5 years will know that a pregnant woman should receive at least 2 TT before delivering		28%	70% (N) 67% (M+Me)	76% (N) 76% (M+Me)
5. Once every quarter, the mobile team and 9 health posts will be supplied with gas bottles, vaccine carriers, cotton, and alcohol			Done as planned, together with village health committees and UNICEF through the Barrako Initiative	
6. Each health post will be given a Honda 50 motorbike			4 health posts (Niakhar) supplied, the remaining 5 will be supplied by UNICEF by Dec. 94	

N = Niakhar
M = Medina Dakar
Me = Meouane

* Conducted in all three arrondissements

A2b. Control of Diarrheal Diseases (CDD)

General Objective: To reduce morbidity and mortality of children under 24 months due to dehydration from diarrhea

Specific Objective as Written in the DIP	Revised or Updated Objective	Baseline Survey Jan. 92*	Midterm Survey July 93	Final Survey Aug. 94
1. Ensure that at least 50% of mothers within the three arrondissements use sugar-salt solution for the rehydration of their children	60% of infants/children (less than 24 months) with diarrhea in the past two weeks will be treated with ORT	13%	41% (N) 8% (M+Me)	60% (N) 47% (M+Me)
2. Ensure that at least 60% of mothers acquire the ability to prepare and correctly administer home solution (or sugar-salt solution)		N/A	N/A	N/A
3. Install 120 environmental sanitation committees within the three arrondissements		0	39 (N)	41 (N) 38 (M+Me)
4. Train 4 project staff and 20 local MOH staff in managing CDD programs	Dropped, as 3 project staff—the CSP manager, technical coordinator, and social change agent—received CDD training through another WW/Senegal CSP			
5. Train 80 ASCs (First Aid Agents), 160 female village health promoters (VHPs), and 80 TBAs on the techniques of preparing and administering home-made solutions and referring severe cases	VHPs and TBAs were targeted instead of ASCs	0	82 VHPs (N) 41 TBAs (N)	76 VHPs (M+Me) 23 TBAs (M+Me)
6. Train at least 60% of mothers on the preventive techniques of hygiene and sanitation	Dropped; not measurable	Nm	N/A	N/A
7. Supply each of the 9 health posts with material necessary for the operation of an Oral Rehydration Unit (e.g. teaspoon, cup, weighing scales)			4 (N)	5 (M+Me)
8. Implement a pilot latrine and jars with faucet project			68 latrines built (N)	221 latrines, 17 jars (N) 198 latrines, 40 jars (M+Me)

N = Niakhar
M = Mering Dalhar
Me = Meouane

* Conducted in all three arrondissements

A2c. Maternal Care

General Objective: To reduce maternal morbidity and mortality related to pregnancy and delivery

Specific Objective as Written in the DIP	Revised or Updated Objective	Baseline Survey Jan. 92*	Midterm Survey July 93	Final Survey Aug. 94	
1. Ensure that 80% of women receive at least three prenatal visits	80% of pregnant women will have at least 2 prenatal visits prior to the birth of their child	20%	87% (N) 89% (M+Me)	81% (N) 80% (M+Me)	✓
2. Ensure that at least 50% of mothers receive postnatal care and counselling 30 days after delivery, with emphasis on healthy practices		14%	N/A	24% (N) 12% (M+Me)	-
3. Ensure that 60% of deliveries are attended by trained TBAs or other health professionals		23%	N/A	36% (N) 33% (M+Me)	-
4. At least 80% of pregnant women will receive nutrition counselling		20%	N/A	81% (N) 80% (M+Me)	✓
5. At least 50% of nursing mothers will receive nutrition counselling		14%	N/A	24% (N) 12% (M+Me)	-
6. Train 4 WV and 20 local MOH staff in managing MCH programs		Done in FY92 with the collaboration of the MCH Institute of Khombola			✓
7. Supply each of the 9 health posts with the necessary material and supplies to carry out prenatal and postnatal visits		All 9 health posts received a standard kit according to the MOH list			✓
8. Train 80 TBAs in conducting prenatal and postnatal clinics and providing IEC on family planning			41 (N)	25 (M+Me)	-
9. Supply the 80 trained TBAs with the necessary equipment and supplies for the above			41 (N)	25 (M+Me)	-
10. Increase the incidence of child spacing of two years or more by 20%		N/A	N/A	N/A	-
11. Achieve a contraceptive use rate of at least 6%	11. 6% of mothers with children 0-23 mos. who want no more children during the next 2 years will use a modern contraceptive	2%	1% (N)	1% (N) 1% (M+Me)	-
12. Supply 80 community distributors trained in FP with condoms	12. Dropped (not MOH policy)				

A2d. Nutrition

General Objective: To reduce the incidence of global malnutrition in children under 3

Specific Objectives Written in the DIP	Refined or Updated Objective	Baseline Survey Jan. 82*	Midterm Survey July 83	Final Survey Aug. 84
1. Ensure that at least 70% of children 0-36 mos. are weighed at least one time every four months		8%	30% (N)	58% (N) 63% (M+Me)
2. Ensure that 100% of children 12-36 mos. are dewormed at least one time each year	Dropped, in accordance with new MOH policy			
3. Train 4 VW staff and 20 nurses and midwives of Mekehe health district in managing applied nutrition programs			Done in FY83 in cooperation with SANAS (Nutrition Department of the national MCH office)	
4. Supply each health post with material necessary for growth monitoring and nutrition education			Each health post received baby weighing scales (SECA) from the project; UNICEF supplied the growth charts	
5. Train 160 VHPs, 80 ASCs and 80 TBAs on the techniques of growth monitoring and nutrition education	VHPs and TBAs were targeted instead of ASCs	0	82 VHPs (N) 41 TBAs (N)	78 VHPs (M+Me) 25 TBAs (M+Me)
6. Supply each of the 120 village centers with material necessary for growth monitoring and nutrition education	Supply each of the 78 village centers with material necessary for growth monitoring and nutrition education	0	41 (N) received registers and visual aids	38 (M+Me) received registers and visual aids
	All infants 0-3 mos. will be given only breastmilk	67%	N/A	90% (N) 94% (M+Me)
	At least 80% of children 5-9 mos. will be given semi-solid foods in addition to breastmilk	25%	N/A	45% (N) 44% (M+Me)
	At least 90% of children 20-23 mos. will still be breastfeeding	78%	N/A	63% (N) 67% (M+Me)
	At least 80% of infants and children 0-23 mos. will have a GM card	28%	N/A	84% (N) 82% (M+Me)

N = Nalkhene
M = Merina Dekher
Me = Meouane

* Conducted in all three arrondissements

A2e. Malaria

General Objective: To reduce morbidity and mortality due to malaria among children under 5 and pregnant women

Specific Objective as Written in the DIP	Revised or Updated Objective	Baseline Survey Jan. 92*	Midterm Survey July 93	Final Survey Aug. 94
1. Ensure that at least 50% of children 6-36 mos. receive weekly malaria chemoprophylaxis from July to December each year		5%	45% (N)	66% (N) 53% (M+Me)
2. Ensure that at least 80% of pregnant women receive weekly malaria chemoprophylaxis from July to December each year		N/A	N/A	86% (N)# 72% (M+Me)#
3. 50% of village households will use impregnated mosquito nets (IMN)			WA	A pilot IMN project was initiated in 2 villages; in each of these 100 nets and deltamethrin were supplied
4. Each of the 120 village centers will be supplied with a first stock of chloroquine as part of the Bamako Initiative	Each of the 79 village centers will be supplied with a first stock of chloroquine as part of the Bamako Initiative			41 (N) 38 (M+Me)
5. An environmental sanitation committee will be established in each of the 120 village centers	An environmental sanitation committee will be established in each of the 79 village centers		41 (N)	38 (M+Me)

N = Niakhar
M = Merina Dalthar
Me = Mecoune

* Conducted in all three arrondissements
According to longitudinal data collected by the MCH coordinator

- A4. While the project intended to encourage the participation of communities, the degree of participation which was realized was greater than expected. Many communities have gone beyond the levels of participation expected of them and begun initiatives of their own which will directly or indirectly impact health. One community, for example, with assistance from village members living abroad, has begun construction of their own health hut.

One local leader also remarked that an unintended benefit of the project was the improved health of horses, on which the community relies for all its transport needs. Because health services are now accessible at the village level, the community is no longer required to transport patients on horses, which are., as a result, better rested!

- A5. A report on the project's final evaluation survey is attached as Appendix 2.

B. Project Expenditures

- B1. A pipeline analysis of project expenditures is attached as Appendix 1.
- B2. Overall, project expenditures amounted to \$677,564 out of an approved budget of \$688,555 (roughly 98 percent). Expenditures by most major line items in the budget, however, varied ten percent or more from that planned in the budget. The categories of expenditure that were lower than originally planned include equipment, evaluations, and personnel. Those that were higher than planned include travel/per diem, supplies, and other direct costs (rent, maintenance, communications, etc.).
- B3. In general, project finances were properly handled in accordance with WV and USAID accounting procedures.
- B4. Lessons learned that are relevant to USAID's support strategy include the following: a) the more flexibility that is allowed in the use of the budget and, specifically, in the movement of funds between budget line items, the more effective a program can be in using a grant to achieve a positive impact on the beneficiary population in the most effective and efficient way; and b) regulations governing the use of 'program income,. for example, affect the ability of PVOs to encourage and maximize the benefits from community contributions, which are fundamental to successful program implementation and to the promotion of sustainability of project benefits beyond the life of the project.

C. Lessons Learned

Among the main lessons learned regarding this project are the following:

- The chances of success in a child survival program are greatly enhanced if it is built on a foundation of community participation and addresses community felt needs (such as village water supply).
- Giving village health committees clearly defined job functions and, most importantly, something tangible to manage (in the case of this project, funds generated through the sale of medicines and other user fees) gives weight to their role in the project, increases their participation, and helps to ensure their longevity.

- The incorporation of income-generating activities (IGAs) into project activities addresses one of the key constraints to good health and increases the capacity of community members to address their own health needs. It can thus help to ensure financial sustainability of project activities and benefits.
- A key means of institutionalizing health activities at the village level is the integration of project activities with other sectors-agriculture, water, literacy, women in development, and social mobilization.
- Major participation by the PVO in actual service delivery is not always essential to improving coverage rates as long as adequate social mobilization and community participation have been promoted.
- Better results can be expected when women have a significant role in the CSP.

II. PROJECT SUSTAINABILITY

A. Community Participation

- A1. The following community leaders and members were interviewed:

Village Health Committee, Ndialba
 Village Health Committee, Golobe
 Cheik Seek, Chief, Ndialba village
 President of the Women's Association, Golobe village

- A2. The project activities most often cited at the community level as being effective were the training and equipping of community-based VHPs and TBAs and the construction of village-based health huts. This was perceived as having increased effective community access to health services and community-level capacity to address the majority of health needs.

Other activities mentioned by community members as being effective included the provision of latrines, water jars with faucets (to promote hygienic water storage and handling), ant insecticide-treated mosquito nets.

- A3. In order to enable communities to better meet their basic health needs and increase their ability to sustain effective child survival activities, the project used the following approaches:

- a. Emphasizing a variety of social mobilization activities, under the direction of an "animateur," to increase community awareness about project activities and to increase community involvement in all phases of project implementation.
- b. Strengthening the community-level health system through the training of women leaders as TBAs and VHPs. TBAs were trained and equipped to conduct safe and hygienic deliveries in the villages and to refer high-risk births to health facilities.

Health promoters were trained to do the following:

Mobilize community members to attend vaccination and growth-monitoring rounds conducted by MOI personnel.

- Encourage pregnant women to attend prenatal care (PNC) consultations.
 - Provide education to community members at vaccination/PNC sessions and at their homes on key health and nutrition-related topics, including the importance of immunizations, the EPI schedule, prevention and home management of diarrheal diseases, prevention and treatment of malaria, breastfeeding and improved weaning practices, the importance of growth monitoring, family planning, and PNC.
 - Follow up immunization defaulters, malnourished children, and other cases needing special attention.
- C. Supporting the government's initiative to establish a cost-recovery system, whereby funds are generated through the sale of medicines and through fee-for-services and are used to replenish supplies of essential medicines, provide transport for MOH staff, pay honorariums to VHPs and TBAs, etc.
- d. Facilitating the formation of VHCs. VHC members were trained to collect and make decisions about the use of the cost-recovery funds.
- e. Extending the health infrastructure to the village level by providing resources for the construction of health huts at each of the village centers (a primary village surrounded by several 'satellite' villages).
- f. Improving the ability of community members to maintain appropriate levels of hygiene and sanitation by providing resources and training for the construction of latrines and ceramic jars equipped with faucets.
- g. Providing mosquito nets, training, and materials for impregnating the nets with insecticides.
- h. Addressing other development needs in the project area through integration of the project with other World Vision Senegal development initiatives (e.g., constructing boreholes and providing education related to the use of safe water, giving assistance with market gardens, promoting IGAs, and conducting literacy training).
- A4. Communities were involved in the design of project activities through a series of social mobilization meetings prior to the initiation of the project to identify problems, establish priorities, and discuss possible strategies for addressing these. Communities also gave advice to project staff regarding the most appropriate way to cluster the villages in the project area, and they selected candidates to be trained at VHPs, TBAs, and VHC members.
- The community's role in the implementation of project activities is described in the preceding section. Additional activities include the provision of local materials and labor for the construction of health huts and latrines. Finally, through feedback sessions, communities have participated in analyzing the baseline and final data survey results.
- AS. At the time of the final evaluation, there were 79 functional VHCs (out of the 80 formed and trained) and an additional nine

health post committees. The committee members were selected by the communities themselves (from all those living in the central and satellite villages) and include among others the trained VHPs and TBAs. This assured the participation of women (in fact, the two VHCs interviewed during the course of this evaluation were composed entirely of women).

One of the committees interviewed met once each week. The other met regularly on an informal basis and formally three to four times a year. On average, project staff believe that these committees are meeting at least quarterly.

- A6. Since VHCs manage the user fees and funds generated through sales of medicines, latrines, water jars, and mosquito nets, decisions related to the use of these funds are among the most significant made during meetings. One committee also expressed that they often met to discuss the most effective means for educating community members on health-related issues.

Other decisions made by VHCs, according to project staff, are those related to the planning of maternal and child health care activities with the health post chief, motivation of community health workers, IGAs, renewal of TBA and VHE supplies, encouraging community participation, and construction of health huts and latrines.

- A7. A major responsibility of the health committees is to fix the fees for health services and to decide how to use the money collected (e.g., purchase of additional medicines, supplies for TBAs, payment for services of VHPs and TBAs, etc.). VHCs are also responsible for managing health hut supplies and materials provided by WV for building latrines. Finally, since VHPs and TBAs are members of the committees, these meetings provide a forum for discussing their activities and obtaining necessary support.

During quarterly feedback meetings with project staff, committee members have the opportunity to make recommendations for more effective project implementation. One instance where a VHC was instrumental in affecting the direction of the project came when it was observed that many pregnant women were not attending prenatal consultations despite the promotional activities of the health workers. During a feedback meeting, the committee decided that they would be more actively involved in the sensitization for PNC. They began to identify pregnant women and to refer them for consultation. This procedure was adopted by the project for other VHCs with impressive results.

- A8. As part of the cost-recovery strategy, communities pay nominal fees for the following: vaccinations, growth monitoring, PNC consultations, medicines (including chloroquine), family planning supplies, deliveries, latrines, water jars with faucets, and mosquito nets. These funds are then used to purchase more drugs and supplies, to motivate community health workers, and to pay for some of the costs for refresher training of promoters and TBAs.

Community members volunteer their time and labor as VHPs, TBAs, and VHC members. They contribute their labor and local materials for the construction of health huts and latrines. In some areas, horse-drawn carriages are provided by communities for transport of patients and to carry health post chiefs without motorized transport to villages for the mobile clinics.

- A9. The successful involvement of communities in project activities can be attributed in large measure to the emphasis placed on community awareness building, education, and mobilization to participate. The fact that the individuals working on the project's behalf are community members selected by the communities is another reason for the successful community participation. Another key factor is the involvement of communities themselves, through the VHCs, in the management of the locally generated resources.

Chronic drought over the past decade and the recent devaluation of the local currency constitute two major external constraints which could negatively impact the ability of local committees to ensure financial viability of project activities (see also section II.C2).

B. Ability and Willingness of Counterpart Institutions to Sustain Activities

- B1. The following people were interviewed:

Fatimata Hane Sy	Rural Health Officer, USAID
Chris Barret	Health Officer, USAID
Dr. Birahime Diongue	Director, World Bank Rural Health Project
Dr. Lenin Guzman	Director of Bamako Initiative Project, UNICEF
Dr. Lamine Sarr	Director General, Department of Public Health, MOH
Dr. Issatha Diallo	National PHC Supervisor, MOH
Dr. Mactar Camara	Regional Medecin Chef, Thies
Lamine Gueye	Regional PHC Supervisor, Thies
Fulgence Ndiaye	District Medecin Chef, Mekhe
Lamine Dielhieu	District PHC Supervisor, Mekhe
Marieme Mbaye	Nurse Midwife in charge of TBA training, Mekhe
Malick Kaire	Nurse in Charge, Mbayene Health Post
Mr. Ndiaye	Nurse in Charge, Koul Health Post
David Gaye	Director, CERP (Center for Expansion of Rural Programs)
Bruce Wilkinson	Director, WV West Africa Regional Office
Al Johnson	Director, WV Senegal National Office

- B2. The project is closely linked with the MOH, particularly at the district level. The project was designed together with the MOH, based on the Mekhe district five-year health plan, and a letter of execution detailing the roles and responsibilities of each party was written and signed. The project's annual plans of action are coordinated with and incorporated into those of the district. Ad hoc coordinating meetings between project and key MOH staff occurred frequently.

At the level of implementation, the project has helped to equip and provide supplies for all nine of the health posts in

the area and has provided transport (motorcycles) to four of the health posts. Several MOH staff received training from project staff (see section II.B5).

Training for and supervision of VHPs and TBAs was conducted jointly with the health post chiefs. WV sponsored (provided per diems) for 66 TBAs to attend MOH training at the Mekhe maternity center, and project staff have also assisted in the facilitation of some of this training.

Other organizations active in the project area include UNICEF, The World Bank, and a French NGO, Source de Vie. UNICEF has supported the MOH's EPI program through the provision of vaccines, cold chain equipment, and a motorcycle for the district health supervisor. Project staff meet periodically with UNICEF staff during regional-level meetings and attended an EPI training workshop coordinated by UNICEF. The project has coordinated training activities with The World Bank, which has also provided a vehicle for the supervision of health activities in Mekhe district and has rehabilitated the Mekhe health center. Source de Vie built a health hut in one of the villages where WV trained and equipped a TBA and two VHPs.

- B3. The main institutions expected to take part in sustaining project activities are the MOH at the regional, district, and health post levels. At the community level, VHCS, village women's groups, the Centre d'Expansion Rural Polyvalent, and GIEs (Economic Interest Groups) constitute the key local institutions for sustaining activities.

UNICEF has a relatively long-term presence, and The World Bank's rural health program will be in place through 1997. Finally, and significantly, WV will continue to be involved in health activities and will integrate them with initiatives in other sectors such as water, agriculture, women in development, and education as part of its long-term area development plan (up to an additional five years or so after the second phase of funding ends; i.e., after FY97).

- B4. Several project activities were repeatedly cited during this evaluation for their effectiveness, including:
- a. Community mobilization and education.
 - b. Training of 158 VHPs and 66 TBAs.
 - c. Support for the construction of 75 health huts.
 - d. Provision of material support (e.g., motorcycles, health post supplies, and equipment).

The project was also widely praised for its integration with and support of government services and for its strategy of integration with other WV development activities such as the provision of potable water. One senior member of the regional MOH team also commended the project for its ongoing monitoring, evaluation, and refinement of project activities, which has made them even more effective.

- B5. In addition to working together with the health post chiefs (in supervision of community-based health workers, conducting mobile service delivery, etc.), project staff have provided formal training to the health post chiefs, the district medecin chef, and eight midwives/nurses at the district level in the following: EPI, IEC techniques, nutrition, maternal care, management of health information systems, survey methodologies, and computers/software. All but the last two

were conducted during five-day workshops, in collaboration with national- and regional-level trainers from the MOH.

One key member of the staff, the Technical Coordinator, has been seconded to the project from the MOH.

- B6. The focus of the project has been on promoting community-level capacity to sustain project activities. To this end, two VHPS, a TBA, and a VHC have been trained in each village center to continue mobilizing and educating communities, to manage locally generated resources, to provide first-line health care, and to support the MOH health services. Local craftsmen have been trained in the construction of latrines.

Given that a) resources are generated on an ongoing basis through the Bamako Initiative, b) levels of community health knowledge have increased, and c) village-level volunteers seem to be well-motivated and have incentives that they consider to be adequate, activities are likely to be sustained at the village level. The fact that WV will continue to work in the project area well after A.I.D. funding ends and will continue to integrate health activities with other activities that have a critical impact on health (water, agriculture, IGAs, literacy), with a focus on women, will lend crucial support to communities.

It is less certain that the MOH will be able to provide all of the necessary financial, human, and material resources necessary to sustain project benefits. Currently, there are nine health posts, each staffed with one nurse, serving the entire project area. In addition to the responsibilities at the health post (consultations, prenatal care, immunizations, etc.), nurses are expected to provide weekly (mobile) services to all villages in their zones of responsibility and also to provide supervision for their VHPs and TBAs.

Further, there are only two staff members at the district level responsible for supervision of all the nurses, coordination of all health activities in the district, management of the district health center, etc. Workloads are too heavy, but there are not likely to be additional staff any time soon. The need for additional training in management of health services and

In terms of financial and material resources, the MOH is putting its hopes in the successful implementation of the Bamako Initiative which since its inception has shown very promising results. However, there is some question about community members' ability to continue paying for services over the long run, particularly given the recent drop in purchasing power after the devaluation of the local currency.

There are commitments from UNICEF and The World Bank to continue supplying certain material needs (drugs, equipment, etc.) as well as training, though these commitments are for limited periods of time. The World Bank is discussing with the MOH the possibility of constructing an additional health post in the project area.

- B7. See section B4.
- B8. The major shift in responsibilities from the project to local institutions came after the mid-term evaluation near the end of the second year of project funding, when it was recommended that project staff discontinue actually providing services (accompanying health post chiefs during vaccination rounds, etc.). This is now strictly the responsibility of the health

post chief. During the third year, it appears that supervision of promoter and TBAs was also largely phased over to MOH staff. This was done, however, without a well-documented plan or schedule.

B9. The MOH expects to sustain the current CSP through the financial surplus gained through the implementation of the Bamako Initiative. There have been, however, no written commitments from them, nor from any other NGOs or local agencies.

B10. Not applicable.

B11. Several MOH staff were involved in the design, implementation and analysis of the final evaluation survey. A local organization, Info Service, assisted with the input of data.

Feedback meetings were conducted to discuss the results of the survey and findings of the evaluation team and helped to shape the final recommendations of this team. These meetings included the Medicin Chef of Thies region and Mekhe district and the director of The World Bank Rural Health Program.

C. Attempts to Increase Efficiency

C1. The strategies adopted by the project to reduce costs and/or increase efficiency include the following:

- a. A decentralized approach, focusing on the use of volunteer community health workers and village health committees to plan and provide services and to manage resources, in cooperation with MOH staff at the health posts.
- b. Active social mobilization to promote community participation in project activities and community contributions.
- c. Integration of project activities into the action plans of the MOH.
- d. Integration of project activities into WV's larger area development plan to combine efforts and to take advantage of additional staff, resources, and other complementary inputs for increased benefit at lower cost.
- e. Clustering several villages (satellite villages around a village center) to avoid the need to visit each village separately.
- f. Using project-trained health promoters in village centers to train additional promoters in satellite villages.
- g. Improving staff technical and managerial capacity through training and attendance at a variety of workshops and seminars.
- h. Use of an exclusively Senegalese staff, all but one of whom were based in Mekhe.

c2. Most of the strategies used to increase project efficiency have been highly successful. Two key factors that have negatively influenced project efficiency, however, are the chronic drought and the recent devaluation. Constant shortfalls in the food crop harvest, due to the drought, have greatly diminished the purchasing power and discretionary

income available to many villagers. The drought has also resulted in extensive out-migration from the project area, particularly among the youth, who constitute the bulk of the rural agricultural work force.

The devaluation of the FCFA in January 1994 resulted in widespread inflation, which has affected the government's ability to finance social services, including health, and has reduced many community members' ability to purchase food and essential drugs. Drug prices are expected to continue increasing slowly.

- c3. The strategies used by the project (section C1) were effective and are in large part replicable.

D. Cost-Recovery Attempts

- D1. The cost-recovery activities of the project were based on the principles of the Bamako Initiative. For example, each of the 79 village centers were provided with an initial stock of chloroquine tablets, which were then sold (at a cost of 5 FCFA, or about one penny, each), the proceeds from which were used to renew the stock. User fees are also paid; e.g., for vaccinations/growth monitoring, prenatal consultations, TBA-assisted deliveries; and maternal health cards are purchased. Finally, the project supplied materials for the construction of latrines and ceramic jars with faucets and distributed impregnated mosquito nets, for each of which a small payment was required.

VHCs were responsible for setting the level of the fees and the prices and managed all of the funds generated. These were used to replenish essential drugs and supplies for the health huts or TBAs, to provide transport for health post chiefs, and as motivational stipends for the VHPs.

- D2. The funds generated through the cost-recovery efforts went directly to the health committees rather than to WV and so did not profit WV financially except to the extent that they reduced the amount of money that needed to be budgeted for certain recurrent costs, such as the purchase of additional drugs and supplies.

The dollar amount of costs recovered through the various mechanisms is difficult to estimate given the extent of integration of project efforts and record-keeping with those of the MOH. Funds raised through the sale of latrines, water jars, and mosquito nets, however, totalled \$1,739.62. These funds were added to the VHC accounts.

- D3. As indicated, the project's cost-recovery efforts followed the MOH's implementation of the Bamako Initiative. They are not an initiative of the project itself and thus have not affected the project's reputation in the community. Due in large part to the project's intensive social mobilization activities, WV has established a strong relationship with most villages, and community members have a sense of partnership and ownership of the project due to the contributions they have made.

User fees and the cost of medicines are established by VHCs in order to help ensure that services are affordable to all. Exceptions to the requirement to pay are made in special cases of individuals who cannot, and this has largely eliminated any inequities in service delivery.

- D4. There were no household IGAs implemented directly by this project, though the project benefitted from the IGAs conducted through other WV sectors in the project area (see section E).
- DS. Cost-recovery efforts such as those implemented by the Thies CSP can be a key factor in the sustainability of project activities. Allowing VHCs to manage the funds generated by cost-recovery efforts solidifies their participation by providing them with a very tangible and meaningful responsibility.

With adequate social mobilization and awareness creation, communities, at least in this part of Senegal, are willing and able to participate both in contributing and managing financial resources.

E. Household Income Generation

- E1. The project itself did not implement any IGAs. It was integrated closely, however, with the activities of other WV sectors, such as agriculture and Women in Development, through which IGAs were implemented in the same area. These IGAs included cultivation of market gardens, soap making, milling machines, tie-dyeing, and others. They were largely conducted through women's associations, the members of which were often members also of the VHCs or even trained as VHPs or TBAs. Funds raised were frequently applied as community contributions to the construction of health huts, to the purchasing of supplies for the health huts, and to other health-related activities.
- E2. Not applicable.
- E3. The funds raised through the IGAs increased the capacity of community members to participate in and contribute towards health services and other activities (see section E1) but did not directly cover any project costs.
- E4. Successful IGAs can enable community members to take greater responsibility for ensuring the health of their own families and can thus be considered an integral part of child survival.

F. Other

- F1. The key sustainability-promoting activities effectively carried out by the project are as follows:
- Integrating project activities into the long-term health plans of the MOH and assuming a facilitative, supportive role (focusing on social mobilization, health education, and training) rather than that of service provider.
 - Building the capacities of community beneficiaries in planning, implementing, monitoring, and evaluating their own health and development activities (see section II.A3).
 - Encouraging beneficiaries to participate in cost-sharing through the contribution of personnel, labor, and material and financial resources and to initiate IGAs (see section II.A8).
 - Integrating CSP activities within the broader context of an area development plan involving other WV development activities.

The level of integration of the project within the activities of the local MOH together with the impressive level of participation by project-trained, community-based workers have fostered a sense of ownership of project activities by the MOH and by the community. This is evidence of a significant potential for sustainability.

III. EVALUATION TEAM

A1. The members of the evaluation team were as follows:

Dr. Andrew Haynal Independent Consultant

Lamine Thiam Project Manager, Thies Child Survival Project, World Vision Senegal

Tom Ventimiglia West Africa International Programs Officer, WVRD

A2. This evaluation report was coauthored by the members of the evaluation team.

Appendix 2

Summary of Baseline and Final Survey Results
 Thies Child Survival Project
 World Vision Senegal

#	INDICATORS	Baseline Results Numerator (N) Denominator (D) Percent (P)	Final Results Numerator (N) Denominator (D) Percent (P)
1	<u>NUT: Initiation of Breastfeeding</u> -Percent of Infants/children (less than 24 months) who were breastfed within the first eight hours after birth.		
2	<u>Exclusive Breastfeeding</u> -Percent of infants under 4 months who are being given only breast milk.	1a- 49 P=67.1% D= 73	N= 84 P = 92% D= 91
3	<u>NUT: Introduction of Foods</u> -Percent of infants between five and nine months who are being give solid or m-solid foods.	1a= 14 P=25% D= 55	N= 40 P = 44% D= 90
4c	<u>NUT: Persistence of Breastfeeding</u> -Percent of children between 20-24 months who are breastfeeding (and being given solid/semi-solids).	N= 11 P=79% D= 14	A = 29 P = 64% D= 45
5	<u>CDD: Continued Breastfeeding</u> -Percent of Infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more breast milk.	N= 83 P= 70% D-119	A- 108 P = 73% D= 148
16	<u>CDD: Continued Fluids</u> -Percent of infants/children (less than 24 months) with diarrhea In the past two weeks who were given the same amount or more fluids other than breast milk.	N= 69 P=58% D-119	N= 105 P = 71% D= 148

¹ Including Niakhene, Merina Dakhar, and Meouane Arrondissements

7	CDD: continued Foods- Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more foods.	N= 34 P= 28% D=119	N =76 P = 51% D= 150
8	CDD: ORT Usage-Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.	N= 17 P=14% D= 119	N= 69 P = 47% D= 148
9	Pneumonia Control:Medical Treatment- Percent of mothers who sought medical treatment for infant/child (less than 24 months) with cough and rapid, difficult breathing in the past two weeks.		
10	EPI:Access-Percent of children 12 to 23months who received DPT1.	N= 47 P=64% D= 73	N= 170 P= 86% D= 198
11	EPI:Coverage-Percent of children 12 to 23 months who received DPT3	N= 33 P=45% D= 73	N= 153 P= 77% D= 198
12	EPI:Measles Coverage-Percent of children 12 to 23 months The received Measles vaccine.	N= 30 P=41% D= 73	N= 152 P= 76% D= 198
13	EPI:Drop Out Rate-Percent change between DPT1 and DPT3 doses [(DPT1-DPT3)/DPT1] for children 12 to 23 months.	N=14 P=30% D=47	N= 17 P= 16% D= 170
14	MG: Maternal Card-Percent of mothers with a maternal card.	N= 73 P=31% D= 237	N= 207 P= 43% D=480
15	MG: Tetanus Toxoid Coverage (Card)- Percent of mothers who received two doses of tetanus toxoid vaccine.	N= 47 P= 59% D= 80	N= 163 P= 79% D= 206
16	MG: Ante-Natal Visits (Card)-Percent of mothers who had at least two ante-natal visits prior to the birth Of the birth of the child.	N= 52 P= 68% D= 77	N= 165 P=80% D= 205

1	<u>MC: Modern Contraceptive Usage-</u>	N= 4	N = 3
7	Percent of mothers who desire no more children in the two next years, or are not sure, who are using a modern contraceptive method.	P= 2.1% D= 188	P=0.8% D= 364

Note:

* The Project does not include Pneumonia Control activities.